

LABOR

Panel Rewrites Its Benefits Bill To Cut Millions From Deficit

After discovering that legislation to extend unemployment benefits would add \$140 million to the federal deficit over five years, the House Ways and Means Committee rewrote the financing mechanisms so the measure would instead reduce the deficit by an estimated \$249 million. Without an extension, benefits are set to expire July 4.

The committee approved a new \$5.8 billion bill (HR 5260) by voice vote May 27. It is likely to move to the House floor the week of June 1. (*Weekly Report*, p. 1449)

The measure would provide 20 to 26 weeks of emergency federal benefits to workers whose 26 weeks of state benefits have run out. The new bill includes three changes in revenue-raising provisions. It would:

- Change the date for prohibiting businesses from taking tax deductions for executive compensation packages worth more than \$1 million. The original bill (HR 4727) would have applied the prohibition to compensation paid or accrued beginning July 1, 1992. The new bill would apply the provision retroactively to Jan. 1, 1992. It would bring in \$26 million in fiscal 1992 and \$2 billion over six years.

- Delete the estimated income tax provision for self-employed people who pay on a quarterly basis. The original bill would have required that estimated tax payments be based on 15 percent more than what a person owed the previous year or 90 percent of what a person will earn in the current year. That bill tried to simplify a complicated provision enacted in the unemployment legislation last November. Now the November provision would be left intact. It requires people who estimate their taxes and whose income jumped by at least \$35,000 in one year to pay according to what they actually owe the government, rather than what they owed the year before. The committee dropped the simpler provision after discovering that it would not raise any money.

- Delay for one year the rate decrease in the federal unemployment payroll tax that employers pay. Employers traditionally pay a 0.8 percent tax on the first \$7,000 of each worker's

earnings. But Democrats, believing the system is unfair to employers with a high number of low-income workers, have sought to widen the distribution of the tax by raising the wage base from \$7,000 to \$28,200. At the same time, they want to lower the tax rate so as not to raise taxes — and lose Republican support. Under the new bill, the tax rate would drop from 0.8 percent of an employer's wage base to

0.3 percent in 1995 and 1996, rather than in 1994, and to 0.25 percent in 1997. The bill would also delay for one year — from 1994 to 1995 — the increase in the wage base from \$7,000 to \$28,200. If the provision had taken effect in fiscal 1994, it would have lost \$267 million that year. But over six years, the provision would bring in \$212 million.

With these provisions, the bill would be paid for over a six-year period. But the revenues would not come in during the same year as the outlays. The bill would still require a House waiver of the budget law because it violates the pay-as-you-go requirements of the 1990 budget agreement between Congress and the White House. ■

SECTION NOTES

Treatment Agency Overhaul Fails A Second Time

For the second time in two weeks, the House failed May 28 to approve compromise legislation to reorganize the nation's substance abuse and mental health programs.

By a vote of 214-157, members recommitted S 1306 to a House-Senate conference. (*Vote 150*, p. 1566)

The bill would reauthorize and overhaul the Alcohol, Drug Abuse and Mental Health Administration. On May 19, the House failed to approve the conference report on the bill (H Rept 102-522) by the two-thirds margin required for passage under a fast-track procedure. (*Weekly Report*, p. 1453)

The motion adopted by the House instructs conferees to restore Senate-passed language barring federal funding for "needle-exchange" programs. Such programs provide drug addicts with clean hypodermic needles to prevent the spread of AIDS and other bloodborne diseases.

Expanded Veterans' Benefits Approved by House Panel

Veterans' health-care benefits and services would be expanded under bills approved May 28 by the House Veterans' Affairs Committee.

The committee voted 30-0 to approve legislation (HR 5192) to spend more money on veterans' health-care facilities and serve more veterans.

The bill would clarify that the

Department of Veterans Affairs has the authority to collect on Medicare supplemental insurance policies, known as "medi-gap" policies, for care provided beginning April 7, 1986, for non-service-connected disabilities. Medicare would also reimburse the VA for services to Medicare-eligible veterans receiving "non-mandatory" care.

Other bills were approved by voice vote:

- HR 5193 would expand cost-sharing between the Defense Department and VA. The measure would allow the VA to provide medical services in areas where Defense health facilities are scheduled to close.

- HR 5263 would create three-year demonstration projects at three to seven former Defense sites. The VA would be reimbursed by Medicare for hospital care and services to people who are eligible for Medicare as well as eligible military retirees or veterans' dependents.

Medical Equipment Rules Deadline Extended

The House approved a bill (S 2783) by voice vote on May 28 that would extend until Nov. 28, 1992, the deadline for the Food and Drug Administration to issue final regulations for implementing sections of a 1990 law stiffening federal oversight of medical equipment. The measure is cleared for the president's signature. (*Weekly Report*, p. 1456)

By Jill Zuckman

SECTION NOTES

House GOP Offers Its Plan For Health-Care Reform

House Republicans formally entered the fray over health-care reform June 4, unveiling a package of "incremental" changes that closely tracks the proposals made by President Bush in February.

"We House Republicans feel strongly that we should move ahead with these reasonable measures rather than take an all-out or nothing leap forward toward some ill-defined utopian



Michel

system," said Minority Leader Robert H. Michel, R-Ill.

Developed over nearly a year by two dozen House members with help from administration officials, the measure would overhaul the insurance market for small businesses, expand community health centers that serve low-income patients and alter the way malpractice claims are handled. Unlike the Bush plan, the House proposal does not include expensive new tax credits to help the uninsured purchase coverage. Members would offset the estimated five-year \$8.6 billion cost by lowering Medicare and Medicaid payments.

Judiciary Committee Endorses Voting Rights Measures

Two bills aimed at expanding protections under the Voting Rights Act of 1965 (PL 89-110) were given voice vote approval June 4 by the House Judiciary Committee.

The first measure (HR 4312) would extend for 15 years a provision that provides bilingual voting assistance to non-English speaking minorities. Under current law, set to expire Aug. 6, ballots are printed in two languages in 68 counties in which at least 5 percent of the population does not speak English.

The bill would add major cities — such as Los Angeles, San Francisco and Philadelphia — with single-language minority populations of

at least 10,000 non-English-speaking people.

Bill McCollum, R-Fla., offered an amendment that would have required that localities providing ballots in two languages include a disclaimer saying the English ballot is the official one. It failed 9-25.

Another bill (HR 5236) would reverse U.S. Supreme Court rulings that proponents say have restricted the scope of the Voting Rights Act.

The bill would prevent changes in voting practices, procedural rules or the decision-making power of an elected official without clearance from the Justice Department.

WIC Pilot Project Wins Agriculture Approval

Legislation expanding and reauthorizing a pilot project that promotes the use of fresh fruits and vegetables in the Special Supplemental Food Program for Women, Infants and Children (WIC) received voice approval from the House Agriculture Committee on June 4 after it was amended to emphasize the committee's role in overseeing the program.

The bill (HR 3711) was approved May 20 by the House Education and Labor Committee — the panel with jurisdiction over the WIC program. Agriculture asked for oversight because language in the measure involves the use of fresh commodities.

Agriculture Chairman E. "Kika" de la Garza, D-Texas, offered an amendment to reinstate language saying that a purpose of the bill is to "expand the awareness and use of farmers' markets and increase sales at such markets." This purpose, included in the initial 1988 legislation, was not part of the Education and Labor reauthorization bill.

De la Garza's amendment, approved by voice vote, also requested that a status report to be compiled on the program be submitted to the Agriculture Committee. A companion measure (S 2761) passed the Senate by voice vote on May 20.

WIC participants in the nine states currently involved in the demonstration program are provided with up to \$20 in coupons annually, redeemable for fresh fruits and vegeta-

bles at farmers' markets.

The \$3 million farmers' market project was originally authorized for three years in the 1988 Hunger Prevention Act (PL 100-435). The administration and some WIC advocates oppose an expansion of the program because they see it competing for limited dollars with the main \$2.6 billion WIC program, which provides vouchers for such food items as infant formula and eggs.

Mental Health Agency Bill Is Stalled in Senate

Compromise legislation to reorganize federal substance abuse and mental health programs has hit another roadblock, this time in the Senate.

House and Senate conferees as well as the Bush administration agreed May 12 to a compromise version of a bill (S 1306) to overhaul the Alcohol, Drug Abuse and Mental Health Administration. But approval of the conference report has been anything but routine.

The House twice rejected it, most recently on May 28, when Republicans complained that it lifted a ban on federal funding of "needle exchange" programs designed to help drug addicts protect themselves from AIDS and other blood-borne disease. (*Weekly Report*, p. 1538)

The House voted to recommit the bill to conference; members restored the ban on needle exchanges and a new conference report (H Rept 102-546) was filed June 3.



Graham

But members from states that stand to lose money under a new formula for distributing substance abuse and mental health prevention funds are still unhappy. When the Senate tried to take up the conference report June 4, Sen. Bob Graham, D-Fla., objected. The Senate is currently scheduled to vote June 9 on Graham's motion to recommit the bill to conference yet again.

SECTION NOTES

Substance Abuse Bill Sent to White House

A measure to overhaul federal substance abuse and mental health programs — including block grants to states — finally cleared Congress on July 1 when the House approved the conference report on S 1306 (H Rept 102-546).

The Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) would be substantially overhauled under provisions in the bill now headed to the White House.

The measure also contains language that bans the use of federal funds for "needle exchange" programs that would help prevent the spread of AIDS by providing drug addicts with sanitized needles. The House had twice defeated earlier versions of the conference report because it did not include that ban.

The House first voted, 266-138, to waive all points of order against the conference report; then, following some debate on the funding formula, approved the report on a 358-60 vote. (*Votes* 252-253, p. 1994)

Most of the opposition came from the states that stand to lose money under a new formula for distributing funds. "Florida, a microcosm of the nation's drug problems and anti-drug successes, will lose \$16.5 million in critically needed substance abuse and mental health funding unless implementation of this bill is delayed," said Tom Lewis, R-Fla.

The Senate had approved the conference report on June 9. (*Weekly Report*, p. 1704)

Regulations Approved For Health Insurers

Sellers of insurance to protect consumers from the cost of long-term health care would be subject to new federal regulations under a bill approved by the Senate Labor and Human Resources Committee on July 1.

The bill would establish federal standards for coverage, would prohibit high-pressure sales tactics and would revise the way insurance agents are currently paid so as to deter incentives to sell individuals more policies than they need.

To gain the support of Republicans, bill sponsor and Committee Chairman Edward M. Kennedy, D-Mass., dropped a provision that would have required all policies to include inflation-protection clauses. Many policies, purchased years in advance of the time they will be used, wind up providing insufficient coverage.



Kennedy

House Votes for Independence For Social Security Agency

On June 29, for the third time in the past decade, the House voted overwhelmingly to give the Social Security Administration independence from the Cabinet-level Department of Health and Human Services (HHS). Twice before the measure has died in the Senate; this year, its fate in the Senate is uncertain.

The House passed HR 5429 by a 350-8 vote. "I see this vote as an opportunity to do something tangible this year to strengthen the Social Security system," said Dan Rostenkowski, D-Ill., the bill's sponsor. (*Vote* 242, p. 1992)

Proponents of the legislation say it has a chance of passage in the Senate this year because lawmakers are increasingly concerned about the financial health of the Social Security-administered disability fund.

But the administration has repeatedly said that it opposes any effort to separate Social Security from HHS.

Rostenkowski's Ways and Means Committee had given voice vote approval to the bill June 24. The Senate Finance Committee approved a companion measure (S 33) June 11. (*Weekly Report*, pp. 1890, 1705)

The key difference between the two versions is that the House bill would establish an independent three-member board to run the agency; under the Senate draft, the agency would be governed by a single commissioner appointed by the president and advised by a seven-member board.

Labor-HHS Spending Bill Gets Panel's Approval

Working behind closed doors, members of the House Appropriations Subcommittee on Labor, Health and Human Services, and Education completed work on their fiscal 1993 spending bill July 2.

It took the subcommittee two days to finish marking up the \$244 billion measure, in what members described as one of the most difficult sessions ever. The subcommittee, which funds some of the federal government's most popular health, social service and education programs, was hindered because the approximately \$1 billion increase in budget authority it received in the annual allocation process was more than consumed by the \$3 billion in fiscal 1993 spending that members put in last year's bill. Thus, the amount available for the current bill was reduced by roughly \$2 billion.

The full Appropriations panel is not expected to take up the bill, the second-largest of the 13 regular annual spending bills, until after the Democratic National Convention.

Indian Affairs Panel Acts on Measures

Solid waste disposal on Indian lands would be regulated under a bill approved July 2 by the Senate Indian Affairs Committee. The measure (S 1687), endorsed by voice vote, would provide grants and technical assistance to help Indian tribes develop waste management programs. It would authorize \$25 million for fiscal 1993-97 for the assistance.

Sponsor John McCain, R-Ariz., said the bill is necessary because some states are trying to use Indian lands — which are not subject to state environmental laws — for everyone else's garbage. Also, some tribes want to open waste dumps to help their economies.

The Indian Affairs panel also approved, by voice vote, a measure (S 2044) that would authorize \$5 million in fiscal 1993 to establish a program of grants to help assure the survival of Indian languages. Unspecified sums would be authorized in the following four years for the grant program.

HOUSE VOTES 246, 247, 248, 249, 250, 251, 252, 253

246. HR 5487. Fiscal 1993 Agriculture Appropriations/Food for Peace. Miller, R-Wash., amendment to reduce the \$343.1 million in funding for Title I of PL 480, the Food for Peace program, by \$25 million. Adopted 410-4: R 162-1; D 247-3 (ND 173-2, SD 74-1); I 1-0, June 30, 1992. (Before adoption the Miller amendment was amended by a Kasich, R-Ohio, amendment. Miller would have originally cut \$242.4 million.) (Story, p. 1935)

247. HR 5487. Fiscal 1993 Agriculture Appropriations/Debt Restructuring. Glickman, D-Kan., amendment to reduce the amount the president can forgive for debt restructuring under the Enterprise for the Americas initiative from \$69.5 million to \$34.5 million. Rejected 78-333: R 23-141; D 54-192 (ND 40-131, SD 14-61); I 1-0, June 30, 1992. (Story, p. 1935)

248. HR 5487. Fiscal 1993 Agriculture Appropriations/Overhead Spending. Smith, R-Texas, amendment to cut overhead spending for all agencies in the bill except the Food and Drug Administration by 10 percent. Adopted 214-191: R 125-39; D 88-152 (ND 64-104, SD 24-48); I 1-0, June 30, 1992. (Story, p. 1935)

249. HR 5487. Fiscal 1993 Agriculture Appropriations/Tobacco Promotion Abroad. Separate vote at the request of Owens, D-Utah, on the Owens amendment to prohibit funds for the Market Promotion Program from going to promote tobacco sales abroad. In fiscal 1992, \$3.5 million of the program's funds went to a group called the Tobacco Associates, which promotes the sale of U.S. tobacco products abroad. Adopted 331-82: R 123-41; D 207-41 (ND 163-9, SD 44-32); I 1-0, June 30, 1992. (Story, p. 1935)

250. HR 5487. Fiscal 1993 Agriculture Appropriations/Passage. Passage of the bill to provide \$59 billion in new budget authority for Agriculture, rural development and related agencies for fiscal year 1993. The administration requested \$60.4 million. Passed 312-99: R 79-85; D 232-14 (ND 159-12, SD 73-2); I 1-0, June 30, 1992. (Story, p. 1935)

251. S 429. Vertical Price Fixing/Conference Report. Adoption of the conference report to amend the Sherman Antitrust Act of 1890 to tighten the ban on vertical price fixing, which occurs when a manufacturer conspires with a retailer to force a competing merchant to charge at least a certain price for goods or face a cutoff of supplies. The bill would lower the standard of evidence needed to get a resale price maintenance case to a jury trial. Rejected 175-225: R 9-152; D 165-73 (ND 137-27, SD 28-46); I 1-0, July 1, 1992. A "nay" was a vote in support of the president's position. (Story, p. 1943)

252. S 1306. Alcohol, Drug Abuse and Mental Health Administration Reorganization/Rule. Adoption of the rule (H Res 479) to waive all points of order against and provide for House floor consideration of the conference report to reauthorize the federal substance abuse and mental health programs for fiscal 1993-94. Adopted 266-138: R 36-122; D 229-16 (ND 168-7, SD 61-9); I 1-0, July 1, 1992. (Story, p. 1970)

253. S 1306. Alcohol, Drug Abuse and Mental Health Administration Reorganization/Conference Report. Adoption of the conference report to reauthorize the federal substance abuse and mental health programs for fiscal 1993-94. The bill would split the block grant for mental health and substance abuse services into two separate grants, transfer the research arm of the Alcohol, Drug Abuse and Mental Health Administration to the National Institutes of Health, and provide more money to rural areas under state funding formulas. The revised conference report includes a prohibition on the use of federal funds to buy clean needles or syringes for distribution to drug addicts to use illegal drugs. Adopted 358-60: R 124-38; D 233-22 (ND 172-4, SD 61-18); I 1-0, July 1, 1992. A "nay" was a vote in support of the president's position. (Story, p. 1970)

KEY

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

Democrats Republicans
Independent

	246	247	248	249	250	251	252	253
ALABAMA								
1 Callahan	Y	N	Y	Y	N	N	N	Y
2 Dickinson	Y	N	Y	Y	N	N	N	Y
3 Browder	Y	N	N	Y	N	Y	Y	Y
4 Bevil	?	?	?	?	?	?	?	Y
5 Cramer	Y	N	N	Y	N	Y	Y	Y
6 Erdreich	Y	?	Y	Y	Y	N	Y	Y
7 Harris	Y	N	N	Y	Y	N	Y	Y
ALASKA								
AL Young	Y	N	N	N	N	N	Y	N
ARIZONA								
1 Rhodes	Y	N	N	Y	N	N	N	Y
2 Pastor	Y	N	N	N	Y	N	Y	Y
3 Stump	Y	N	Y	N	N	N	N	N
4 Kyl	Y	N	Y	Y	N	N	N	Y
5 Kolbe	Y	N	Y	Y	N	N	N	Y
ARKANSAS								
1 Alexander	N	N	N	N	Y	Y	?	Y
2 Thornton	Y	N	N	N	Y	N	Y	Y
3 Hammerschmidt	Y	N	N	N	Y	N	Y	Y
4 Anthony	?	?	?	N	Y	?	?	?
CALIFORNIA								
1 Riggs	Y	N	Y	Y	Y	N	?	Y
2 Herger	Y	N	N	N	Y	N	N	N
3 Matsui	Y	?	?	?	?	?	Y	Y
4 Fazio	Y	N	Y	Y	Y	Y	Y	Y
5 Pelosi	Y	N	Y	Y	Y	Y	Y	Y
6 Boxer	?	?	?	Y	Y	?	?	?
7 Miller	Y	N	Y	Y	Y	Y	Y	Y
8 Dellums	Y	N	N	Y	Y	Y	Y	Y
9 Stark	Y	N	?	Y	N	Y	Y	Y
10 Edwards	Y	N	N	Y	Y	Y	Y	Y
11 Lantos	Y	N	Y	Y	Y	Y	Y	Y
12 Campbell	Y	N	Y	Y	N	N	N	Y
13 Mineta	Y	N	N	Y	Y	Y	Y	Y
14 Doalittle	Y	N	Y	Y	N	N	N	N
15 Condit	Y	Y	Y	Y	N	Y	Y	Y
16 Panetta	Y	N	Y	Y	Y	Y	Y	Y
17 Dooley	Y	N	N	Y	Y	N	Y	Y
18 Lehman	Y	N	Y	Y	N	Y	Y	Y
19 Lagomarsino	Y	N	Y	Y	N	N	Y	Y
20 Thomas	Y	N	Y	N	N	N	N	Y
21 Gallegly	Y	N	Y	Y	N	N	Y	Y
22 Moorhead	Y	N	Y	Y	N	N	N	Y
23 Beilenson	Y	N	N	Y	N	Y	Y	Y
24 Waxman	Y	N	N	Y	Y	Y	Y	Y
25 Roybal	Y	N	N	Y	Y	Y	Y	Y
26 Berman	Y	N	N	Y	Y	Y	Y	Y
27 Levine	Y	N	N	Y	Y	Y	Y	Y
28 Dixon	Y	N	N	Y	Y	Y	Y	Y
29 Waters	Y	N	N	Y	Y	Y	Y	Y
30 Martinez	Y	N	Y	Y	?	Y	Y	Y
31 Dymally	?	?	?	?	?	?	?	?
32 Anderson	Y	N	Y	Y	Y	Y	Y	Y
33 Dreier	Y	Y	Y	N	N	N	Y	Y
34 Torres	Y	N	N	Y	Y	?	?	?
35 Lewis	Y	N	N	N	Y	N	N	Y
36 Brown	Y	N	N	N	Y	Y	Y	Y
37 McCandless	Y	Y	Y	Y	N	Y	N	Y
38 Dornan	Y	Y	Y	Y	N	N	N	N
39 Dannemeyer	Y	Y	Y	Y	N	N	N	N
40 Cox	Y	Y	Y	Y	N	N	N	?
41 Lowery	Y	N	N	Y	?	N	Y	Y

	246	247	248	249	250	251	252	253
42 Rohrabacher								
43 Packard	Y	N	Y	Y	N	N	N	Y
44 Cunningham	Y	N	Y	Y	N	N	N	Y
45 Hunter	Y	N	Y	Y	N	N	N	N
COLORADO								
1 Schroeder	Y	?	Y	Y	N	Y	Y	N
2 Skaggs	Y	N	N	Y	Y	Y	Y	Y
3 Campbell	Y	N	Y	Y	Y	N	Y	Y
4 Allard	?	N	Y	Y	N	N	N	N
5 Hefley	Y	N	Y	Y	N	N	N	N
6 Schaefer	Y	N	Y	N	N	N	N	N
CONNECTICUT								
1 Kennedy	Y	N	N	Y	Y	Y	Y	Y
2 Gejdenson	Y	N	N	Y	Y	Y	Y	Y
3 DeLauro	Y	N	Y	Y	Y	Y	Y	Y
4 Shays	Y	Y	Y	Y	N	N	Y	Y
5 Franks	Y	Y	Y	Y	Y	N	N	Y
6 Johnson	Y	Y	N	Y	Y	N	?	Y
DELAWARE								
AL Carper	Y	N	Y	Y	Y	Y	N	N
FLORIDA								
1 Hutto	Y	N	Y	Y	Y	N	N	N
2 Peterson	Y	N	N	Y	N	N	N	N
3 Bennett	Y	Y	Y	Y	N	N	N	N
4 James	Y	Y	Y	Y	N	N	N	N
5 McCollum	Y	N	Y	Y	N	N	N	N
6 Stearns	Y	Y	Y	Y	N	N	N	N
7 Gibbons	Y	N	N	Y	Y	N	N	N
8 Young	Y	N	Y	Y	N	N	N	N
9 Bilirakis	Y	Y	Y	Y	N	N	N	N
10 Ireland	?	N	Y	Y	N	?	N	N
11 Bacchus	Y	N	Y	Y	Y	N	N	N
12 Lewis	Y	N	Y	Y	N	N	N	N
13 Goss	Y	N	Y	Y	N	N	N	N
14 Johnston	Y	N	N	Y	Y	N	N	N
15 Shaw	Y	N	Y	Y	Y	N	?	?
16 Smith	Y	N	Y	Y	Y	N	N	N
17 Lehman	Y	N	?	Y	Y	?	Y	N
18 Ros-Lehtinen	Y	N	Y	Y	N	N	N	N
19 Foscill	Y	N	?	?	?	?	N	N
GEORGIA								
1 Thomas	?	N	?	N	Y	N	N	Y
2 Hatcher	Y	N	N	N	Y	N	?	Y
3 Ray	Y	Y	N	Y	Y	N	Y	Y
4 Jones	?	?	?	?	?	?	?	?
5 Lewis	Y	N	N	Y	Y	Y	Y	Y
6 Gingrich	Y	N	Y	Y	N	N	Y	Y
7 Darden	Y	N	N	Y	Y	N	Y	Y
8 Rowland	Y	N	N	Y	Y	N	Y	Y
9 Jenkins	Y	N	N	Y	Y	N	Y	Y
10 Barnard	Y	N	N	Y	Y	N	?	?
HAWAII								
1 Abercrombie	Y	N	N	N	Y	Y	Y	Y
2 Mink	Y	N	N	Y	Y	Y	Y	Y
IDAHO								
1 LaRocco	Y	N	Y	Y	Y	N	Y	Y
2 Stallings	Y	N	Y	Y	Y	N	Y	Y
ILLINOIS								
1 Hayes	Y	N	N	Y	Y	Y	Y	Y
2 Savage	Y	N	N	Y	Y	?	Y	Y
3 Russo	Y	N	N	Y	Y	Y	Y	Y
4 Sangmeister	Y	N	N	Y	Y	Y	Y	Y
5 Lipinski	Y	N	Y	Y	N	N	Y	Y
6 Hyde	Y	N	N	Y	N	N	Y	Y
7 Collins	Y	N	N	Y	Y	Y	Y	Y
8 Rostenkowski	Y	N	N	Y	Y	Y	Y	Y
9 Yates	Y	N	N	Y	Y	?	Y	Y
10 Porter	Y	N	Y	Y	N	N	Y	Y
11 Annunzio	Y	N	N	Y	Y	?	Y	Y
12 Crane	Y	Y	Y	Y	N	N	N	N
13 Fawell	Y	N	Y	Y	N	N	N	Y
14 Hastert	Y	N	N	Y	Y	N	N	Y
15 Ewing	Y	N	N	Y	Y	N	N	Y
16 Cox	Y	N	Y	Y	Y	Y	Y	Y
17 Evans	Y	N	Y	Y	Y	Y	Y	Y
18 Michel	Y	N	N	Y	Y	N	Y	Y
19 Bruce	Y	Y	Y	Y	Y	Y	Y	Y
20 Durbin	Y	Y	Y	Y	Y	Y	Y	Y
21 Costello	Y	N	Y	Y	Y	Y	Y	Y
22 Poshard	Y	Y	N	Y	Y	Y	Y	Y
INDIANA								
1 Visclosky	Y	Y	N	Y	Y	Y	Y	Y
2 Sharp	Y	N	Y	Y	Y	Y	Y	Y
3 Roemer	Y	Y	Y	Y	Y	N	Y	Y

ND Northern Democrats SD Southern Democrats

"build on the existing system" by expanding low-income people's access to private health insurance through tax credits and providing new tax deductions for middle-income earners who pay their own insurance premiums. Democrats are considerably more divided, with about equal factions backing three proposals: full-scale national health insurance similar to Canada's; a "play or pay" plan under which businesses would either have to provide workers with insurance or pay a tax to have the government do it for them; and a "market-based" system that would rely on better management of the way health care is delivered. Some Democrats, led by Senate Finance Committee Chairman Lloyd Bentsen, D-Texas, prefer an "incremental" bill that would make only minimal changes that both parties agree on, leaving the larger decisions for later.

Bills: S 1227, S 1872, S 1936, HR 5502, HR 5325, HR 5514; many more.

House status: The Ways and Means Subcommittee on Health approved HR 5502 by voice vote June 30. The bill would impose national limits on health spending and expand access to health insurance for pregnant women, children and small-business employees.

Senate status: The Senate Labor and Human Resources Committee approved a version of S 1227, a play-or-pay plan, on Jan. 22; Senate Finance approved HR 1872 as part of the failed tax bill (HR 4210) on March 3. HR 1872 is Bentsen's "incremental" bill. It would reshape the private insurance market for small businesses through federal regulation, limiting costs and prohibiting insurers from denying coverage to those that have been ill in the past.

What to watch for: Already an issue of growing political importance, health-care reform was firmly placed on the national agenda last November with the surprise victory of Democrat Harris Wofford over former Bush Attorney General Dick Thornburgh in Pennsylvania's special Senate election. But while Wofford rode the health issue to victory by keeping his promises general, translating such promises into specifics has proved difficult for lawmakers. House Democrats are currently trying to rally behind a bill (HR 5502) whose primary emphasis is controlling costs by imposing a national health budget. Senate Democrats, by contrast, are continuing a months-long process of building a consensus package behind closed doors. Republicans, in the meantime, while beating up on the Democrats for failing to deliver on promises of legislative action, seem to be gathering behind a package of changes that would build on the existing health-care system. If Democrats in either chamber manage to build a large enough coalition, look for floor action as a way to highlight the issue in the fall. In any event, health reform is likely to loom large in the presidential campaign.

Related stories: Weekly Report, pp. 1964, 1802, 1702, 536; Bush plan, p. 305.

Issue: Alcohol, Drug Abuse and Mental Health Administration reauthorization.

Synopsis: After overcoming a series of unanticipated leg-



islative hurdles, Congress cleared legislation to reorganize the way the federal government funds programs to research and combat mental illness and substance abuse. As signed into law by President Bush on July 10, the measure would disband the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). Its three research branches — the National Institute of Mental Health, National Institute on Drug Abuse, and National Institute on Alcoholism and Alcohol Abuse — would be folded into the National Institutes of Health. ADAMHA's remaining programs, which administer funds to states to provide treatment and prevention services, would be reconstituted as the Substance Abuse and Mental Health Services Administration. In addition, the existing block grant program providing funds for both mental health and substance abuse services would be split in two.

Although the package had bipartisan support in Congress and backing from the Bush administration, final action was delayed by two unrelated legislative skirmishes. First, conferees had to add language to reinstitute a ban on the use of "needle exchange" programs, which provide addicts with clean needles to try to prevent the spread of AIDS, hepatitis and other blood-borne diseases. Next, sponsors had to overcome the objections of legislators from states — particularly Florida — that stood to lose funds under the new block grant formula, which gives less weight to large urban areas. The new formula was not changed.

Bill: S 1306 — PL 102-321

House status: The House approved the conference report on the bill (H Rept 102-546) on July 1 by a vote of 358-60.

Senate status: The Senate approved the conference report by a vote of 86-8 on June 9.

Related stories: Weekly Report, pp. 1704, 1609, 1538, 1453, 1348.

Issue: Family and medical leave.

Synopsis: The family and medical leave bill carries one certainty this year: No one on Capitol Hill expects it to be enacted during the 102nd Congress.

The bill would require businesses with more than 50 workers to give all but their top employees up to 12 weeks of unpaid leave for the birth or adoption of a child, or for the serious illness of the worker or an immediate family member. Under compromise language crafted by Sen. Christopher J. Dodd, D-Conn., and Christopher S. Bond, R-Mo., the bill would exempt the highest-paid 10 percent of an employer's work force and restrict eligibility for leave to employees who have worked at least 25 hours per week for the previous 12 months. Because the bill would apply only to businesses with more than 50 workers, it would exempt more than 95 percent of all employers.

President Bush opposes the measure, saying it would place too great a burden on businesses. Democratic presidential nominee Bill Clinton supports the bill and has made it a major campaign issue, highlighting it at the Democratic National Convention.



APPROPRIATIONS

Senate Resists Adding Money To Popular Social Programs

Senate consideration of the fiscal 1993 spending bill for the departments of Labor, Health and Human Services (HHS) and Education was a battle of competing wants the week of Sept. 14. In the end, senators' desire to avoid a presidential veto so they can leave town overcame the lure of adding money to some of the nation's most popular social programs.

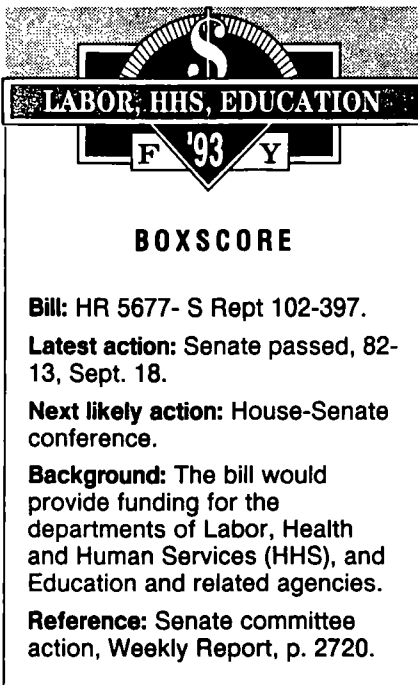
Before the Senate completed action on the measure (HR 5677 — S Rept 102-397) on Sept. 18, following three days of debate, members handily defeated three amendments that would have increased the bill's \$240.9 billion total by moving money from the defense budget. President Bush had expressly promised to veto any bill that breached the so-called walls separating defense and domestic spending.

Members also dropped from the Appropriations Committee version of the bill two other provisions that a Sept. 16 Bush administration policy statement said would prompt a veto. One would have blocked proposed Labor Department regulations imposing new accounting requirements on labor unions. The other would have blocked enforcement of Bush administration regulations barring abortion counseling in federally funded family planning clinics. The latter provision was dropped as part of a deal that brought to the Senate floor free-standing legislation that would overturn the contested rules. (*Story, p. 2818*)

But that could all be for naught, because the bill could yet be vetoed.

The administration says both the House and Senate versions of the measure exceed the amount Bush requested in his fiscal 1993 budget for the "domestic discretionary" programs, over which appropriators have direct control. About three-fourths of the bill's total is for such "mandatory" entitlement programs as Medicaid and Aid to Families with Dependent Children. Bush has promised to veto any appropriations measure whose total exceeds the discretionary amount he requested in January. (*Story, p. 2789*)

By Julie Rovner



LABOR, HHS, EDUCATION

F '93 Y

BOXSCORE

Bill: HR 5677- S Rept 102-397.

Latest action: Senate passed, 82-13, Sept. 18.

Next likely action: House-Senate conference.

Background: The bill would provide funding for the departments of Labor, Health and Human Services (HHS), and Education and related agencies.

Reference: Senate committee action, Weekly Report, p. 2720.

The White House Office of Management and Budget (OMB) says the House bill is \$234 million over Bush's domestic discretionary total of \$61.7 billion, while the Senate version is \$1.8 billion over.

Appropriators and the Congressional Budget Office dispute the way OMB "scored" some of the bill's provisions and say both bills are lower than Bush's request. But under the 1990 budget agreement, OMB's estimates govern, leaving Congress to either cut the bills or risk a veto of the second-largest of the 13 regular spending bills.

And even if the scoring disputes are settled, the Senate version still contains a veto-bait provision that would allow federal funding of abortions in certain cases of rape or incest. Similar language included in the fiscal 1990 bill drew one of Bush's first abortion-related vetoes.

Dozens of Amendments

As usual, the dozens of floor amendments offered fell into three categories: those addressing spending totals, those addressing sensitive social policy issues such as AIDS and drug abuse, and those with little to do with the measure — but whose sponsors

saw the must-pass spending bill as a good vehicle for pet proposals that would otherwise die as Congress rushes to adjourn.

Of the spending amendments, by far the most controversial were the three that sought to transfer defense funds to the Labor-HHS bill.

For the second consecutive year, Labor-HHS Subcommittee Chairman Tom Harkin, D-Iowa, sought unsuccessfully to augment his bill by transferring money from unobligated Defense Department funds.

"This amendment does not really make a dent in these amounts on the [defense] side of the ledger, but for millions of American kids it can mean the difference between life and death," Harkin said of his proposal to take \$4.1 billion in defense money and apportion it to health, social service and education programs, most of them aimed at children.

But defense budget guardians did not take kindly to Harkin's plan.

"Some people have the mistaken impression that unobligated balances really amount to money just simply lying around waiting for someone to come along and pluck it," said Sam Nunn, D-Ga., chairman of the Armed Services Committee. "It has not been obligated, but that does not mean it will not be obligated."

Others suggested that adopting the amendment would be making a promise Congress could not keep.

"We are only fooling ourselves if we think that this amendment will solve any of our problems," said Appropriations Committee Chairman Robert C. Byrd, D-W.Va. "Even if the House were to agree to this amendment . . . the president is going to veto this bill, and we cannot override his veto."

Under Senate rules, Harkin's amendment needed 60 votes to pass because it required waiving congressional budget rules. It got 36, up from the 28 Harkin got in 1991, but still a long way from 60. (*Vote 208, p. 2867*)

Two smaller amendments to add to the bill by taking defense money, both offered by Republicans, fared no better than Harkin's.

By a 30-67 vote, members defeated an amendment by the subcommittee's ranking Republican, Arlen Specter, Pa., to move \$2.9 billion in defense funds to the Pell grant college scholarship program, enough to fund the maximum grants at \$2,800 per year. Under the bill as it stands, the amount of the maximum grant would drop from \$2,400 in fiscal 1992 to \$2,300 in fiscal 1993. (*Vote 209*, p. 2867)

And by 43-53, members defeated a proposal by Alfonse M. D'Amato, R-N.Y., to commandeer \$214 million from defense research for research on breast cancer. (*Vote 211*, p. 2869)

Smoking Ban To Protect Kids

Among the non-spending amendments, the most sweeping was one offered by Frank R. Lautenberg, D-N.J., that would require a ban on smoking in facilities that receive federal funds for programs serving children under age 5. It was adopted by voice vote.



Lautenberg

"This amendment will do for our youngest children what the airline smoking ban did for flight attendants and air passengers, and that is to protect them from deadly secondhand smoke, which the Environmental Protection Agency has confirmed to be a class A carcinogen," said Lautenberg, a longtime smoking foe.

Members also adopted two amendments offered by Jesse Helms, R-N.C., for whom the Labor-HHS bill has become a favorite target.

One Helms amendment, adopted by voice vote, would bar from participation in the annual federal employee charity drive any organization that seeks to compel the Boy Scouts of America to accept as members or leaders homosexuals or individuals "who reject the Boy Scout's oath of allegiance to God and country." Helms cited specifically the United Ways of San Francisco and Chicago, which he said had threatened to cut off funding for the scouts unless they accepted homosexuals and atheists.

The other amendment would bar the use of anti-drug funds "to pay for homosexual educational, counseling or support services ... or to promote ... intravenous drug abuse or homosexual, bisexual or heterosexual activity,

A Last Shot at 'Gag Rule'

The Senate on Sept. 14 set up a final showdown with President Bush over the so-called gag rule, which would prohibit abortion counseling in federally funded family planning clinics. Senators abandoned two other attempts to block or delay implementation of the rules, set to take effect Oct. 1.

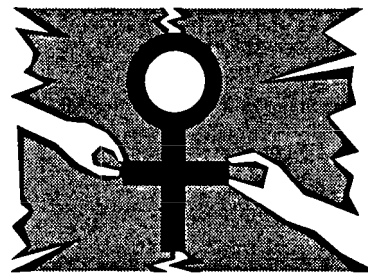
Members gave voice vote approval to the conference report on S 323 (H Rept 102-767), which would both overturn the Bush administration's rules and reauthorize for five years the federal family planning program, Title X of the Public Health Service Act. The program funds 4,000 family planning clinics for teenagers and low-income women nationwide. The House approved the conference report Aug. 6, but by a margin short of the two-thirds needed to override the virtually certain Bush veto. (*Weekly Report*, p. 2360)

But the deal that allowed the family planning bill to come to the floor without a filibuster by abortion opponents (who support the counseling ban) required gag rule opponents to drop provisions blocking the rules from two appropriations bills.

As approved by the Senate Appropriations Committee on Sept. 10, both the supplemental appropriations bill that includes money for storm-torn Florida, Louisiana and Hawaii (HR 5620) and the fiscal 1993 spending bill for the departments of Labor, Health and Human Services (HHS) and Education (HR 5677) included slightly different versions of language to temporarily bar the Bush administration from implementing the rules.

The language in the Labor-HHS bill would have blocked implementation of the rules through the end of fiscal 1993. It was identical to language that drew a veto of the fiscal 1992 bill last November, which the House failed to override. The language in the storm-relief bill would have blocked enforcement pending the outcome of a court case brought by family planning groups and nurse-practitioners challenging the way the Bush administration plans to put the rules into effect. Sponsors said the language in the supplemental spending bill was intended to be a shorter-term delay, because a federal appeals court is set to hear the case in October. Abortion opponents, however, pointed out that the delay could actually have been longer if the court case dragged on.

—Julie Rovner



whether premarital or extramarital, in elementary or secondary schools."

But Helms was unsuccessful in pushing two other amendments.

One would have effectively barred any "needle-exchange" programs using public money, by forbidding federal funds to states or localities that operate such programs, intended to reduce the spread of AIDS and other blood-borne diseases.

Members adopted instead, by a vote of 69-29, a substitute amendment offered by Sens. Edward M. Kennedy, D-Mass., and Orrin G. Hatch, R-Utah, reiterating a modified ban on the use of federal funds for such programs. The ban was originally enacted as part of the reauthorization of the Alcohol,

Drug Abuse and Mental Health Administration (PL 102-321) signed by Bush in July. (*Vote 212*, p. 2869)

Also defeated was a Helms amendment, similar to one included in the House bill, to block a rule proposed by the Occupational Safety and Health Administration (OSHA) regarding on-the-job use of seat belts and motorcycle helmets and requiring employers to provide driver safety programs.

The amendment was defeated by voice vote after members killed, by a vote of 43-55, a virtually identical substitute offered by Trent Lott, R-Miss. (*Vote 213*, p. 2869)

Among the amendments unrelated to the bill was one offered by John McCain, R-Ariz., to give the president

a limited line-item budget veto by making it easier for him to rescind individual provisions of appropriations bills without vetoing entire bills.

"We have to begin deficit reduction by eliminating government waste," said McCain, who led a similarly unsuccessful battle in February. (*Weekly Report*, p. 459)

But as in February, Appropriations Chairman Byrd led the successful charge against the plan by reminding his colleagues of the importance of maintaining the separation of powers among the branches of government.

"Once we ever give that power to the president," said Byrd, "we will never get that power over the purse back."

McCain's amendment, which needed 60 votes to pass because it amended the budget rules, fell on a 40-56 vote. (*Vote 210*, p. 2869)

Other Amendments

Among the dozens of other amendments adopted, all by voice vote, were the following:

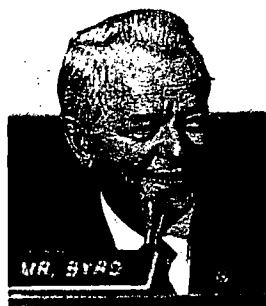
- By Ernest F. Hollings, D-S.C., to increase by \$40 million funding for community health centers, boosting

that program's total to \$583 million. The amendment would reduce by a comparable amount funding for Public Health Service evaluations.

- By Pete V. Domenici, R-N.M., to



John McCain



Robert C. Byrd

increase by \$21 million, to \$596 million, funding for the National Institute of Mental Health. The amendment would reduce by a similar amount funding for HHS' Health Resources and Services Administration.

- By Domenici, to increase by \$6 million funding for health care for the homeless. The amendment would cut \$6 million from the National Institute of General Medical Sciences.

- By Dennis DeConcini, D-Ariz., to increase by \$7 million, to \$12 million, funding for the National Youth Sports program. The amendment would pay for itself by reducing by 4.1 percent the amount agencies covered under the bill may spend for consultants.

- By Don Nickles, R-Okla., to boost by \$6.4 million funding for programs under the Older Americans Act, raising that total to \$844.3 million. The amendment would increase by a similar amount, from \$100.4 million to \$106.7 million, salary reductions ordered for HHS.

- By Paul Wellstone, D-Minn., to strike from the bill a provision prohibiting part-time students from receiving Pell grants.

- By David Pryor, D-Ark., to require agencies covered by the bill to account separately for consultant expenses.

Members also approved, 94-1, a Hatch amendment to delay for one year regulations regarding nutrition labeling on diet supplements, such as vitamins. Sen. Howard M. Metzenbaum, D-Ohio, author of the 1990 law the rules would implement, said he opposed the amendment, but voted for it on the theory that it would be dropped in conference. ■

LABOR

Bush's Family Leave Plan Comes Late For Action

Although both the House and Senate already had passed family and medical leave bills and approved a conference report on the final bill, President Bush announced Sept. 16 an alternative to the mandate for big businesses to provide unpaid leave to their workers.

Bush wants to offer businesses tax credits of up to \$1,200 per worker if they give employees time off for family emergencies. The plan, to be offered to businesses with fewer than 500 employees, would cost about \$500 million, according to the White House.

Bush's timing, however, ensures that his plan cannot become law this year. The day after his announcement, Congress sent its bill (S 5 — S Rept 102-816) to the White House for Bush's promised veto. The House does not have enough support for the legis-

lation to override a veto.

The congressional measure would require businesses with more than 50 workers to give all but their top employees up to 12 weeks of unpaid leave for the birth or adoption of a child, or for the serious illness of the worker or an immediate family member. The bill would exempt the highest-paid 10 percent of an employer's work force and restrict eligibility for leave to employees who have worked at least 25 hours per week for the previous 12 months.

Because the bill would apply only to businesses with more than 50 workers, it would exempt more than 95 percent of all employers. Nevertheless, business groups have complained strenuously that the bill would place too great a burden on businesses.

Rep. Marge Roukema, R-N.J., a longtime supporter of the legislation, called Bush's idea "an interesting sup-

plement to the basic bill. But it is no substitute."

"To use the tax incentives does not give you the job guarantee," she said.

Roukema said she was extremely disappointed that Bush did not try to compromise on the family leave legislation while it was going through the legislative process.

"I think his advisers have painted him into a very unfortunate corner," she said. The proposal, she said, is obviously an attempt to give Bush a reason for vetoing the legislation.

"I don't know of anybody who doubts that at all," agreed Sen. Christopher J. Dodd, D-Conn. "This is not a sincere offer at all."

Rep. Dick Armey, R-Texas, who opposes the family leave legislation, said the timing of Bush's proposal is "unfortunate," but added that he and the administration were busy fighting the S 5 mandate earlier on.

"To the extent the president's proposal is political, it's in response to the timing of the Democrats," Armey said. "They thought this is a great time to embarrass the president" by sending him a family leave bill so close to the election. ■

By Jill Zuckman

	210	211	212	213	214	215
ALABAMA						
Heflin	N	N	Y	N	N	Y
Shelby	Y	N	Y	N	N	Y
ALASKA						
Murkowski	Y	Y	N	Y	N	Y
Stevens	N	N	N	Y	N	Y
ARIZONA						
DeConcini	N	Y	Y	N	Y	N
McCain	Y	N	N	Y	N	Y
ARKANSAS						
Bumpers	N	N	Y	N	Y	N
Pryor	N	N	Y	N	Y	N
CALIFORNIA						
Cranston	N	N	Y	N	Y	N
Seymour	Y	Y	Y	N	Y	Y
COLORADO						
Wirth	?	?	?	?	?	?
Brown	Y	N	N	Y	N	Y
CONNECTICUT						
Dodd	N	N	Y	N	Y	N
Lieberman	N	N	Y	N	Y	N
DELAWARE						
Biden	N	Y	Y	Y	Y	N
Roth	Y	Y	Y	Y	Y	Y
FLORIDA						
Graham	Y	N	Y	N	N	Y
Mack	Y	N	Y	N	N	Y
GEORGIA						
Fowler	N	N	Y	N	Y	N
Nunn	N	N	Y	N	Y	N
HAWAII						
Akaka	N	Y	Y	N	Y	N
Inouye	N	N	Y	N	N	Y
IDaho						
Craig	Y	N	N	Y	N	Y
Symms	Y	Y	N	Y	N	Y
ILLINOIS						
Dixon	N	Y	Y	N	Y	Y
Simon	N	Y	Y	N	Y	Y
INDIANA						
Coats	Y	N	N	Y	N	Y
Lugar	Y	N	N	Y	N	Y

	210	211	212	213	214	215
IOWA						
Harkin	N	Y	Y	N	Y	N
Grassley	Y	N	N	Y	Y	N
KANSAS						
Dole	Y	N	N	N	N	Y
Kassebaum	Y	N	Y	Y	N	Y
KENTUCKY						
Ford	N	Y	Y	Y	Y	N
McConnell	Y	N	N	Y	Y	Y
LOUISIANA						
Breaux	N	N	Y	N	Y	N
Johnston	N	N	Y	N	Y	N
MAINE						
Mitchell	N	Y	Y	N	Y	N
Cohen	N	N	Y	Y	N	Y
MARYLAND						
Mikulski	N	Y	Y	N	Y	N
Sarbanes	N	Y	Y	N	Y	N
MASSACHUSETTS						
Kennedy	N	Y	Y	N	Y	N
Kerry	N	Y	Y	N	Y	N
MICHIGAN						
Levin	N	N	Y	N	Y	N
Riegle	N	Y	Y	N	Y	N
MINNESOTA						
Wellstone	N	Y	Y	N	Y	N
Durenberger	N	N	Y	Y	N	Y
MISSISSIPPI						
Cochran	N	N	N	Y	N	Y
Lott	Y	N	N	Y	N	Y
MISSOURI						
Bond	Y	Y	N	Y	N	Y
Danforth	Y	N	N	N	N	Y
MONTANA						
Baucus	N	N	Y	N	Y	N
Burns	Y	Y	N	Y	N	Y
NEBRASKA						
Exon	Y	N	Y	N	Y	N
Kerrey	N	N	Y	N	Y	N
NEVADA						
Bryan	N	Y	Y	Y	N	N
Reid	N	Y	Y	Y	N	N

	210	211	212	213	214	215
NEW HAMPSHIRE						
Rudman	N	N	Y	Y	N	Y
Smith	Y	N	N	Y	N	Y
NEW JERSEY						
Bradley	N	Y	Y	N	Y	N
Lautenberg	N	Y	Y	N	Y	N
NEW MEXICO						
Bingaman	N	N	Y	N	Y	Y
Domenici	N	N	N	Y	N	Y
NEW YORK						
Moynihan	N	Y	Y	N	Y	N
D'Amato	Y	Y	Y	N	N	Y
NORTH CAROLINA						
Sanford	?	?	Y	Y	Y	N
Helms	Y	N	N	Y	N	Y
NORTH DAKOTA						
Burdick	N	Y	Y	N	Y	N
Conrad	N	Y	Y	Y	N	N
OHIO						
Glenn	N	N	Y	N	Y	Y
Metzenbaum	N	Y	Y	N	Y	N
OKLAHOMA						
Boren	Y	N	Y	N	N	Y
Nickles	?	?	N	Y	N	Y
OREGON						
Hatfield	N	Y	Y	N	Y	N
Packwood	Y	Y	Y	N	N	Y
PENNSYLVANIA						
Wolford	N	Y	Y	N	Y	N
Specter	Y	Y	Y	N	N	Y
RHODE ISLAND						
Pell	N	Y	Y	N	Y	N
Chafee	Y	N	Y	N	Y	N
SOUTH CAROLINA						
Hollings	Y	Y	Y	N	N	Y
Thurmond	Y	N	N	Y	N	Y
SOUTH DAKOTA						
Daschle	N	Y	Y	N	Y	N
Pressler	Y	Y	N	Y	Y	Y
TENNESSEE						
Gore	?	?	?	?	?	?
Sasser	N	N	Y	N	Y	N

KEY

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

Democrats Republicans



	210	211	212	213	214	215
TEXAS						
Bentsen	N	N	Y	N	Y	Y
Gramm	Y	N	N	Y	N	Y
UTAH						
Garn	Y	N	N	Y	N	Y
Hatch	Y	Y	N	N	Y	Y
VERMONT						
Leahy	N	Y	Y	N	Y	N
Jeffords	N	N	Y	N	Y	N
VIRGINIA						
Robb	Y	N	Y	N	N	Y
Warner	Y	Y	N	N	Y	Y
WASHINGTON						
Adams	N	Y	Y	N	Y	N
Gorton	Y	Y	Y	N	N	Y
WEST VIRGINIA						
Byrd	N	N	Y	N	Y	N
Rockefeller	N	Y	Y	N	Y	N
WISCONSIN						
Kohl	N	N	Y	Y	Y	N
Kasten	Y	N	N	Y	N	Y
WYOMING						
Simpson	Y	N	N	Y	N	Y
Wallop	Y	N	N	Y	N	Y

ND Northern Democrats SD Southern Democrats

Southern states - Ala., Ark., Fla., Ga., Ky., La., Miss., N.C., Okla., S.C., Tenn., Texas, Va.

210. HR 5677. Fiscal 1993 Labor, Health and Human Services, Education Appropriations/Enhanced Rescission Authority. McCain, R-Ariz., motion to waive the Budget Act with respect to the Sasser, D-Tenn., point of order against the McCain amendment to grant the president enhanced authority to rescind individual spending items. Motion rejected 40-56: R 34-8; D 6-48 (ND 1-38, SD 5-10), Sept. 17, 1992. A three-fifths vote of the total Senate (60) is required to waive the Budget Act. (The Sasser point of order was subsequently sustained and the McCain amendment fell.) (Story, p. 2817)

211. HR 5677. Fiscal 1993 Labor, Health and Human Services, Education Appropriations/Breast Cancer Research. D'Amato, R-N.Y., motion to waive the Budget Act with respect to the Stevens, R-Alaska, point of order against the D'Amato amendment to transfer \$214 million from the Defense Department's research account to the National Cancer Institute for breast cancer research. Motion rejected 43-53: R 14-28; D 29-25 (ND 27-12, SD 2-13), Sept. 17, 1992. A three-fifths vote of the total Senate (60) is required to waive the Budget Act. (The Stevens point of order was subsequently sustained and the D'Amato amendment fell.) (Story, p. 2817)

212. HR 5677. Fiscal 1993 Labor, Health and Human Services, Education Appropriations/Needle Exchange Programs. Kennedy, D-Mass., amendment to the Helms, R-N.C., amendment, to prohibit funding for the distribution of sterile needles to illegal drug users, unless the Surgeon General determined that such programs would help prevent the spread of AIDS and would not encourage the use of illegal drugs. The Helms amendment would prohibit states that conduct clean needle

programs from receiving funds under the bill, unless the president, certified that such programs are effective. Adopted 69-29: R 14-29; D 55-0 (ND 39-0, SD 16-0), Sept. 17, 1992. (The Helms amendment as amended by the Kennedy amendment was adopted by voice vote.) (Story, p. 2817)

213. HR 5677. Fiscal 1993 Labor, Health and Human Services, Education Appropriations/OSHA Regulations. Lott, R-Miss., technical amendment to the Helms, R-N.C., amendment, to prohibit funding for the implementation of Occupational Safety and Health Administration (OSHA) regulations affecting mandatory seat belt use, mandatory motorcycle helmet use and mandatory employer driver safety awareness programs. Rejected 43-55: R 34-9; D 9-46 (ND 6-33, SD 3-13), Sept. 17, 1992. (The Helms amendment was subsequently rejected by voice vote.) (Story, p. 2817)

214. S 3114. Fiscal 1993 Defense Authorization/Strategic Defense Initiative. Bumpers, D-Ark., amendment to provide \$3.3 billion for the Strategic Defense Initiative in fiscal 1993. The committee bill would provide \$4.3 billion; the administration requested \$5.4 billion. Rejected 48-50: R 5-38; D 43-12 (ND 35-4, SD 8-8), Sept. 17, 1992. A "nay" was a vote in support of the president's position. (Story, p. 2831)

215. S 3114. Fiscal 1993 Defense Authorization/Strategic Defense Initiative. Nunn, D-Ga., amendment to provide \$3.8 billion for the Strategic Defense Initiative in fiscal 1993. The committee bill would provide \$4.3 billion; the administration requested \$5.4 billion. Adopted 52-46: R 39-4; D 13-42 (ND 5-34, SD 8-8), Sept. 17, 1992. (Story, p. 2831)

Date: 10/01/93 Time: 08:28

Study Says Needle Exchange Programs Cut Down On Syringe Sharing

(San Francisco) -- A study has found that needle exchange programs appear to be working.

The study by the University of California at San Francisco says such programs reduced needle-sharing among addicts, without increasing drug use.

But researchers say it's impossible to conduct a large enough study to determine if the exchange programs curb the spread of AIDS among I-V drug users.

There are about 37 needle exchange programs in the U-S, and nearly five and a-half (M) million clean needles have been passed out since 1988.

Results of the study could affect federal funding of such programs.

APNP-10-01-93 0829EDT

To: Ed - FYD
From: Jose



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

October 27, 1993

MEMORANDUM FOR DR. BROWN
RICIA McMAHON
ED JURITH
JOSE CERDA,
JOHN GREGRICH
HANK MARSDEN
GEORGE KOSNIK
AL BRANDENSTEIN

FROM: JOHN CARNEVALE *JC*
SUBJECT: Revised Executive Summary of the CDC Needle
Exchange Study

Ben Merrill of the AIDS Czar Office dropped off the attached, revised Executive Summary of the CDC Needle Exchange Study. According to Merrill, on November 15th, the Surgeon General will present findings to HHS (Dr. Lee) that 1) Needle Exchange programs do not contribute to increased drug use, and 2) there is evidence that such programs reduce the incidence of AIDS. These findings are required before HHS can allocate its substance abuse block grant funds.

Merrill is hopeful that we will continue to view this as a health care issue. This is a tough one. Most of us who have reviewed the numerous needle exchange programs and studies are less confident than the AIDS Czar about the efficacy of needle programs.

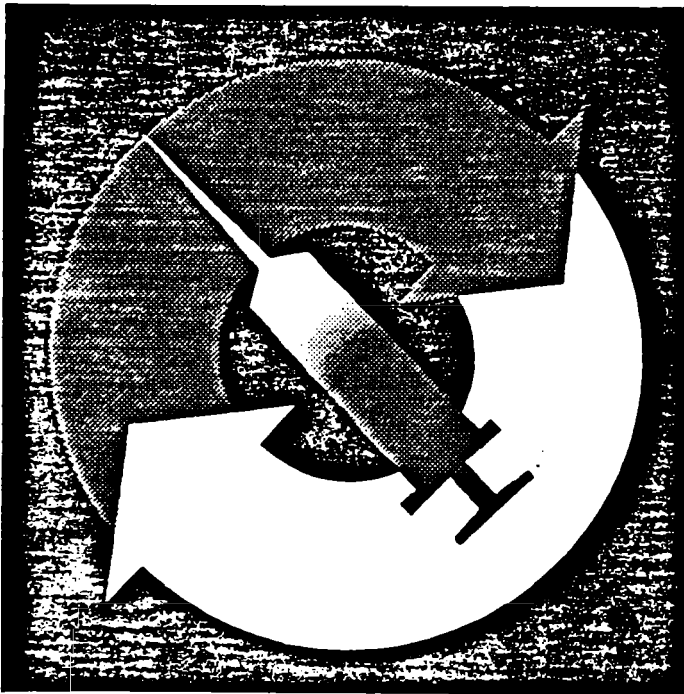
Merrill promised to keep us apprised of developments.

Attachment.

cc: Ross Deck
Babette Hankey

THE PUBLIC HEALTH IMPACT OF NEEDLE EXCHANGE PROGRAMS IN THE UNITED STATES AND ABROAD

SUMMARY, CONCLUSIONS,
AND RECOMMENDATIONS



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PREPARED FOR THE CENTERS FOR DISEASE CONTROL AND PREVENTION

October 1993

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Funded through a cooperative agreement with the Association of Schools of Public Health (ASPH Agreement No. M1589)

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ACKNOWLEDGMENTS

The authors would first like to express gratitude to the staff of the needle exchange programs visited during this project, who agreed to meet with us during our site visits and answered the many questions that arose after our visits. Programs not visited were of great assistance by filling out a questionnaire describing their activities. Many public health officials, researchers, elected officials, and other community leaders also took the time to meet with us during the site visits. Centers for Disease Control and Prevention staff T. Stephen Jones, Brian R. Edlin, Joann Valentine, and P. Imani Thompson accompanied us on site visits, wrote up several interviews, and provided critical insights.

We would like to thank Don C. Des Jarlais and Samuel R. Friedman for providing us with behavioral data on injecting drug users collected under National Institute on Drug Abuse grant DA03574. Helpful reviews of drafts were received from the contracted reviewers,* staff at the Centers for Disease Control and Prevention, the National Institute on Drug Abuse, and the Government Accounting Office.

Robert A. Rubinstein provided important computer assistance, Hannah Raiden aided in the preparation of Chapters 2 and 7, and Jeremiah Holland helped in the preparation of the final document. Finally, we would like to acknowledge the administrative contributions of Theresa Brimer at the Centers for Disease Control and Prevention and Stephanie Caselli at the University of California, Berkeley.

DEFINITION OF TERMS

Because injecting drug users in the US tend to use syringes with non-removable needles, we use the terms "needle" and "syringe" interchangeably in this report. We use the term "needle exchange program" to refer to any establishment at which injecting drug users can exchange an old needle or syringe for a new one, because this term has become the most common way to refer to these programs.

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EXECUTIVE SUMMARY

CONCLUSIONS

How and Why did Needle Exchange Programs Develop?

Needle exchange programs have continued to increase in number in the US and by September 1, 1993 at least 37 active programs existed. The evolution of needle exchange programs in the US has been characterized by growing efforts to accommodate the concerns of local communities, increasing likelihood of being legal, growing institutionalization, and increasing federal funding of research, although a ban on federal funding for program services remains in effect.

How do Needle Exchange Programs Operate?

About one-half of US needle exchange programs are legal, but funding is often unstable and most programs rely on volunteer services to operate. All but six US needle exchange programs require one-for-one exchanges and rules governing the exchange of syringes are generally well enforced. In addition to having distributed over 5.4 million syringes, US needle exchange programs provide a variety of services ranging from condom and bleach distribution to drug treatment referrals.

Do Needle Exchange Programs Act as Bridges to Public Health Services?

Some needle exchange programs have made significant numbers of referrals to drug abuse treatment and other public health services, but referrals are limited by the paucity of drug treatment slots. Integrating needle exchange programs into the existing public health system is a likely future direction for these programs.

How Much Does it Cost to Operate Needle Exchange Programs?

The median annual budget of US and Canadian needle exchange programs visited is relatively low at \$169,000, with government-run programs tending to be more expensive. Some needle exchange programs are more expensive because they also provide substantial non-exchange services such as drug treatment referrals. The annual cost of funding an average needle exchange program would support about 60 methadone maintenance slots for one year.

Who Are the IDUs Who Use Needle Exchange Programs?

Although needle exchange program clients vary from location to location, the programs generally reach a group of injecting drug users with long histories of drug injection who remain at significant risk for human immunodeficiency virus (HIV) infection. Needle exchange program clients in the US have had less exposure to drug abuse treatment than IDUs not using the programs.

What Proportion of All Injecting Drug Users in a Community Uses the Needle Exchange Program?

Studies of adequately-funded needle exchange programs suggest that the programs do have the potential to serve significant proportions of the local injecting drug user population. While some needle exchange programs appear to have reached large proportions of local drug injectors at least once, others are reaching only a small fraction of them. Consequently, other methods of increasing sterile needle availability must be explored.

What Are the Community Responses to Needle Exchange Programs?

Unlike in many foreign countries, including Canada, proposals to establish needle exchange programs in the US have often encountered strong opposition from a variety of different communities. Consultation with affected communities can address many of the concerns raised.

Do Needle Exchange Programs Result in Changes in Community Levels of Drug Use ?

Although quantitative data are difficult to obtain, those available provide no evidence that needle exchange programs increase the amount of drug use by needle exchange program clients or change overall community levels of non-injection and injection drug use. This conclusion is supported by interviews with needle exchange program clients and by injecting drug users not using the programs, who did not believe that increased needle availability would increase drug use.

Do Needle Exchange Programs Affect the Number of Discarded Syringes?

Needle exchange programs in the US have not been shown to increase the total number of discarded syringes and can be expected to result in fewer discarded syringes.

Do Needle Exchange Programs Affect Rates of HIV Drug and/or Sex Risk Behaviors?

The majority of studies of needle exchange program clients demonstrate decreased rates of HIV drug risk behavior, but not decreased rates of HIV sex risk behavior.

What is the Role of Studies of Syringes in Injection Drug Use Research?

The limitations of using the testing of syringes as a measure of injecting drug users' behavior or behavior change can be minimized by following syringe characteristics over time, or by comparing characteristics of syringes returned by needle exchange program clients with those obtained from non-clients of the program.

Do Needle Exchange Programs Affect Rates of Diseases Related to Injection Drug Use Other than HIV?

Studies of the effect of needle exchange programs on injection-related infectious diseases other than HIV provide limited evidence that needle exchange programs are associated with reductions in subcutaneous abscesses and hepatitis B among injecting drug users.

Do Needle Exchange Programs Affect HIV Infection Rates?

Studies of the effect of needle exchange programs on HIV infection rates do not and, in part due to the need for large sample sizes and the multiple impediments to randomization, probably cannot provide clear evidence that needle exchange programs decrease HIV infection rates. However, needle exchange programs do not appear to be associated with increased rates of HIV infection.

Are Needle Exchange Programs Cost-effective in Preventing HIV Infection?

Multiple mathematical models of needle exchange program impact support the findings of the New Haven model. These models suggest that needle exchange programs can prevent significant numbers of infections among clients of the programs, their drug and sex partners, and their children. In almost all cases, the cost per HIV infection averted is far below the \$119,000 lifetime cost of treating an HIV-infected person.

RECOMMENDATIONS

Recommendations for the federal government

- The federal government should repeal the ban on the use of federal funds for needle exchange services.
- Substantial federal funds should be committed both to providing needle exchange services and to expanding research into these programs.

Recommendations for state governments

- State governments in the ten states and the District of Columbia that have prescription laws should repeal these laws.*
- States should repeal the paraphernalia laws as they apply to syringes.**

Recommendations for local governments and communities

- Local governments should enter into discussions with local community groups to develop a comprehensive approach to preventing HIV in injecting drug users, their sex partners, and their offspring. This approach should include needle exchange programs and the expansion of drug treatment services.
- Local communities should seek to further increase sterile syringe availability by encouraging the sale, distribution, or exchange of syringes by pharmacists.

Recommendations for researchers

- Descriptions of the "kinetics" and determinants of needle use patterns: injecting drug users' sources of needles, methods of disposal of needles, frequency of needle re-use, and needle-sharing patterns. How do these change when a needle exchange program or other changes in needle availability are implemented?
- Evaluations of "natural experiments" in which needle availability laws change or pharmacists expand the over-the-counter sales of syringes.

*Prescription laws preclude the purchase of a syringe without a prescription, limiting sterile syringe availability and creating a risk of arrest for needle exchange program staff and clients.

**Paraphernalia laws exist in 46 states and the District of Columbia and preclude the possession or distribution of syringes except for "legitimate medical purposes." Conviction under a paraphernalia law is a felony or a misdemeanor.

- **Surveys of pharmacists to determine their willingness to participate in pharmacy-based syringe sale, distribution, or exchange and to identify the barriers to their participation.**
- **Assessments of the effects of design features of needle exchange programs (e.g., administering bodies, site characteristics, opening hours, and program rules) upon process measures of needle exchange programs (e.g., needles distributed, drug treatment referrals, discarding of needles).**
- **Ethnographic and other qualitative research to assess the factors involved in drug use initiation and in transitions between various routes of drug use.**
- **Case-control studies of the relationship between use of the needle exchange program and acute hepatitis B, particularly in cities with active surveillance for the infection.**
- **Large, multicenter case-control studies within existing cohorts of injecting drug users to assess whether use of the needle exchange program is associated with hepatitis B or HIV seroconversion.**
- **Mathematical modeling using program data and behavior change evaluations to determine which aspects of program design determine effectiveness and cost-effectiveness.**

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SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

[S]ubstance use plays a major role in the transmission of HIV disease—indeed, a much larger role than has been generally recognized. Clearly, our nation's drug control policies must recognize this inextricable linkage between drugs and HIV disease and be designed to address the two aggressively and simultaneously.

—National Commission on AIDS, The Twin Epidemics of Substance Use and HIV, 1991¹

Because neither a vaccine nor a cure for HIV infection appears likely in the near future, planning is needed for the long term to limit the spread of HIV among drug injectors, their sexual partners, and their potential offspring.

—National Research Council, AIDS: The Second Decade, 1990²

A. Background

Any assessment of the public health impact of needle exchange programs (NEPs) must commence with the recognition of the critical links between the epidemics of human immunodeficiency virus (HIV) and substance abuse, and the relationship between HIV infection among injecting drug users (IDUs) and transmission to sexual partners and children. Unless these phenomena are fully appreciated, the public health significance of HIV infection among IDUs cannot be fully comprehended, and the impact of measures to prevent HIV infection in this group will be underestimated.

Estimates of the numbers of IDUs in the US range from 1.1 to 1.5 million.^{3,4} The societal costs of injection drug use include the costs of drug treatment, lost productivity, motor vehicle accidents, crime, and stolen property, and have been estimated at \$58.3 billion per year.⁵ With the lifetime cost of treating an HIV-infected person estimated at approximately \$119,000,⁶ and the number of IDU acquired immunodeficiency syndrome (AIDS) cases growing during the 1980s,⁷ HIV among IDUs will exact a growing economic toll in the years to come.

By early 1993, 253,448 people in the US had been diagnosed with AIDS. Of these, 73,311 (29%) were IDUs, 8,481 (3%) people with heterosexual contact with an IDU, and 2,420 (1%) children born to IDUs and their sex partners.⁷ Thus cases related to injection drug use account for fully one-third of all AIDS cases in the US to date. The impact is felt disproportionately in communities of color; IDU-associated AIDS cases accounted for 52% of African-American and 45% of Latino cases in the US in 1991, while the corresponding percentage for whites was only 19%.⁸

The HIV seroprevalence among IDUs varies substantially according to geographic region. In studies of IDUs entering drug treatment centers in the US, seroprevalences ranging from 0% to 65% were recorded.⁹⁻¹² The highest rates were recorded in the northeastern US and in Puerto Rico. Using HIV seroprevalence rather than AIDS case rates reveals the same

disproportionate burden of disease among minority communities; approximately eight of 10 IDUs with HIV infection in the US are African-American or Latino.¹³

HIV is primarily transmitted between IDUs by the inoculation of an HIV-negative IDU with traces of blood from a contaminated syringe or other drug paraphernalia previously used by an HIV-infected individual. Sexual transmission of HIV among IDUs and to their non-IDU sex partners, as well as transmission to their offspring, are also important.¹⁴ Decreases in HIV drug risk behavior in response to the epidemic have been documented since the mid-1980s. For example, cross-sectional studies of out-of-treatment IDUs in San Francisco between 1986 and 1989 revealed steadily decreasing rates of syringe sharing.¹⁵ Between 1985 and 1987 the proportion of IDUs in San Francisco who reported usually or always using bleach to disinfect syringes rose from 6% to 47%.¹⁶

Risk reduction, however, is not the same as risk elimination, and the need for a comprehensive approach to disease prevention among IDUs remains as critical now as it was at the beginning of the HIV epidemic. Drug treatment resources remain woefully inadequate; fewer than 15% of IDUs are in treatment on any given day.¹⁷ Many active IDUs express no interest in entering treatment.^{18, 19} For active IDUs who will not or cannot stop injecting drugs, there are only three reliable methods of preventing HIV infection from injection drug use: 1) use a sterile syringe for each injection; 2) if you cannot use a sterile syringe for each injection, do not share syringes; and 3) if you do share syringes, disinfect with bleach. However, many IDUs do continue to share, at least occasionally, and recent guidelines from the Public Health Service indicate that "Disinfecting previously used needles and syringes...is not as safe as always using a sterile needle and syringe (emphasis in original)."²⁰

It is in this milieu that NEPs have arisen. An NEP has been defined by one group of researchers as "a facility where drug injectors can obtain sterile needles and syringes and return used injecting equipment."²¹ Although NEPs may make referral to drug treatment an important part of their services, they acknowledge that many IDUs, including some in drug treatment programs, continue to inject drugs and share injection equipment. They therefore seek to reduce the harm associated with these practices, a philosophy sometimes referred to as harm reduction or harm minimization.²² The essential arguments in favor of NEPs are that they could decrease the transmission of HIV by increasing the probability that IDUs use uninfected syringes, produce reductions in HIV risk behaviors, and refer IDUs with little or no contact with the public health system to drug treatment or other public health services. Opponents of NEPs contest these assertions and counter that NEPs will increase drug use in the community, particularly in those communities of color already disproportionately affected by the drug trade, and condone drug use. Both beneficial and adverse effects of NEPs on the number of discarded syringes have been claimed.

In the US an additional complicating factor is the existence of two types of laws that restrict the possession, distribution, or sale of injecting equipment. Such laws do not exist in Canada or in the majority of Western

European countries. Paraphernalia laws make the manufacture, possession, or distribution of drug paraphernalia a misdemeanor or felony offense; such laws exist in 46 states and the District of Columbia.²³ Prescription laws require a physician's prescription in order to purchase a syringe; these laws exist in 10 states and the District of Columbia; Maine recently revoked its prescription law and the prescription law in Connecticut has been modified (see below).²³

Several lines of evidence suggest a potential connection between HIV infection and these laws. HIV seroprevalence among IDUs entering drug treatment tends to be higher in states that have prescription laws (median = 15.0%) than in states that do not have these laws (median = 2.7%), although this relationship may not be causal. Moreover, the repeal of such a law in France was followed by increased use of sterile injection equipment²⁴ and decreases in reported equipment sharing rates.²⁵ In Connecticut, where the paraphernalia and prescription laws were modified to permit the purchase of up to 10 syringes without a prescription, sales of syringes to IDUs appear to have increased.²⁶ Although Connecticut IDUs responding to a questionnaire reported no change in the proportion who had shared at least one, those in four focus groups reported fewer sharing episodes.²⁷ Finally, researchers in Baltimore, MD, a state without a prescription law, found a 2.5-fold higher HIV seroprevalence among non-diabetic compared to diabetic IDUs, a finding they attributed to diabetics having better access to sterile syringes.²⁸

There is evidence that in the US IDUs may have difficulty purchasing syringes in pharmacies, even in states without prescription laws.^{29, 30} No national survey of US pharmacists has been done, but several reports are available from Europe, Australia, and Canada.^{21, 25, 31-38} In most studies, at least one-third of pharmacies or pharmacists were willing to sell syringes to IDUs, but many pharmacists were concerned about used syringe disposal and the potential adverse effects of IDUs' presence on their businesses.

Studies in the US and abroad demonstrate that, even when NEPs are operating, IDUs remain dependent upon a variety of primarily black market sources for their syringes.³⁹⁻⁴³ It should be clear, therefore, that NEPs are but one of several methods by which the availability of sterile syringes for IDUs could be enhanced. Schemes to promote the sale, distribution, or exchange of syringes in pharmacies have been a central element of the response to the HIV epidemic in Canada, Britain, Australia, New Zealand, Switzerland, Spain, France, and Germany.^{25, 31, 44-48} The only pharmacy-based NEP in the US is in Tacoma and operates on a one-for-one exchange basis out of a health department pharmacy.⁴⁹ IDUs who obtain their syringes from pharmacists can be assured of sterile syringes, whereas syringes obtained on the street may be repackaged to appear new.⁵⁰ Finally, Germany, Italy, Denmark, and the Netherlands have taken the lead in developing vending machines which either sell or exchange syringes.⁵¹⁻⁵⁴

B. Project Methods

The current evaluation was funded through a cooperative agreement between the Centers for Disease Control and Prevention (CDC) and the Association of Schools of Public Health, which contracted with University of California, Berkeley (UCB) to conduct the study. A significant amount of the work was subcontracted to the Institute for Health Policy Studies at the University of California, San Francisco (UCSF). The project began in April 1992 and was funded through October 1993.

We assembled a 12-person multidisciplinary research team in which no investigator was identified in his or her writing as either in favor of or opposed to NEPs. Community and expert input was sought by convening a 13-member Advisory Committee based in the San Francisco Bay Area and by contracting with seven outside experts to review draft chapters.

The goal of the project was: "To assess the public health impact of needle exchange programs." Fourteen research questions were identified; Chapters 5 through 18 of Volume I of the report each address one of these research questions. The study consisted of four components: 1) formal review of existing research, 2) NEP site visits; 3) mail surveys of NEPs not visited; and 4) cost-effectiveness modeling.

A total of 1,972 sources were reviewed during the study. These included 475 journal articles, 381 conference abstracts, 236 reports, 499 newspaper articles, and 159 unpublished materials.

Between May and September 1992 site visits to 15 cities with 23 NEPs were conducted: 10 cities in the US,* three in Canada,** and two in Europe.*** In all but three cities, site visits were at least three days in duration. Volume II of the report contains descriptions of the 12 cities with NEPs that were fully evaluated in our site visits. Following semi-structured interview guidelines,⁵⁵ project members interviewed a total of 239 individuals, including 25 NEP directors and staff, 14 public health officials, 22 IDU researchers, and 47 community leaders known for their support of or opposition to the local NEP. A total of 129 IDUs were also interviewed, most in 11 NEP client and seven non-client focus groups; a small number of IDUs were interviewed individually.

Twenty US NEPs not visited by project members were surveyed using a mail questionnaire. To our knowledge, all but four active NEPs in the US were either visited or surveyed by project members. These four NEPs were identified too late for inclusion in the evaluation.

Cost-effectiveness modeling involved a four-step process: 1) an assessment of NEP budgets; 2) the systematic evaluation of studies of NEP impact on HIV risk behaviors; 3) the assessment and further development of

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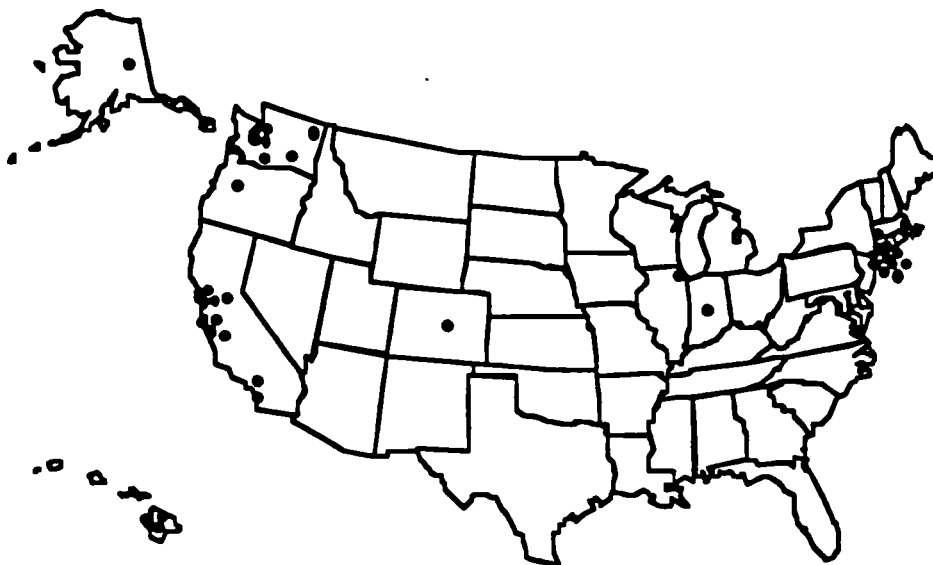
existing mathematical models of NEP impact on HIV transmission; and 4) the use of mathematical models to estimate the cost-effectiveness of NEPs, defined as cost per HIV infection averted.

The research protocol was submitted to and approved by the Committee for Protection of Human Subjects at UCB. Two Draft/Interim report were completed and submitted to the CDC and the reviewers on April 1, 1993 and July 16, 1993. The drafts were extensively reviewed by the contracted experts and other reviewers.

C. How and Why did NEPs Develop?

The first NEP was established in Amsterdam, the Netherlands in 1984 by a drug users advocacy group called the Junkie Union that wished to prevent an epidemic of hepatitis B when an inner-city pharmacist planned to discontinue selling syringes to IDUs.⁵⁶ The first person to distribute drug injection equipment publicly in the US was Jon Parker, in New Haven, CT and Boston, MA in November 1986 (Dan Waldorf, personal communication, September 1, 1992).⁵⁷ The first US NEP to provide comprehensive services was established in Tacoma, WA in 1988. As of September 1, 1993 there are at least 37 NEPs operating in 30 US cities (see Appendix and Figure 1). In addition, we are aware of three states (Florida, Minnesota, and Arkansas) and two cities (Cincinnati, OH and Baltimore, MD) that are considering establishing NEPs.

Figure 1: US NEPs Active In First Quarter 1993



Based on NEP staff interviews at 13 programs visited and mail surveys of 20 programs not visited. Four NEPs subsequently identified are also represented on the map.

We discuss here four trends that characterize the evolution of NEPs in the US. Jon Parker, who states that he has been arrested 27 times in

seven states and has publicly challenged the prescription laws in all states that have them,⁵⁷ perhaps best exemplified the civil disobedience approach to NEPs. While this approach has succeeded in making NEPs a prominent public issue, it has at times alienated the very community groups whose support is critical to the establishment of NEPs—African-Americans and providers of drug treatment. Later NEPs, such as those in New Haven and Portland, OR were established only after prolonged periods of community consensus-building.

A second trend has been that NEPs are now more likely to be legal than in the past. Several programs that were initially illegal and underground, such as Prevention Point in San Francisco, CA, subsequently received approval and even funding from local governments. Nonetheless, of the 12 NEPs that opened in 1992, only five are legal.

A third trend has been the growing institutionalization of US NEPs. Several programs started by activists now receive government or foundation funding and some are run directly by health departments (e.g., Boulder, CO and Seattle, WA). NEPs are now less reliant upon volunteer staff and have better linkages to other public health services.

A final trend has been increasing US federal funding of NEP research. A total of five bans on the use of federal funds for either providing NEP services or conducting research into the programs have existed. Although a ban on federal funding for NEP services remains, there have now been seven federally-funded studies of NEPs. Four of these, including the present study, are concerned primarily with the synthesis of existing information; three studies entail the collection of new data. In a 1993 report, the GAO concluded that "Existing statutory authority does, however, in our opinion, permit use of federal funds for studies or demonstrations of needle exchanges, which might involve the provision of needles."⁵⁸

The Canadian experience with NEPs has been dramatically different from that in the US. As early as 1989, the Canadian federal government offered to co-fund comprehensive pilot IDU HIV prevention programs that included NEPs. By February 1993, a total of 28 Canadian cities had active NEPs (Betsy MacKenzie, personal communication, February 25, 1993). While some Canadian community and neighborhood groups have opposed NEPs, the debate has generally been less politically charged than in the US. The fact that pilot NEPs operate within a multifaceted approach to drug use that combines education, counseling, law enforcement, and linkages to other services, including drug treatment, has helped minimize community opposition.

Conclusion:

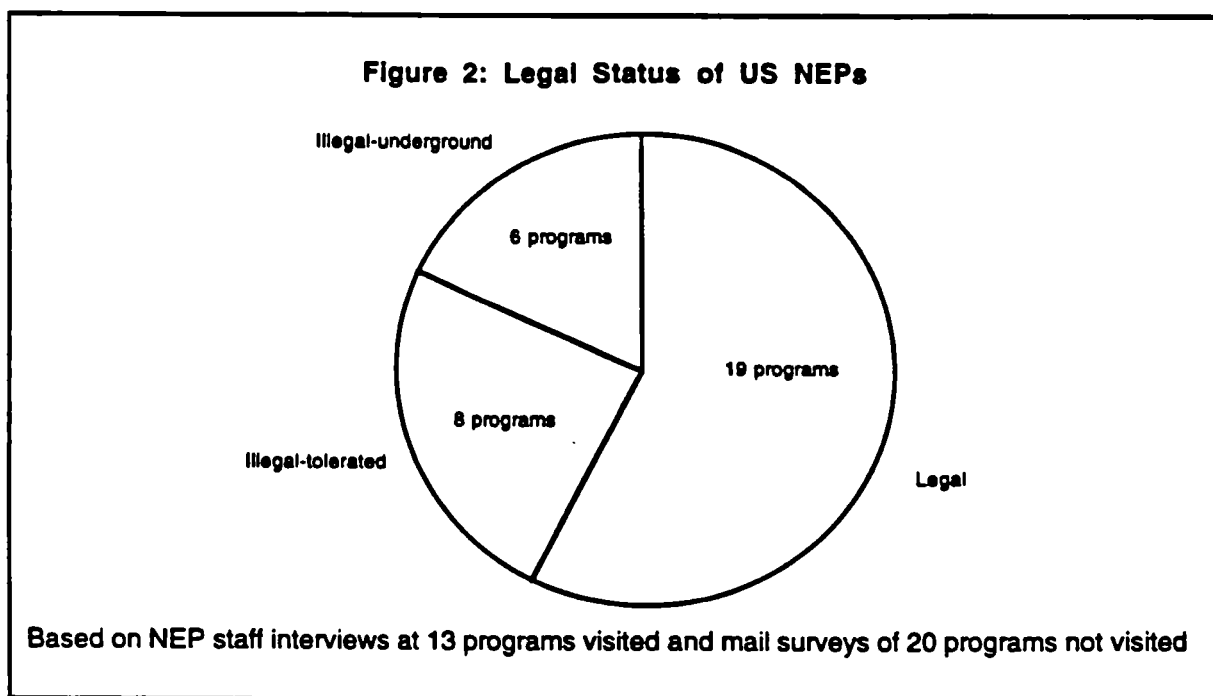
- *NEPs have continued to increase in number in the US and by September 1, 1993 at least 37 active programs existed. The evolution of NEPs in the US has been characterized by growing efforts to accommodate the concerns of local communities, increasing likelihood of being legal, growing institutionalization, and increasing federal funding of research,*

although a ban on federal funding for program services remains in effect.

D. How Do NEPs Operate?

There are almost as many NEP operating models as there are NEPs. Each is the unique product of an often extended interaction between the NEP, its clients, and the broader community. Four aspects of NEP operations can be delineated: 1) legal status; 2) organizational structures; 3) operating characteristics; and 4) services provided. We summarize here the results of information gathered on site visits and in the project mail survey.

Of the 33 NEPs visited or surveyed in this project, 19 are legal,* eight are illegal but have received the support of a local elected body (illegal-tolerated), and six are illegal and operate without such support (illegal-underground; see Figure 2). All Canadian NEPs are legal.



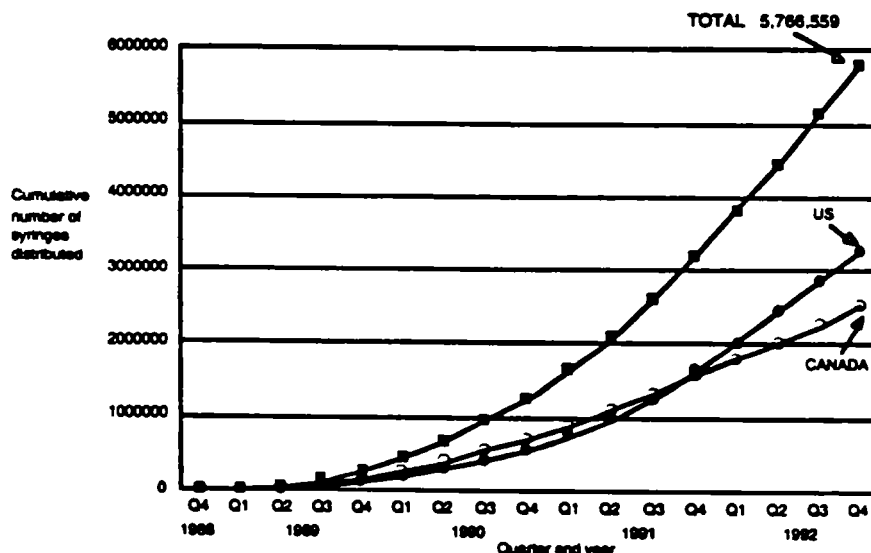
Four distinct categories of NEP administering bodies can be delineated: activists (13 programs), community-based organizations (CBOs) without government sponsorship (eight programs), CBOs with government sponsorship (six programs), and state or local government-operated NEPs (six programs). For many NEPs, funding is secured from a patchwork of different sources, among which private donations and foundation grants are the most common. Fifteen US NEPs receive state or local government funds for operations, but no program receives federal funds.

*NEPs are defined as legal if they exist in a state without a prescription law or operate under an exemption to the prescription law.

The 33 US NEPs operate a total of 102 sites, which can be divided into the more common fixed sites (65 sites) and less common mobile sites (37 sites). The most common fixed sites are scheduled van stops (27 sites) and scheduled street exchanges (26 sites), while delivery services (20 sites) are the most numerous of the mobile sites. US NEPs are open a median of three days per week for a mean of 23.9 hours. Twenty-six NEPs use volunteers, including 15 that rely exclusively upon volunteers to provide services. Almost all US NEPs (27 NEPs) provide only one syringe for each syringe brought in to the NEP; about one-half (17 NEPs) provide small numbers of syringes to IDUs making their first visit to the NEP. For the most part, therefore, US NEPs take in as many syringes as they give out. At 11 NEPs restrictions on the number of syringes that can be exchanged exist. Minimum age limits and requirements to show evidence of current drug injection are rare characteristics of US NEPs, probably because they are difficult to enforce.

We estimate that over 5.4 million syringes have been distributed by US NEPs by June 1993; due to missing data for some NEPs, this number is an underestimate. US NEPs distributed more than 2.4 million syringes in 1992. Figure 3 displays data on syringes distributed by the 15 US and Canadian NEPs visited and Hawaii that provided us with detailed breakdowns of syringes distributed.

Figure 3: Cumulative Number of Syringes Distributed by Selected US and Canadian NEPs Through Fourth Quarter 1992



Based on 15 programs visited and Hawaii. Data missing for Boulder 10/92–12/92; Berkeley 10/92–12/92; Santa Cruz 7/92–12/92; and Toronto, Parkdale 4/92–12/92. Data interpolated for Toronto, The Works; Montreal, CACTUS; Vancouver; and San Francisco.

Recognizing that sexual transmission of HIV is also a risk for IDUs, all US NEPs provide condoms to clients. Almost all programs also distribute bleach for syringe disinfection, health pamphlets, and alcohol wipes, with fewer programs providing cotton, water bottles, or cookers,

items used in the preparation of drugs for injection. While most NEPs do refer clients to a variety of public health services, they have limited ability to provide these services on-site. Services provided by all US NEPs are thus considerably broader than simply the exchange of syringes, and emphasize links to other public health services, including drug treatment.

Conclusion:

- *About one-half of US NEPs are legal, but funding is often unstable and most NEPs rely on volunteer services to operate. All but six NEPs require one-for-one exchanges and rules governing the exchange of syringes are generally well enforced. In addition to having distributed over 5.4 million syringes, US NEPs provide a variety of services ranging from condom and bleach distribution to drug treatment referrals.*

E. Do NEPs Act as Bridges to Public Health Services?

As NEPs have become more institutionalized, they have increasingly been touted as a potential method for referring IDUs to the public health system. NEPs have contact with IDUs with limited or no prior experience with drug treatment; these IDUs could benefit from referrals not only to drug treatment, but also to HIV counseling and testing, primary medical care, tuberculosis and sexually transmitted diseases screening and treatment, and psychological counseling and support. NEPs would thus become one part of a comprehensive approach to the prevention of HIV in IDUs, an approach that would also emphasize the expansion of drug treatment and school- and community-based interventions to prevent the initiation of drug use.

A significant limitation on the ability of NEPs to refer IDUs to drug treatment is the paucity of drug treatment slots. As mentioned, fewer than 15% of IDUs are in drug treatment on any given day.¹⁷ From a public health perspective, NEPs cannot be a meaningful bridge to treatment if all they can do is refer IDUs to waiting lists or help NEP clients displace others waiting for admission to drug treatment.

NEPs vary greatly with respect to the emphasis they place upon making referrals to drug treatment and other public health services. This stems in part from the desire to make the NEP "user-friendly," the recognition that many active IDUs express no interest in entering drug treatment,^{18, 19} and the related belief that an overemphasis on drug treatment referral could alienate potential NEP clients. Many NEPs have therefore evolved an approach where they selectively refer clients to drug treatment, based on either staff perceptions of the client's readiness for treatment or the client's declared interest.

Staff of all but one of the 18 US and Canadian NEPs visited during this project stated that they refer clients to drug treatment. The six NEPs visited that maintained records of these referrals had made a total of 2,208 referrals to drug treatment, an underestimate because recent data are lacking for all (see Table 1). Although there are limited data on whether these

referrals are completed, at least 794 NEP clients have entered drug treatment in Hawaii,⁵⁹ Seattle, WA,⁶⁰ Tacoma, WA,⁶¹ New Haven, CT,⁶² and Vancouver, BC.⁶³

Table 1: Referrals Made by Selected US and Canadian NEPs Visited

<u>NEP</u>	<u>Dates</u>	<u>Referrals</u>
New Haven NEP	11/90–6/91	186 drug treatment
Seattle NEP	2/90–3/92	179 drug treatment
Tacoma, Point Defiance	2/91–6/93	982 drug treatment
Montreal, CACTUS	7/89–12/90	94 medical care 160 detoxification 125 psycho-social support
Toronto, The Works	8/89–1/93	294 drug treatment 80 drug detoxification 226 medical services 663 "other" services
Vancouver, DEYAS	7/90–3/91	327 drug treatment 244 medical treatment 209 social services 66 youth worker

Only three of the 33 US NEPs are able to provide drug treatment services on-site. Ten NEPs provide on-site social services, eight on-site primary medical care, and seven on-site HIV testing and counseling and sexually transmitted diseases screening. Referral linkages appear to be stronger in the better-funded NEPs and those that are more integrated into the public health system.

Conclusion:

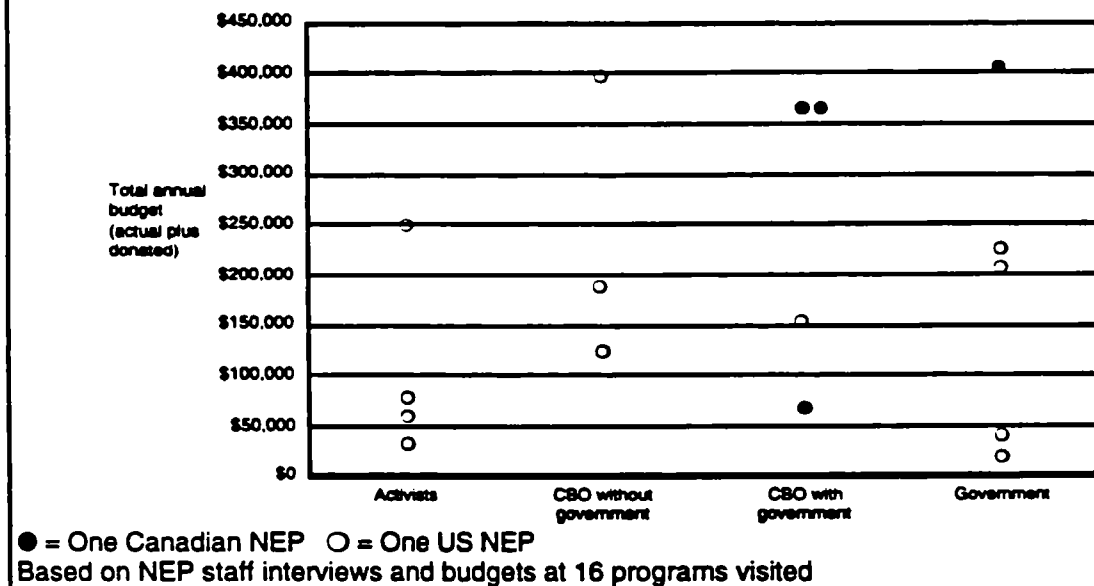
- *Some NEPs have made significant numbers of referrals to drug abuse treatment and other public health services, but referrals are limited by the paucity of drug treatment slots. Integrating NEPs into the existing public health system is a likely future direction for NEPs.*

F. How Much Does it Cost to Operate NEPs?

The diversity and continuing evolution of NEPs point to a need to assess program budgets and examine the key determinants of cost. In particular, the relationship between NEP administering body and budget is of great policy relevance.

NEPs in the US and Canada visited by project members vary greatly in total* annual budgets; these range from a low of \$18,628 at Tacoma, WA's Pharmacy NEP to a high of \$403,464 at Toronto, ON's The Works, with a median of \$168,650 (see Figure 4). This relatively low median program budget could support about 60 methadone maintenance slots for one year.⁶⁴ Activist programs tend to be least expensive and government programs most expensive, with CBO-run programs in between. Much of the cost of the more expensive NEPs is for items that do not add directly to services (e.g., staff supervision and rent) and for non-exchange services (e.g., drug treatment referrals and counseling).

Figure 4: Total Annual NEP Budget, by Administering Body



The largest cost component is personnel, accounting for a median of 66% of total budgets. Syringe costs represent a median of 7% of total budgets.

Three indices permit assessment of NEP productivity. The median cost per syringe distributed is \$1.35 and the median cost per hour open is \$145. The median number of syringes distributed per hour is 205.

Conclusion:

- *The median annual budget of US and Canadian NEPs visited is relatively low at \$169,000, with government-run programs tending to be more expensive. Some NEPs are more expensive because they also provide substantial non-exchange services such as drug treatment referrals. The annual cost of funding an average NEP would support about 60 methadone maintenance slots for one year.*

*Includes both actual expenditures and donated services and supplies

G. Who Are the IDUs Who Use NEPs?

A central assertion of NEP proponents is that NEPs provide services to "isolated IDUs": those with little contact with the public health system. Thus, NEPs may provide a point of contact to help IDUs gain access to the public health services discussed in Chapter 7.

US NEPs serve an ethnically diverse clientele. The mean age of US NEP clients ranges from 33 to 41 years; the mean duration of drug use ranges between seven and 20 years. One-third to one-half of NEP clients have never been in drug treatment, and clients are primarily regular and frequent injectors. These clients are at substantial risk for HIV infection; approximately one-third report sharing syringes in the month preceding the interview.

Fifteen studies have compared NEP client and non-client samples.^{36, 61, 65-79} These studies suggest that, compared to non-clients, NEP clients may be slightly more likely to be male, are somewhat less likely to be African-American, and are older. These findings generally hold in the US and abroad. NEP clients in the US appear to have been enrolled less often in drug treatment programs than non-clients, while the opposite seems to be true in foreign countries. In the US, NEP clients and non-clients appear to be at similar risk of acquiring HIV through their drug use; clients abroad are consistently at lower risk for drug-related HIV infection. HIV seroprevalences are similar in NEP clients and non-clients in the six studies that evaluated this outcome.^{59, 72-75, 79, 80}

In focus groups with NEP clients and non-clients conducted for this report, IDUs identified several factors that influence their use of the NEP. These included fear of arrest or harassment by police, NEP locations and hours, NEP staff attitudes, the desire not to be identified as an IDU, and the existence of alternative sources of sterile syringes.

Conclusion:

- *Although NEP clients vary from location to location, NEPs generally reach a group of IDUs with long histories of injection drug use who remain at significant risk for HIV infection. NEP clients in the US have had less exposure to drug abuse treatment than IDUs not using the NEP.*

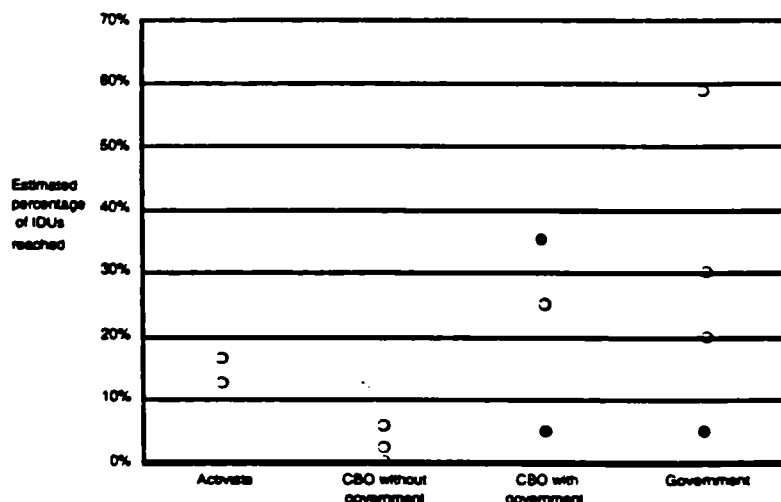
H. What Proportion of All IDUs in a Community Uses the NEP?

The overall public health impact of NEPs will be strongly related to the proportion of IDUs who use them. Studies from abroad indicate that NEPs, if adequately funded, have the capacity to reach significant proportions of the local IDU population. By 1988, over 50% of IDUs attending methadone or sexually transmitted diseases clinics in Amsterdam, the Netherlands were using the local NEPs as their sole source of syringes.⁸¹ (In Amsterdam methadone maintenance therapy is frequently used to decrease injection frequency, not necessarily to induce abstinence.)

Thirty-four percent of opiate injectors in Manchester, England use NEPs regularly.⁶⁹

Information gathered by project members suggests that, to date, coverage by US and Canadian NEPs has been more limited, perhaps due to funding and legal constraints. US and Canadian NEPs visited by project members have had contact on at least one occasion with a median of 14.5% of the estimated number of IDUs in those cities (see Figure 5) and have distributed a median of 2.3 syringes per IDU per quarter. Because almost all US NEPs are distributing increasing numbers of syringes, it is also useful to consider the NEPs that perform most successfully on these measures, as they suggest the potential impact of NEPs. The New Haven, CT NEP is estimated to have reached between 49% and 68% of local IDUs and Tacoma, WA's Point Defiance distributes about 21 syringes per IDU per quarter.

Figure 5: Estimated Percentage of IDUs Reached by US and Canadian NEPs, by Administering Body



● = One Canadian NEP ○ = One US NEP

Overall median = 14.5%

Based on 12 programs visited. Data for the Point Defiance and Pharmacy NEPs in Tacoma are combined and presented as a CBO with government.

In considering these findings, it is critical to acknowledge the inherent uncertainty in estimates of the numbers of IDUs and to mention that estimates of total numbers of IDUs were only available by metropolitan area, thus underestimating the impact of NEPs in large cities that serve only IDUs in specific neighborhoods. Because many IDUs, particularly those in states without prescription laws, may have access to a regular supply of syringes, and because some IDUs may have others exchange on their behalf, the optimal proportion of IDUs that should be reached by NEPs remains unclear. However, it appears that NEPs alone cannot distribute sufficient numbers of syringes, and alternative methods of syringe distribution, such as pharmacy sale, distribution, or exchange, must be explored.

Conclusion:

- *Studies of adequately-funded NEPs suggest that NEPs do have the potential to serve significant proportions of the local IDU population. While some NEPs appear to have reached large proportions of the local IDU population at least once, others are reaching only a small fraction of local IDUs. Consequently, other methods of increasing sterile needle availability must be explored.*

I. What Are the Community Responses to NEPs?

Proposals to establish NEPs in US cities have frequently encountered vigorous opposition from a variety of individuals and community groups. The US community responses have been in marked contrast to those in foreign countries, including Canada, where debate over the issue was less contentious and often largely confined to the public health community.

Many US NEPs were initially proposed and/or established by activist groups, including the gay and lesbian activist group ACT-UP. Local elected officials who supported NEPs were opposing the stance of President George Bush⁸² and some received letters from the federal Office of National Drug Control Policy (ONDCP) lobbying against the NEP.⁸³ Health department staff were critical in communicating the urgency of the HIV epidemic to policymakers, and some volunteered their time and skills to work with the local NEP.

Opposition often came from law enforcement authorities, drug treatment providers, local businesspeople, and residential groups. Although several police chiefs supported NEPs (e.g., Portland, OR; San Francisco, CA; and New Haven, CT), others saw the programs as inconsistent with the "War on Drugs." Drug treatment providers who opposed NEPs did so either because they saw the programs as being in conflict with the abstinence ethic of many drug treatment programs, or because they were concerned about competition for scarce resources. Local businesspeople and residents who opposed NEPs generally opposed the local presence of IDUs, not the NEP *per se*.

The most consistent sources of opposition to NEPs were African-American church and community leaders. There were four major reasons for African-American community opposition to NEPs. First, the repeated failure to provide sufficient drug treatment capacity led some to oppose NEPs. Second, activists at times failed to meet and consult with African-American community leaders. Third, African-American community leaders felt that NEP advocates did not understand the often ruinous effects of the drug market and drug use on communities of color. Fourth, if NEPs were to lead to increased drug use rates, African-American communities would bear a disproportionate share of the burden. This was described by some African-American leaders as "genocide."⁸⁴⁻⁸⁷ However, newer African-American organizations established specifically to address HIV prevention (e.g., the Black Coalition on AIDS in San Francisco) generally supported NEPs as did several African-American mayors (e.g., New York City,

Baltimore, MD, New Haven, CT, and Washington, DC). African-American and Latino community leaders must be consulted if harm reduction and community-based HIV prevention strategies such as NEPs are to be effective.

Public opinion polls⁸⁸⁻¹⁰¹ indicate that approximately half of the general public has supported harm reduction efforts, including needle cleaning, legalization of needle sales, needle exchange, and needle distribution. Support has tended to grow with time and has been higher for needle exchange than for needle distribution schemes. African-Americans are about as likely to support needle exchange or distribution as the general public.

Conclusion:

- *Unlike in many foreign countries, including Canada, proposals to establish NEPs in the US have often encountered strong opposition from a variety of different communities. Consultation with affected communities can address many of the concerns raised.*

J. Do NEPs Result In Changes in Community Levels of Drug Use?

The debate over whether NEPs facilitate drug use has probably been more hotly contested than any other issue regarding NEPs. A requirement that NEPs be shown to "not encourage the use of illegal drugs" before NEP services can be funded by the federal government has even been established by Congress.¹⁰²

The intensity of the debate has tended to obscure the fact that the question of whether NEPs increase drug use can be divided into three sub-questions: 1) are NEPs associated with a change in the frequency of drug injection among IDUs who use the NEP? 2) are NEPs associated with changes in community levels of injection and non-injection drug use? and 3) do NEPs deter IDUs from seeking drug treatment? It is critical to address these three components of the question separately.

With respect to the first question, the studies reviewed in Section L as well as focus groups conducted with NEP clients and non-clients suggest that NEPs are not associated with a change in injection frequency among NEP clients.

To answer the second question definitively, one would have to establish large cohorts of IDUs and non-IDUs in numerous communities and follow these subjects prospectively for several years. Outcome measures would include the incidence and prevalence of drug use as well as assessments of changes in the frequency and routes of drug use. The multiple complex logistical, ethical, and political obstacles likely to be encountered would prevent such a study from ever being conducted.

Two studies in San Francisco, CA^{76, 103} evaluated the second question by demonstrating that the mean age of drug users either rose or

stayed stable over time. In Amsterdam, the Netherlands, annual capture-recapture studies of "hard" drug users showed their numbers to be stable, the mean age of this population to be increasing, and the proportion under 22 years of age to be declining.⁵⁶ We also evaluated three national drug use indicators:¹⁰⁴ 1) Drug Abuse Warning Network (DAWN), which records emergency room and medical examiner mentions of drug use; 2) Drug Use Forecasting (DUF), which conducts random urine tests of arrestees or detainees; and 3) Uniform Crime Reports (UCR), which summarize drug-related arrests. These data, while limited in their precision (making detection of small changes in drug use difficult), provide no evidence of any changes in community levels of drug use. Almost all IDU focus group members stated that NEPs would not affect the numbers of injecting and non-injecting drug users in the community.

No formal studies of the third question have been reported. Any assessment of the net effect of NEPs on drug treatment utilization would also have to factor in the substantial numbers of new referrals to drug treatment generated by some NEPs. Some public health officials and IDUs found the possibility of drug treatment deferral more plausible than the other two scenarios discussed.

Conclusion:

- *Although quantitative data are difficult to obtain, those available provide no evidence that NEPs increase the amount of drug use by NEP clients or change overall community levels of non-injection and injection drug use. This conclusion is supported by interviews with NEP clients and by IDUs not using the NEP, who did not believe that increased needle availability would increase drug use.*

K. Do NEPs Affect the Number of Discarded Syringes?

The debate over the effect of NEPs on the number of discarded syringes is unique among the 14 research questions surrounding NEPs in that both opponents and advocates have claimed that the evidence favors their point of view. This question has been of concern both to members of the public and law enforcement officers, who fear needlestick injuries while searching suspects. Fortunately, theoretical analysis and empirical evidence can help resolve this issue.

Fifteen of the 33 US NEPs evaluated in this report operate on a one-for-one exchange basis and provide no syringes to IDUs presenting without a syringe at their first visit. These NEPs give clients one sterile syringe for every used syringe turned in to the NEP and thus cannot increase the total number of discarded syringes, although they could change the geographical distribution of the discarded syringes. Because a used syringe in a city with an NEP now has value (it can be exchanged for a sterile syringe), it is plausible that the discarding of syringes would decrease in much the same way as "bottle bills" have decreased discarded bottles and cans. IDUs might pick up discarded syringes to bring to the NEP to exchange; NEP staff confirm that this occurs.¹⁰⁵ Although 17 US NEPs do provide

syringes to IDUs presenting to the NEP for the first time, these "starter needles" are few in number and are dwarfed by the overall number of syringes distributed by any NEP. Even those NEPs without one-for-one exchange rules or that provide starter needles do not diverge greatly from the one-for-one exchange condition; the NEPs in Portland, OR (one-for-one; provides three starter needles) and Vancouver, BC (not one-for-one; provides two starter needles) had 99% and 97% return rates in 1992. It is worth noting, however, that schemes that distribute or sell syringes through pharmacies do have the potential to increase the total number of discarded syringes, although this problem can be at least partially addressed by either distributing sharps containers with the syringes or providing a discount on syringe purchases if used syringes are returned.^{45, 106}

Empirical studies confirm these theoretical predictions. The number of discarded syringes in the vicinity of the Portland NEP decreased by almost two-thirds after the NEP opened.¹⁰⁷ Because this research design cannot assess whether used syringes might have simply been discarded elsewhere in the city, it is useful to examine community-wide indices. In Toronto, ON the number of syringes collected by various community and governmental organizations appears to have decreased since the opening of the NEP.¹⁰⁸ In Amsterdam, the Netherlands, needlestick injuries reported by members of the general public to the Municipal Health Service have increased somewhat since the NEP opened, but a similar rise in reported needlestick injuries by the medical profession suggests that this is a reporting artifact due to increased awareness of needle-borne infections.¹⁰⁹

Conclusion:

- *NEPs in the US have not been shown to increase the total number of discarded syringes and can be expected to result in fewer discarded syringes.*

L. Do NEPs Affect Rates of HIV Drug and/or Sex Risk Behaviors?

In part because changes in HIV infection rates are difficult to demonstrate empirically, a substantial amount of NEP research has sought to assess whether NEPs can affect the behaviors that result in the transmission of HIV. Such behavior change may include decreased sharing of used syringes, as well as other risk reductions (e.g., increased bleaching of used syringes or decreased sex risk). These changes would produce risk reduction in addition to that resulting from the essential rationale for establishing NEPs: removing contaminated syringes from circulation and replacing them with sterile ones.

Studies of behavior change associated with NEPs, like studies of many other HIV prevention strategies, can never satisfy the ideal standards of randomized controlled trials. For example, randomization of IDUs to NEP use or non-use raises significant ethical issues in the minds of some, and inevitable cross-over between NEP client and non-client groups would complicate interpretation.¹¹⁰ Randomizing communities to having an NEP or not, another possible approach, is likely to be extremely expensive,

probably costing in the tens of millions of dollars.¹¹¹ Political obstacles at the local level and the fact that many cities already have NEPs make such a study unlikely. Blinding, at least of study subjects, is also impossible. Without randomization and blinding, comparison of NEP clients to non-clients, while useful, will always be imperfect.

We identified a total of 26 evaluations of the effect of NEPs on HIV drug and sex risk behavior. Study designs included seven cross-sectional analyses,^{65, 66, 69, 76, 112-114} five serial community cross-sectional studies,^{42, 45, 76, 103, 115-117} seven studies based on recall,^{36, 65, 80, 106, 118-121} and six prospective cohort studies of NEP clients.^{59, 68, 72, 73, 78, 122-127} Each study was evaluated and graded on a quality scale ranging from one (lowest quality) to five (highest quality) based on its ability to assess behavior change due to the NEP.

Sixteen of the 26 evaluations provide credible evidence (quality rating ≥ 3) about NEP effects on behavior (see Table 2). Ten of the 16 studies included comparison groups. No study received a quality rating of five; limitations included lack of randomization, NEP client self-selection, dependence upon self-reported behaviors of IDUs, poor follow-up in prospective studies, and lack of detail in reporting of behavior. Formal meta-analysis was precluded by the use of differing research approaches and inconsistent measures of risk behavior change.

Table 2: Summary of Studies of Behavior Change With Quality Rating of Three or Greater

<u>Outcome measure</u>	<u>Beneficial NEP effect</u>	<u>Mixed or neutral NEP effect</u>	<u>Adverse NEP effect</u>
Drug risk			
Sharing frequency	10 studies	4 studies	
Giving away used syringes	3 studies	1 study	1 study
Needle cleaning	3 studies	1 study	
Injection frequency	3 studies	4 studies	1 study
Sex Risk			
Number of partners	2 studies*	1 study**	
Partner choice	1 study***	1 study†	
Condom use	1 study††	1 study†††	1 study ^f

References:

See text for drug risk references

* 68, 124, 125, 106

** 72, 126

*** 68, 124, 125

† 72, 126

†† 106

††† 36

^f 68, 124, 125

Most of the 16 acceptable studies showed drug-related risk reductions during NEP participation. Of the 14 studies examining sharing,

ten suggested reduced sharing^{36, 65, 72, 76, 78, 80, 106, 115, 116, 118-120, 122, 123, 126} and four no effect.^{66, 68, 69, 114, 124, 125} None found an increase in risk behaviors. Of the five studies looking at IDUs giving away used syringes, three found beneficial effects,^{72, 80, 119, 120, 126} one found mixed effects,¹¹⁴ and one found adverse effects.⁶⁹ Of the four studies examining needle cleaning, three found a benefit associated with the NEP^{78, 106, 120, 122, 123} and one found no effect.⁶⁶ Finally, of the eight studies considering the effect of NEPs on the frequency of injecting, three found reductions in injection,^{36, 65, 80, 119} four found a mixed or no effect,^{76, 103, 115, 116, 118, 120} and one found an increase in injection compared with controls.^{72, 126}

The four evaluations of the effects of NEPs on HIV sex risk behaviors found no clear trend toward either a beneficial or adverse effect of NEPs on number of partners, choice of partners, or frequency of condom use.^{36, 68, 72, 106, 124-126}

Conclusion:

- *The majority of studies of NEP clients demonstrate decreased rates of HIV drug risk behavior, but not decreased rates of HIV sex risk behavior.*

M. What is the Role of Studies of Syringes in IDU Research?

Although the data presented show a decrease in HIV drug risk behaviors, all of the behavioral data are self-reported. While we believe that self-reported data, if interpreted cautiously, can be used to assess IDU behaviors and behavior change, others, including the former Director of the ONDCP, have questioned the validity of such data.¹²⁸

For these reasons, some have proposed the assessment of used syringes as a potential method for addressing the limitations of self-reported data. Such data could serve the following possible purposes: 1) validating self-reported needle sharing by IDUs;^{79, 129} 2) estimating the prevalence of HIV antibody;^{112, 130-137} 3) estimating the prevalence of HIV itself;¹³⁸⁻¹⁴⁴ 4) evaluating syringe HIV infectiousness;¹⁴¹ 5) estimating the prevalence of hepatitis B virus;¹⁴⁵ 6) detecting bleach (Guydish and Barnett, unpublished data); and 7) visually inspecting syringes to estimate circulation times.¹⁴⁶

The validity of testing of syringes is limited by the following factors: 1) limited sensitivity due to the small amount of blood in the syringe; 2) dilution effects due to serial use of the syringe; 3) for some techniques, high cost; 4) changes in access to sterile syringes; 5) changes in client recruitment; and 6) decreased effectiveness in the presence of bleach or specific drugs for some testing methods.

Syringe HIV positivity rates should not, therefore, be used as simple proxies for IDU seroprevalence. In general, tests for HIV antibody or deoxyribonucleic acid (DNA) are quite specific, but their sensitivity is limited. These limitations can be minimized by comparing syringe characteristics over time or between NEP clients and non-clients.

Researchers in New Haven, CT have made creative use of syringe testing to estimate HIV incidence in NEP clients.¹⁴⁷

Conclusion:

- *The limitations of using the testing of syringes as a measure of IDU behavior or behavior change can be minimized by following syringe characteristics over time, or by comparing characteristics of syringes returned by NEP clients with those obtained from non-clients of the NEP.*

N. Do NEPs Affect Rates of Diseases Related to Injection Drug Use Other than HIV?

Researchers have considered examining rates of hepatitis B and C infection, subcutaneous abscesses, right-sided endocarditis, cellulitis, and sexually transmitted diseases as objective measures of NEP effectiveness. Only studies of abscesses and hepatitis B have been reported to date. Although much of the information related to abscess rates is anecdotal, that information is consistent with the ability of NEPs to decrease abscess rates, although abscess rates are also reflective of skin cleaning and drug preparation methods.¹⁴⁸⁻¹⁵²

The outcome of greatest interest in answering this question is the change in the hepatitis B seroconversion rate, which can only be measured in prospective studies. However, new cases of hepatitis B are relatively rare; thus cases are likely to be uncommon in any cohort regardless of the intervention, and differences between control and NEP arms will be difficult, if not impossible, to demonstrate. It is for this reason that we believe that case-control studies of hepatitis B represent the most fruitful line of research to address this question.

Six studies have examined the effect of NEPs on hepatitis B; three are serial community cross-sectional studies,^{15, 117, 119, 153, 154} one is a serial NEP cross-sectional study,¹⁵⁵ one is a case-control study,¹⁵⁶ and one is an open cohort study.^{78*} The sole case-control study demonstrates a strong protective effect against acute hepatitis B for IDUs who had used the Tacoma, WA NEP (odds ratio = 3.9; 95% confidence interval: 1.1-13.4). As differences between cases and controls other than their use of the NEP may explain these results, a multivariate statistical analysis of the data is now being conducted. The Portland, OR open cohort study is hampered by small sample size and short follow-up period, but the results demonstrate that attending an NEP is insufficient on its own to completely prevent cases of infections related to injection drug use.

*An open cohort study is one without formal prospective follow-up, but subjects may return periodically to the study site and be retested (e.g., at a drug treatment center).

Conclusion:

- *Studies of the effect of NEPs on injection-related infectious diseases other than HIV provide limited evidence that NEPs are associated with reductions in subcutaneous abscesses and hepatitis B among IDUs.*

O. Do NEPs Affect HIV Infection Rates?

Studies of the effects of NEPs on HIV infection rates are hampered by the methodological limitations mentioned as well as the fact that new HIV infections are even rarer and more difficult to detect than hepatitis B infections. Thus, studies with HIV infection as the outcome measure require still larger sample sizes; using favorable assumptions (50% decrease in new HIV infections due to the NEP; 5% baseline seroconversion rate; and 70% follow-up rate), we estimate that over 2,500 IDUs would have to be followed for one year to conduct such a study.

Our review has identified two case studies,^{156, 157} seven community cross-sectional studies,^{15, 34, 42, 59, 155, 158-161} six serial NEP cross-sectional studies,^{72, 127, 155, 162-165} one case-control study,¹⁶⁶ two open cohort studies,^{78, 163} and three prospective studies.^{72, 119, 127} In this summary we focus on the case-control study and the prospective studies.

A case-control study in Amsterdam, the Netherlands failed to demonstrate a statistically significant relationship between HIV seroconversion and use of the NEP.¹⁶⁶ However, with only 31 HIV seroconverters, the study had limited statistical power to detect even relatively powerful NEP effects. In addition, in Amsterdam the use of NEPs is so widespread and pharmacy sales of syringes so large that even non-clients or infrequent clients of the NEP probably had substantial access to sterile syringes, potentially obscuring any NEP effect. A number of HIV seroconversions may have been due to sexual rather than drug risk behaviors.

Seroconversions have been rare in prospective studies of HIV incidence in NEP clients. In two such studies,^{72, 119} no seroconversions were noted and in a third¹²⁷ the two seroconversions reported may have occurred prior to enrollment in the NEP. Two of these studies^{72, 119} included control groups; no HIV seroconversions were detected in either control group.

It should be noted that all currently accepted HIV prevention interventions (e.g., condoms) were initially advocated in the absence of data suggesting that they had decreased HIV seroconversion rates. For most interventions, such data have never been generated and there is no HIV prevention intervention that has been shown to decrease HIV seroconversion rates in a randomized trial. Although having clearcut evidence that NEPs reduce HIV seroconversion rates is certainly optimal, public health officials frequently advocate (or oppose) interventions in the absence of such data. Such an approach is clearly justifiable, particularly when there is an epidemic of a highly lethal, potentially preventable infectious disease.

Conclusion:

- *Studies of the effect of NEPs on HIV infection rates do not and, in part due to the need for large sample sizes and the multiple impediments to randomization, probably cannot provide clear evidence that NEPs decrease HIV infection rates. However, NEPs do not appear to be associated with increased rates of HIV infection.*

P. Are NEPs Cost-effective in Preventing HIV Infection?

Four methods were utilized to assess NEP effectiveness and cost-effectiveness. In the first, the New Haven needle circulation model,¹⁴⁷ was reviewed and each of its assumptions evaluated. Based on this review, we conclude that the model is a significant, innovative, and sound addition to NEP evaluation efforts. Because it does not include estimates of risk behavior change (other than the act of exchanging), it probably underestimates the true impact of NEPs.

In a second model (see Table 3), a simplified version of the circulation model was combined with data collected for this report to estimate NEP effectiveness and cost-effectiveness in four hypothetical cities. HIV incidence in NEP clients is estimated to decline between 17% and 70% in these hypothetical cities. The cost per HIV infection averted ranges between \$12,000 and almost \$100,000.

Table 3: Comparison of Model Estimates of NEP Impact and Cost-effectiveness, In One Hypothetical City

<u>Outcome measure</u>	<u>Simplified circulation model</u>	<u>Behavior change model</u>	<u>Combined model</u>
Relative decrease in HIV incidence, NEP clients	17%	15%	17%
HIV infections averted during program operation, NEP clients	50	46	53
Additional HIV infections averted*	0	113	11
Cost per HIV infection averted	\$12,000	\$3,773	\$9,375

*In NEP clients, their drug and sex partners, and their children over five years (one year of NEP operation and four years of delayed effects)

The third model used self-reported behavior change data from a separate study of IDUs in a city similar to one of the four hypothetical cities. An estimated total of 159 infections in NEP clients, their drug and sex

partners, and their children would be prevented over five years at a cost per HIV infection averted of approximately \$3,800.

The fourth model combined descriptions of HIV risk behaviors from the same dataset with the circulation model, and applied them to the same hypothetical city. This model predicts that, over five years, 64 infections in NEP clients, their drug and sex partners, and their children would be prevented at a cost of approximately \$9,400 per HIV infection averted.

Conclusion:

- *Multiple mathematical models of NEP impact support the findings of the New Haven model. These models suggest that NEPs can prevent significant numbers of infections among clients of the programs, their drug and sex partners, and their children. In almost all cases, the cost per HIV infection averted is far below the \$119,000 lifetime cost of treating an HIV-infected person.*

Q. Recommendations

The preceding review demonstrates that needle exchange programs can provide a variety of public health services to significant numbers of injecting drug users who continue to inject drugs and who may otherwise not receive these services. Such services can be provided cost-effectively and are associated with diminutions in HIV drug (but not sex) risk behavior. Although the data available are limited, they provide no evidence that needle exchange programs increase the amount of drug use by needle exchange program clients or change overall community levels of injection and non-injection drug use. Any controversy in local communities can be minimized by involving all interested communities in the planning of needle exchange services, both prior to opening the needle exchange program and after it is implemented, to address concerns such as program sites and hours of operation. Needle exchange programs should be conceptualized as an integral part of public health efforts to stem HIV infection among drug users and should be *part of a comprehensive approach to drug use*, that should also emphasize expanded access to drug treatment and school- and community-based interventions to prevent the initiation and continuation of drug use.

Needle exchange programs should be supplemented by the expanded sale of syringes by pharmacists, an approach that has the advantage of protecting client confidentiality while still guaranteeing the client that the syringe obtained is sterile. This is in marked contrast to the situation on the street, where syringes are often repackaged by unscrupulous dealers so as to appear new.⁵⁰ However, pharmacy schemes provide a weaker link to other public health services and pharmacists may be reluctant to participate because of concerns about syringe disposal and the effect of injecting drug users' presence on their businesses.

Although the research studies upon which this report's conclusions and recommendations are based cannot definitively prove that needle exchange programs decrease HIV infection rates, four lines of evidence suggest that this is likely. First, needle exchange is an intervention based on the sound theoretical principle of eliminating the item (a contaminated syringe) that transmits infection from one person to another.¹⁴⁷ This is analogous to reducing the number of mosquitoes in an attempt to prevent malaria. Second, there is clear evidence of decreases in HIV drug risk behavior among needle exchange program clients, which should translate into decreased HIV infection rates. Third, hepatitis B infections appear to be reduced by needle exchange programs. Fourth, mathematical modeling by this project and other researchers consistently estimate substantial decreases in HIV transmission rates.

We believe that the data reviewed in this report meet the criteria established by the US Congress for lifting the ban on the use of federal funds for needle exchange program services. Federal law currently requires that "the Surgeon General of the United States [determine] that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs."¹⁰² With new HIV infections in

injecting drug users and their offspring occurring daily, the time has arrived for federal, state, and local governments to remove the legal and administrative barriers to increased needle availability and to facilitate the expansion of needle exchange programs in the US.

Recommendations for the federal government

- *The federal government should repeal the ban on the use of federal funds for needle exchange services.*
- *Substantial federal funds should be committed both to providing needle exchange services and to expanding research into these programs.*

Recommendations for state governments

- *State governments in the ten states and the District of Columbia that have prescription laws should repeal these laws.**
- *States should repeal the paraphernalia laws as they apply to syringes.***

Recommendations for local governments and communities

- *Local governments should enter into discussions with local community groups to develop a comprehensive approach to preventing HIV in injecting drug users, their sex partners, and their offspring. This approach should include needle exchange programs and the expansion of drug treatment services.*
- *Local communities should seek to further increase sterile syringe availability by encouraging the sale, distribution, or exchange of syringes by pharmacists.*

Recommendations for researchers

Although we believe that the data reviewed in this report are sufficient to support the recommendations listed above, the proposed expansion of needle exchange services in the US will generate additional research questions that will have to be addressed. The implementation of our recommendations should not, however, be delayed pending the results of these studies, many of which will take years to complete. The following are the areas most critical for further research:

*Prescription laws preclude the purchase of a syringe without a prescription, limiting sterile syringe availability and creating a risk of arrest for needle exchange program staff and clients.

**Paraphernalia laws exist in 46 states and the District of Columbia and preclude the possession or distribution of syringes except for "legitimate medical purposes." Conviction under a paraphernalia law is a felony or a misdemeanor.

- *Descriptions of the "kinetics" and determinants of needle use patterns: IDUs' sources of needles, methods of disposal of needles, frequency of needle re-use, and needle-sharing patterns. How do these change when a needle exchange program or other changes in needle availability are implemented?*
- *Evaluations of "natural experiments" in which needle availability laws change or pharmacists expand the over-the-counter sales of syringes.*
- *Surveys of pharmacists to determine their willingness to participate in pharmacy-based syringe sale, distribution, or exchange and to identify the barriers to their participation.*
- *Assessments of the effects of design features of needle exchange programs (e.g., administering bodies, site characteristics, opening hours, and program rules) upon process measures of needle exchange programs (e.g., needles distributed, drug treatment referrals, discarding of needles).*
- *Ethnographic and other qualitative research to assess the factors involved in drug use initiation and in transitions between various routes of drug use.*
- *Case-control studies of the relationship between use of the needle exchange program and acute hepatitis B, particularly in cities with active surveillance for the infection.*
- *Large, multicenter case-control studies within existing cohorts of injecting drug users to assess whether use of the needle exchange program is associated with hepatitis B or HIV seroconversion.*
- *Mathematical modeling using program data and behavior change evaluations to determine which aspects of program design determine effectiveness and cost-effectiveness.*

R. Appendix

NEPs in the US Through August 1993

<u>State</u>	<u>City</u>	<u>Name and Address</u>	<u>Month and Year Opened</u>
Alaska	Fairbanks	The Exchange 1109 O'Connor Road Fairbanks, AK 99701	August 1989
California	Berkeley	Needle Exchange Emergency Distribution (NEED) 3884 Shafter Avenue Oakland, CA 94609	November 1990
	Los Angeles	Clean Needles Now (CNN) P.O. Box 128 Topanga Canyon, CA 90290	June 1992
	Monterey County	Monterey Needle Exchange 91 Chestnut Street Apt. 228 Santa Cruz, CA 95060	April 1992
	Novato	Marin County NEP 172 Escollonia Drive Novato, CA 94945	October 1992
	Oakland	Alameda County Exchange (ACE) 2512 Regent Street, #6 Berkeley, CA 94704	July 1992
	San Diego	San Diego Clean Needle Exchange Team ACT-UP San Diego P.O. Box 5341 San Diego, CA 92165	January 1992
	San Francisco	Prevention Point 1090 Eddy Street #604 San Francisco, CA 94109	November 1988
	San Jose	Risk Reduction Task Force* No mailing address Hotline telephone number: 408-236-2121	July 1992
	San Mateo	AIDS Prevention Action Network, Inc. (APN) 609 Edinburgh Street San Mateo, CA 94402	September 1990

NEPs in the US Through August 1993 (continued)

<u>State</u>	<u>City</u>	<u>Name and Address</u>	<u>Month and Year Opened</u>
California (continued)	Santa Cruz	Santa Cruz Needle Exchange Program 180 Dakota, Unit 6 Santa Cruz, CA 95060	December 1989
Colorado	Boulder	The Works Boulder County Health Department 3450 Broadway Boulder, CO 80304	May 1989
Connecticut	Bridgeport	Bridgeport NEP* 725 East Main Street Bridgeport, CT 06608	May 1993
	Hartford	Hartford NEP Hartford Health Department AIDS/HIV Program 80 Coventry Street Hartford, CT 06112	March 1993
	New Haven	New Haven Needle Exchange Program Department of Health 540 Ella Grasso Boulevard New Haven, CT 06519	November 1990
	Willimantic	Willimantic NEP P.O. Box 752 Willimantic, CT 06226	March 1990
Hawaii	Honolulu	CHOW Project Needle Exchange 710 North King Street Honolulu, HI 96817	September 1991
		Kalihi-Palama Health Care for the Homeless 350 Summer Street Honolulu, HI 96817	November 1991
		"Rubber Room" Life Foundation 81 North Hotel Street Honolulu, HI 96817	July 1990
Illinois	Chicago	Chicago Recovery Alliance P.O. Box 470688 Chicago, IL 60647	January 1992
Indiana	Indianapolis	National AIDS Brigade Prevention Point 111 East 16th Street #201 Indianapolis, IN 46202	October 1992

NEPs in the US Through August 1993 (continued)

<u>State</u>	<u>City</u>	<u>Name and Address</u>	<u>Month and Year Opened</u>
Massachusetts	Boston	ACT-UP/Boston I.V. League P.O. Box 483 Kendall Square Station Cambridge, MA 02142	February 1991
		National AIDS Brigade (currently exchanging in New York City, New Haven, Los Angeles, and Chicago) 492 East Broadway P.O. Box 201 Boston, MA 02127	November 1986
New York	Buffalo	Prevention Point of Buffalo, Inc. 593 Winspear Ave., upper apt. Buffalo, NY 14215-1209	April 1992
	New York City	ADAPT Community Based Comprehensive Harm Reduction Needle Exchange Program 552 Southern Boulevard Bronx, NY 10455	December 1992
		Bronx-Harlem Needle Exchange Program c/o Bronx AIDS Services 1 Fordham Plaza #903 Bronx, NY 10458	February 1990
		Housing Works, Inc. 594 Broadway, Suite 700 New York, NY 10012	September 1992
		Lower East Side Needle Exchange Program 39 Avenue C New York, NY 10009	February 1990
		St. Ann's Corner of Harm Reduction* 295 St. Ann's Avenue Bronx, NY 10454	August 1990
Oregon	Portland	Outside-In Needle Exchange/AIDS Prevention Program 1236 SW Salmon Portland, OR 97205	November 1989

NEPs in the US Through August 1993 (continued)

<u>State</u>	<u>City</u>	<u>Name and Address</u>	<u>Month and Year Opened</u>
Pennsylvania	Philadelphia	Prevention Point Philadelphia Health Center #5 1900 North 20th Street Philadelphia, PA 19121	December 1991
Washington	Olympia	Olympia Underground Exchange 114 Cherry St., NE Olympia, WA 98501	April 1992
	Seattle	Seattle-King County Department of Public Health Needle Exchange 400 Yesler Way, 3rd floor Seattle, WA 98104	March 1989
	Spokane	Outreach Center* 1025 West First Avenue Spokane, WA 99204	May 1991
	Tacoma	Tacoma Needle Exchange/Point Defiance AIDS Projects 535 East Dock Street #108 Tacoma, WA 98402	August 1988
		Tacoma-Pierce County Health Department Needle Exchange 3629 South D Street Tacoma, WA 98408	March 1989
	Yakima	Yakima Health District Needle Exchange 104 North 1st Street Yakima, WA 98901	November 1992

* Not included in the results of this report

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CAROL H. RASCO
Assistant to the President for Domestic Policy

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Jose

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FACSIMILE TRANSMISSION - COVER PAGE

JUN 3 1994

TO: Carol Rasco
Assistant to the President
For Domestic Policy

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DATE: 6/3/94

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COMMENTS: _____

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June 3, 1994

Carol Rasco
Assistant to the President
for Domestic Policy
The White House
2nd Floor, West Wing
1600 Pennsylvania Avenue, N.W.
Washington, D.C.

Dear Ms. Rasco:

Last month 29 people were murdered in Atlanta. This week's Money Magazine labeled our city "the most dangerous" in America. The Project PACT Forum, which we plan to hold the week of June 20th, would be a perfect opportunity for the President to let law enforcement and citizens know that the Administration is doing something to stop the violence.

As you probably know, Project PACT (Pulling America's Communities Together) is a cabinet-level joint anti-violence initiative aimed at four sites across the country. Metro Atlanta was selected as one of those sites, presumably because of our extraordinary problems with violence.

Over the last several months, the City of Atlanta, the five metro counties, and our office have met with hundreds of concerned law enforcement personnel and citizens to develop presentations for the upcoming Project PACT Forum. The expectations are high that the Administration and PACT, in conjunction with the Crime Bill, will help our community stop the violence.

I would very much like the President to open up the PACT Forum and stay for the law enforcement presentation. If he wants to send a tough-on-crime message, a large crowd of prosecutors and men and women in blue will be present. We can also arrange a display of automatic weapons and other firearms confiscated from children.

While a large part of PACT, importantly, is to attack the problem of violence on the front end through community based initiatives, an equally important part is the hard-hitting, more traditional law enforcement. That part in particular may serve the President's interests well in promoting the Crime Bill.

Carol Rasco
June 3, 1994
Page - 2 -

The President's participation in the Forum would go a long way toward making PACT a success, toward promoting the Crime Bill, and toward letting people know that the Administration is truly doing something about the violence.

Please do not hesitate to call me if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Kent Alexander". The signature is fluid and cursive, with the first name "Kent" and last name "Alexander" clearly distinguishable.

Kent B. Alexander
United States Attorney

NEEDLE EXCHANGE

- o ONDCP can find no compelling reason for the Administration to depart from existing Federal policy regarding needle exchange.
- o The United States Congress incorporated the following language, regarding the use of Federal block grant funds, in the Appropriations Act for Fiscal Year 1993

"[N]o funds...shall be used to carry out any program distributing sterile needles for the hypodermic injection of any illegal drug, unless the Surgeon General of the United States determines that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs..."

(Public Law 102-321)

- o The most extensive study to date, the CDC-funded study, "The Public Health Impact of Needle Exchange Programs in the United States and Abroad," is now under review within the Department of Health and Human Services. This study presents a review and summary of existing research through late 1993.
 - Although generally positive in its discussion of reports on needle exchange programs (NEP), the CDC report concludes, in part, "These studies do not...provide clear evidence that NEPs decrease HIV infection rates." (at pages v and 465)
- o On a related matter, a recent ONDCP assessment of heroin use trends found a growing number of drug treatment entrants who administer heroin intranasally, now up to 50 percent in the northeastern United States.
 - Given the anticipated graduation of heroin "snorters" to injection heroin use, Federal government advocacy for the distribution of needles and syringes to drug users might have extremely negative consequences for both HIV transmission and drug addiction.

- o Furthermore, injecting is not the only way that drugs are linked to HIV transmission. A recent report from Denver is likely to be duplicated in many areas where there is not a long history and large population of injectors.
- o According to the University of Colorado researcher's study of drug users in Denver:
 - 2.2 percent of heroin injectors test positive for HIV;
 - 5.3 percent of crack users test positive; and
 - 4.6 percent of Denver street addicts in general test positive.
- o The routes of contagion/transmission are:
 - crack addiction, sex trading, STDs, lesions, to HIV; or
 - foil crack pipes, burned lips, lesions, to HIV.
- o Another study is now being conducted by The Institute of Medicine, and ONDCP will review that study with care when it is available this fall.
- o Needle exchange programs, like all programs geared to drug demand reduction and HIV/AIDS reduction, must be assessed in terms of their actual performance. Especially if they are to be funded with moneys that would otherwise go to drug treatment.
 - Although negative impacts of earlier concern, such as increased drug use and increased needle stick accidents, do not appear in recent reports on the practice of these programs, the positive impacts claimed for these programs have not been demonstrated. It may be that these programs have had only marginal impact of any kind to date.
- o Finally, ONDCP strongly encourages jurisdictions that do decide to experiment with needle exchange programs to conduct thorough outcome evaluations on the positive and negative impact of these programs.

① CDC Study

② New Haven Study

- ↳ based on mathematical model
- ↳ not empirical evidence

③ GAO — went out of its way not to say that.
↳ foreign don't work? can't measure?

Bottom-line

- move users into Drug Treatment
- ↳ Direct contradiction w/ our "demand" But
bc users get treatment policy.
- Syringes are illegal in 14 states

Policy Statement

— Check & set Mayors recs on needle exchange.

POLICY PERSPECTIVE

- needle policy — overall drug, MDS + Domestic
- ①
 - ② Federal money would it be circumventing state & local laws.

Office of the National AIDS Policy Coordina



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Some background
on needles

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HHS DRUG COUNSEL

007

Current law prohibits the use of HHS Substance Abuse Block Grant dollars to fund needle exchange programs unless the Surgeon General "determines that a needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for acquired immune deficiency syndrome."

Section 506 of the General Provisions of the 1994 Labor-HHS Appropriations Act contains a provision prohibiting the use of any HHS funds for needle exchange programs unless the Surgeon General "determines that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs"

In sum, HHS funding of a needle exchange program is prohibited unless the program can satisfy one of the two standards stated above, depending on the funding source.

Note, however, that the 1994 Labor-HHS Appropriations Act specifically permits use of HHS dollars "in furtherance of demonstrations or studies authorized in the ADAMHA Reorganization Act (Public Law 102-321)." Section 706 of P.L. 102-321 requires the Secretary to conduct a study of programs distributing clean needles and bleach.

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2002

NIDA BUDGET OFC.

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APR 08'93

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DRAFTPrepared by LGCBB/OSPEL/NIDA
February 17, 1993**Legislative History on the Prohibition of Federal Funds
for Distributing Clean Needles and/or Use of Bleach**

Congress began to prohibit certain Federal funds for distributing needles in 1988. The first such language was under section 256(b) of the Health Omnibus Extensions Act, P.L. 100-607, which was enacted in early November 1988. This section read:

"(b) Certain Use of Funds.--None of the funds provided under this Act or an amendment made by this Act shall be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for acquired immune deficiency syndrome."

P.L. 100-607 effected only those funds described in the Act and only for the time period that the law was effective. A few weeks later, in mid-November of 1988, enactment of the Anti-Drug Abuse Amendments of 1988 (P.L. 100-690) took place. Section 2025, of the Act, amended section 1915(c) of the PHSA to read as follows:

"(A) to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug or distributing bleach for the purpose of cleansing needles for such hypodermic injection; and"

P.L. 100-690 is the only law throughout the legislative history expressly prohibiting the distribution of bleach. This prohibition only targeted ADHS Block Grant funds.

DHHS policy was expressed during hearings in July 1989 by then Secretary of HHS, Louis B. Sullivan before the Energy and Commerce Subcommittee on Health and the Environment:

"While we won't use Federal funds to implement needle exchange programs, we will be willing to receive research grant applications from scientists who wish to evaluate the effectiveness of such programs and to review the merits of the proposals through our regular research grant process."

On November 17, 1989, then Assistant Secretary for Health and Acting Surgeon General, James O. Mason, wrote to Senator Tom Harkin, expressing his concern about the effects of a proposed amendment to the FY 90 appropriations bill to prohibit the use of Federal funds for distributing clean needles and bleach to drug users. While Mr. Mason pointed out that the Department agreed that programs distributing clean needles could be interpreted as encouraging drug use, bleach is readily available legally and as part of a comprehensive drug abuse outreach program only gives drug users the means to protect themselves and others from fatal infection.

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HHS DRUG COUNSEL

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NIDA BUDGET OFC.

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P.L. 101-166, making FY 1990 appropriations for HHS, included a prohibition on distributing needles. Section 520, of the Act, read as follows:

"None of the funds appropriated under this Act shall be used to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug unless the President of the United States certifies that such programs are effective in stopping the spread of HIV and do not encourage the use of illegal drugs."

P.L. 101-517, the FY 91 appropriations law for HHS, included identical language as that of the FY 1990 appropriations law for HHS. Section 513 of that Act reads:

"None of the funds appropriated under this Act shall be used to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug unless the President of the United States certifies that such programs are effective in stopping the spread of HIV and do not encourage the use of illegal drugs."

The FY 1992 HHS appropriations law did not include any provisions prohibiting the distribution of needles or bleach.

The current prohibition on the use of Federal funds for needle exchange programs comes from the July 10, 1992 enactment of P.L. 102-321, the ADAMHA Reorganization Act. This law split the ADMS block grant into two separate block grants [one for mental health and one for substance abuse], and subsequently omitted the existing prohibition under section 1915(c)(A) [this section of law was incorporated into Title XIX of the PHSA by the enactment of the Anti-Drug Abuse Act of 1988]. A prohibition now exists at new section 1935(a)(1)(F) PHSA and is identical to the language of the Health Omnibus Extensions Act of 1988 [described below]. Unlike previous bans included previous appropriations laws, P.L. 102-321 provides the Surgeon General with the authority to overturn the ban rather than the President.

During inception of the reorganization act, the Senate's bill, S. 1306, included a provision referring to section 256(b) of the 1988 Health Omnibus Extensions Act. This language was included in all versions of the Senate bill until it reached conference where the conferees omitted the provision in the conference report. On May 28, the House sent the bill back to the conferees with instructions that this language be reinstated, which the June 6 conference report does.

In contrast, the House reauthorization bill (H.R. 3698) never did include a section to prohibit the distribution of needles or bleach; however, it did require a study by the National Academy of Sciences on the effectiveness of distributing needles and bleach to individuals. This provision is incorporated into P.L. 102-321 at Section 706, which requires the National Academy of Sciences to conduct a study of U.S. programs that distribute sterile needles and/or bleach.

Like the FY 1991 appropriations law, the FY 1993 HHS appropriations law [P.L. 102-394], at Section 514, includes a prohibition against using

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NIDA BUDGET OFC.

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Federal funds appropriated by the Act for needle distribution. No mention of bleach is made. This language is as follows:

"Notwithstanding any other provision of Act, no funds appropriated under this Act shall be used to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug unless the Surgeon General of the United States determines that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs, except that such funds may be used for such purposes in furtherance of demonstrations or studies authorized in the ADAMHA Reorganization Act (Public Law 102-321).

The House originally introduced the FY 1993 appropriations bill without any provisions on the prohibition of needle exchange programs. However, during Senate floor debate of the House-passed bill, Senator Helms introduced a very restrictive amendment on the prohibition of using Federal funds for needle exchange programs. Senator Kennedy, however, was immediately informed and came onto the floor explaining the intent of the language included in P.L. 102-321, the ADAMHA Reorganization Act. The Kennedy amendment (above) was passed while the Helms amendment failed to be approved.

The difference between the appropriations language and that in the reauthorization law is the inclusion of "...demonstrations or studies authorized in the ADAMHA Reorganization Act. . ." which is intended as a specific reference to Section 706, requires a study by the National Academy of Sciences of U.S. programs that distribute sterile needles and/or bleach, of P.L. 102-321.

NOTE: DOES NOT REFERENCE THE 1994 APPROPRIATIONS LANGUAGE WHICH ONLY EXTENDS THE 1993 APP. PROVISION.

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009

PROBLEM

While attempting to decrease the spread of the usually fatal disease, AIDS, there is serious concern that a measure such as needle exchange programs (NEPs) might increase the likelihood of the often fatal and both individually and socially destructive condition of drug addiction. At a minimum, such concern involves two issues: the "message" about drug use that is given by governmental approval and funding of such projects; and, the possible diversion of addiction treatment funds to NEPs, making it harder for addicts to eventually give up drugs altogether.

As Congressman Rangel has noted, "...clean needles are no substitute for a firm commitment to make effective, comprehensive drug abuse treatment available to all who need and want such help and to use aggressive outreach and prevention efforts to bring addicts into treatment...I cannot condone my government telling communities ravaged by the twin epidemics of drugs and AIDS that clean needles are the best we can do for you...I believe government has an obligation to do more than just help people use illegal drugs more safely. We should be doing all we can to offer them the hope and opportunity to become productive, drug-free citizens."

EVALUATION OF NEPs FINDINGS TO DATE

1. Potential Harm: There is no evidence to date that needle exchange programs (NEPs) are related to an increase in substance abuse in general or injecting patterns in particular--although, it is recognized that subtle attitudinal changes might take years to manifest themselves in behavioral change.

2. Potential Good: Conversely, the evidence to date provides inadequate support for the proposition that NEPs decrease the spread of HIV infection, although such evidence as does exist is in the desired direction.

3. Much of the claimed evidence for the effectiveness of NEPs is from the self-report of behavioral change by NEP participants.

4. NEPs have significant problems with retention, frequency of client involvement, and selection bias (i.e., not reaching the groups most at risk for sharing behavior).

5. NEPs differ widely in terms of cost, both for delivering the injecting equipment and any ancillary services. As NEPs become institutionalized and run by paid staff rather than volunteers, costs sharply rise.

6. As costs rise and programs become more comprehensive, the potential for diverting funds from treatment increases. Also, there needs to be decisions made between attempting to increase the reach of the programs versus providing more ancillary services.

POSSIBLE RECOMMENDATIONS

1. If the government is to announce approval of NEPs, it should be as Margaret Thatcher did: i.e., We are firmly against the use of illegal drugs and will not waiver in this commitment. However, we are a compassionate people and wish to take steps to decrease the likelihood of our citizens dying from AIDS..., etc., etc.
 2. The federal government should modify any regulations which forbid needle exchange programs from being carried out by voluntary organizations.
 3. The federal government should encourage the nine states that have prescription laws requiring a prescription for syringes to abolish such laws.
 4. Similarly, the federal government should encourage states that have paraphernalia laws to modify them to permit addicts to possess injection equipment without penalty of law. Care must be taken to explain the rationale for this to opposing community groups who may view such repeal either as a step towards legalization or genocidal activity.
 5. The federal government should not fund needle exchange programs, but instead should focus on expansion of addiction treatment to make it available as needed. The federal government should also fund badly needed research in this area. Voluntary agencies should be encouraged to carry out needle exchange programs.
- Having injection equipment cheap and readily available in pharmacies should meet the needs of most addicts for sterile equipment. Voluntary agencies should focus their efforts, therefore, on strategies to reach the high-risk drug user.
7. Because even with legal availability via pharmacies and NEPs, there will be many times when the injecting addict does not have a clean syringe, the proper use of bleach for disinfection needs to be taught and samples of bleach made available.

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MESSAGE:

Some background
on needles

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HHS DRUG COUNSEL

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Prepared by LGCRR/OSPEL/NIDA
February 17, 1993

**Legislative History on the Prohibition of Federal Funds
for Distributing Clean Needles and/or Use of Bleach**

Congress began to prohibit certain Federal funds for distributing needles in 1988. The first such language was under section 256(b) of the Health Omnibus Extensions Act, P.L. 100-607, which was enacted in early November 1988. This section read:

"(b) Certain Use of Funds.--None of the funds provided under this Act or an amendment made by this Act shall be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for acquired immune deficiency syndrome."

P.L. 100-607 effected only those funds described in the Act and only for the time period that the law was effective. A few weeks later, in mid-November of 1988, enactment of the Anti-Drug Abuse Amendments of 1988 (P.L. 100-690) took place. Section 2025, of the Act, amended section 1915(c) of the PHSA to read as follows:

"(A) to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug or distributing bleach for the purpose of cleansing needles for such hypodermic injection; and"

P.L. 100-690 is the only law throughout the legislative history expressly prohibiting the distribution of bleach. This prohibition only targeted ADHS Block Grant funds.

DEHS policy was expressed during hearings in July 1989 by then Secretary of HHS, Louis B. Sullivan before the Energy and Commerce Subcommittee on Health and the Environment:

"While we won't use Federal funds to implement needle exchange programs, we will be willing to receive research grant applications from scientists who wish to evaluate the effectiveness of such programs and to review the merits of the proposals through our regular research grant process."

On November 17, 1989, then Assistant Secretary for Health and Acting Surgeon General, James O. Mason, wrote to Senator Tom Harkin, expressing his concern about the effects of a proposed amendment to the FY 90 appropriations bill to prohibit the use of Federal funds for distributing clean needles and bleach to drug users. While Mr. Mason pointed out that the Department agreed that programs distributing clean needles could be interpreted as encouraging drug use, bleach is readily available legally and as part of a comprehensive drug abuse outreach program only gives drug users the means to protect themselves and others from fatal infection.

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P.L. 101-166, making FY 1990 appropriations for HHS, included a prohibition on distributing needles. Section 520, of the Act, read as follows:

"None of the funds appropriated under this Act shall be used to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug unless the President of the United States certifies that such programs are effective in stopping the spread of HIV and do not encourage the use of illegal drugs."

P.L. 101-517, the FY 91 appropriations law for HHS, included identical language as that of the FY 1990 appropriations law for HHS. Section 513 of that Act reads:

"None of the funds appropriated under this Act shall be used to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug unless the President of the United States certifies that such programs are effective in stopping the spread of HIV and do not encourage the use of illegal drugs."

The FY 1992 HHS appropriations law did not include any provisions prohibiting the distribution of needles or bleach.

The current prohibition on the use of Federal funds for needle exchange programs comes from the July 10, 1992 enactment of P.L. 102-321, the ADAMHA Reorganization Act. This law split the ADMS block grant into two separate block grants [one for mental health and one for substance abuse], and subsequently omitted the existing prohibition under section 1915(c)(1) [this section of law was incorporated into Title XIX of the PHS Act by the enactment of the Anti-Drug Abuse Act of 1988]. A prohibition now exists at new section 1915(a)(1)(F) PHS Act and is identical to the language of the Health Omnibus Extensions Act of 1988 [described below]. Unlike previous bans included previous appropriations laws, P.L. 102-321 provides the Surgeon General with the authority to overturn the ban rather than the President.

During inception of the reorganization act, the Senate's bill, S. 1306, included a provision referring to section 256(b) of the 1988 Health Omnibus Extensions Act. This language was included in all versions of the Senate bill until it reached conference where the conferees omitted the provision in the conference report. On May 28, the House sent the bill back to the conferees with instructions that this language be reinstated, which the June 6 conference report does.

In contrast, the House reauthorization bill (H.R. 3698) never did include a section to prohibit the distribution of needles or bleach; however, it did require a study by the National Academy of Sciences on the effectiveness of distributing needles and bleach to individuals. This provision is incorporated into P.L. 102-321 at Section 706, which requires the National Academy of Sciences to conduct a study of U.S. programs that distribute sterile needles and/or bleach.

Like the FY 1991 appropriations law, the FY 1993 HHS appropriations law [P.L. 102-394], at Section 514, includes a prohibition against using

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Federal funds appropriated by the Act for needle distribution. No mention of bleach is made. This language is as follows:

"Notwithstanding any other provision of Act, no funds appropriated under this Act shall be used to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug unless the Surgeon General of the United States determines that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs, except that such funds may be used for such purposes in furtherance of demonstrations or studies authorized in the ADAMHA Reorganization Act (Public Law 102-321).

The House originally introduced the FY 1993 appropriations bill without any provisions on the prohibition of needle exchange programs. However, during Senate floor debate of the House-passed bill, Senator Helms introduced a very restrictive amendment on the prohibition of using Federal funds for needle exchange programs. Senator Kennedy, however, was immediately informed and came onto the floor explaining the intent of the language included in P.L. 102-321, the ADAMHA Reorganization Act. The Kennedy amendment (above) was passed while the Helms amendment failed to be approved.

The difference between the appropriations language and that in the reauthorization law is the inclusion of "...demonstrations or studies authorized in the ADAMHA Reorganization Act. . ." which is intended as a specific reference to Section 706, requires a study by the National Academy of Sciences of U.S. programs that distribute sterile needles and/or bleach, of P.L. 102-321.

NOTE: DOES NOT REFERENCE THE 1994 APPROPRIATIONS
LANGUAGE WHICH ONLY EXTENDS THE 1993
APP. PROVISION.

PROBLEM

While attempting to decrease the spread of the usually fatal disease, AIDS, there is serious concern that a measure such as needle exchange programs (NEPs) might increase the likelihood of the often fatal and both individually and socially destructive condition of drug addiction. As a minimum, such concern involves two issues: the "message" about drug use that given by governmental approval and funding of such projects; and, the possible diversion of addiction treatment funds to NEPs, making it harder for addicts to eventually give up drugs together.

As Congressman Rangel has noted, "...clean needles are no substitute for a firm commitment to make effective, comprehensive drug abuse treatment available to all who need and want such help and to use aggressive outreach and prevention efforts to bring addicts into treatment...I cannot condone my government telling communities ravaged by the twin epidemics of drugs and AIDS that clean needles are the best we can do for you...I believe government has an obligation to do more than just help people use illegal drugs more safely. We should be doing all we can to offer them the hope and opportunity to become productive, drug-free citizens."

EVALUATION OF NEPs FINDINGS TO DATE

1. **Potential Harm:** There is no evidence to date that needle exchange programs (NEPs) are related to an increase in substance abuse in general or injecting patterns in particular—although, it is recognized that subtle attitudinal changes might take years to manifest themselves in behavioral change.
2. **Potential Good:** Conversely, the evidence to date provides inadequate support for the proposition that NEPs decrease the spread of HIV infection, although such evidence as does exist is in the desired direction.
3. Much of the claimed evidence for the effectiveness of NEPs is from the self-report of behavioral change by NEP participants.
4. NEPs have significant problems with retention, frequency of client involvement, and selection bias (i.e., not reaching the groups most at risk for sharing behavior).
5. NEPs differ widely in terms of cost, both for delivering the injecting equipment and any ancillary services. As NEPs become institutionalized and run by paid staff rather than volunteers, costs sharply rise.
6. As costs rise and programs become more comprehensive, the potential for diverting funds from treatment increases. Also, there needs to be decisions made between attempting to increase the reach of the programs versus providing more ancillary services.

POSSIBLE RECOMMENDATIONS

1. If the government is to announce approval of NEPs, it should be as Margaret Thatcher did: i.e., We are firmly against the use of illegal drugs and will not waiver in this commitment. However, we are a compassionate people and wish to take steps to decrease the likelihood of our citizens dying from AIDS..., etc., etc.
2. The federal government should modify any regulations which forbid needle exchange programs from being carried out by voluntary organizations.
3. The federal government should encourage the nine states that have prescription laws requiring a prescription for syringes to abolish such laws.
4. Similarly, the federal government should encourage states that have paraphernalia laws to modify them to permit addicts to possess injection equipment without penalty of law. Care must be taken to explain the rationale for this to opposing community groups who may view such repeal either as a step towards legalization or genocidal activity.
5. The federal government should not fund needle exchange programs, but instead should focus on expansion of addiction treatment to make it available as needed. The federal government should also fund badly needed research in this area. Voluntary agencies should be encouraged to carry out needle exchange programs.
6. Having injection equipment cheap and readily available in pharmacies should meet the needs of most addicts for sterile equipment. Voluntary agencies should focus their efforts, therefore, on strategies to reach the high-risk drug user.
7. Because even with legal availability via pharmacies and NEPs, there will be many times when the injecting addict does not have a clean syringe, the proper use of bleach for disinfection needs to be taught and samples of bleach made available.



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

SEP 2 1994

August 29, 1994

MEMORANDUM FOR ROBERT WASSERMAN
RICIA McMAHON
FRED GARCIA

FROM: JOHN CARNEVALE

SUBJECT: Conference of Mayors Report on Needle Exchange

OMB forwarded the attached *HIV Capsule Report* published July 1994 by the U.S. Conference of Mayors (USCOM). The report was published with the support of a HHS grant. The report is careful to note, however, that opinions expressed in it "do not necessarily reflect the policies of the U.S. Department of Health and Human Services."

The report is based on a survey of 594 health departments about the need for needle exchange programs and perceived obstacles encountered in establishing needle exchange programs in their communities. A total of 170 health departments responded to the survey. The survey results are also attached.

In a nutshell, this report discusses all the problems local communities tend to encounter when a needle exchange program is established. The USCOM report is clearly pro-needle exchange for purposes of confronting HIV transmission. It concludes:

"Communities need to work together to address issues concerning needle exchange that may relate to local conditions. The development of programs can be facilitated by open discussions involving needle exchange advocates, policymakers, local health departments, law enforcement, service providers, and potential clients. Communities must advocate at the state and national level for the removal of legal barriers that will enable the adoption of effective HIV prevention measures targeting injection drug users."

The basis of USCOM's favorable view on needle exchange programs is a cost/benefit argument. The report notes that the average cost of a needle exchange program is about \$169,000. The average lifetime cost of treating a person with HIV is \$119,000. The report notes that if two persons are prevented from being infected with HIV per year, the benefits of the program will exceed its cost. Now, wait a minute. We know from other studies that chronic, hardcore drug users engage in illegal activities to support their habit, tend to be on welfare, visit public hospitals for treatment whenever they have an adverse reaction to their drug use, are unemployed, occasionally take up court time because of their use or illegal behavior to support their habit, and so forth. It is likely that individuals who receive needles will continue to use drugs and will impose these substantial social costs beyond those associated HIV transmission.

My personal view is that we stand little chance of convincing anyone of the efficacy of the current Federal restriction against the use of Federal funds for needle exchange programs so long as local communities are overwhelmed with misinformation and outright panic about HIV. Of course, we must not forget the political popularity of the simple fix. The problem with this simple fix -- giving out free needles -- is that it will do little to reduce the spread of HIV. More importantly, from our perspective, it will do little to reduce hardcore drug use and its deleterious consequences.

Accordingly, we should continue to make the following case:

1. Injecting drug use is a small part of the story in the transmission of HIV. More often than not, it is the sexual behavior of IV drug users that lies behind HIV transmission. (in fact, 52% of the respondents to the USCOM survey said that 20% or less of the HIV cases in their community identified IV drug use as the transmission mode.)
2. Educating drug users about HIV transmission (especially about how to engage in safe sex) is more relevant than handing out drug paraphernalia.
3. Needle exchange is not drug treatment or prevention. If the current restriction against using Federal funds for needle exchange programs were lifted, funds currently in the HHS block grant for treatment could be diverted to needle exchange programs. This would reduce treatment capacity, which prolongs drug use and its consequences.

Of course, the Federal government does not need to interfere with local decision about needle programs, so long as Federal funds are not diverted in such programs. Our interest is in getting users to stop their drug use, which is the best way to cope with the issue of HIV transmission.

I recommend that we write the USCOM about the report. We have a policy of non-interference in local efforts to promote needle exchange programs (so long as localities use their own-source local funding), we should clarify the recent studies that allegedly find that needle exchange programs work. ODR has extensive material about the shortcomings of these studies. I also suggest we give HHS a copy of this letter since its funding contributed to the USCOM report.

attachment

cc: John Gregrich
Jose Cerda
Planning and Budget Staff



HIV CAPSULE REPORT

Reports of local policy responses to the AIDS/HIV epidemic

Needle Exchange: Evolving Issues

It is a basic concept of public health that in order to reduce the spread of disease the simplest solution is to remove the means of transmission. A popular example is with malaria and mosquitos. To prevent the spread of malaria, eliminate through eradication programs the mosquitos that spread the disease. This concept has not, however, been widely accepted when applied to the spread of HIV through infected injection equipment (needles, syringes, cookers, cotton) used by those injecting illegal drugs. The logical public health approach would be to reduce the use of infected injection equipment either by making clean equipment more available through needle (syringe) exchange programs, retail sales, or other measures or through promoting the cessation of drug use altogether. Unfortunately, the shortage of drug treatment and the prevailing attitudes in society and among some policymakers concerning the use of illegal drugs have turned what is considered by many to be a public-health issue into an extended public debate.

While many may get bogged down in the debate about how society should deal with illegal drug use, the need to act immediately to stem the spread of HIV among injection drug users (IDUs) is clearly evident. Currently, 34 percent of the nation's AIDS cases are among IDUs. Additionally, the sex partners and unborn children of IDUs are at risk of HIV infection. Most HIV prevention efforts targeting IDUs emphasize cleaning syringes with bleach and water and not sharing syringes. While some drug users have adopted these measures, the lack of access to sterile syringes continues to be a major factor in the spread of HIV among IDUs.

In Spring 1994, the National Institute on Drug Abuse, the Centers for Disease Control and Prevention, and the Center for Substance Abuse Treatment issued a joint notice indicating that decontamination of injection equipment with bleach is not entirely effective and that "persons who inject drugs...should be urged to obtain sterile, never-used needles and syringes." The major questions for policy makers and the public health professionals is how to make sterile needles and syringes available to IDUs.

Where Does Needle Exchange Fit in the Battle Against AIDS?

Needle exchange has been described in many ways. It has been called a necessary public health measure, a bridge to drug treatment, an invitation to drug use, and genocide. Obviously, there is no clear consensus on how people view needle exchange. This broad range of viewpoints has made it difficult for communities readily to adopt needle exchange as an HIV prevention measure. Needle-exchange programs (NEPs) are designed to provide sterile injection equipment to drug users. Programs operate from fixed sites (store fronts, health-department facilities, community-based clinics) or conduct exchange through street outreach.

Two years ago there were fewer than 20 NEPs operating in the United States. Of these programs, less than half were authorized, or operating legally, with the support of the health departments in their communities. Forty-six states and the District of Columbia have existing paraphernalia laws prohibiting the possession or distribution of sy-

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rings except for legitimate medical purposes. In nine states and the District of Columbia a prescription is necessary in order to obtain syringes. The distinction between authorized and unauthorized programs is that syringe distribution is legal or waivers have been obtained by programs that are authorized (operate legally). With unauthorized programs, syringe possession is illegal and waivers have not been obtained, and both those running the exchange and clients are subject to arrest if they are caught possessing syringes. Congress has passed several laws that prohibit or restrict the use of federal funds for needle-exchange services.

Is Needle Exchange Effective?

Over the past two years, needle exchange programs have been extensively studied. Reports on the efficacy and impact of needle exchange have been carried out by the Institute for Health Policy Studies at the University of California, San Francisco (funded by the U.S. Centers for Disease Control and Prevention and released in September 1993) and the U.S. General Accounting Office (March 1993). Existing programs also evaluate their efforts.

The studies conducted indicate that needle-exchange programs do not increase drug use, do not increase the number of discarded syringes in a community, are effective in reducing the spread of HIV, and serve as a bridge to drug treatment and services for clients of the needle exchange. Despite these findings, there are still fewer than fifty authorized and unauthorized needle-exchange programs in operation today. This HIV Capsule Report will discuss both ongoing and newly-emerging policy-related and operational issues in the debate about needle exchange at the local level.

Ongoing Issues

Despite studies that have answered some of the initial questions about needle exchange—Will NEPs increase drug use and encourage non users to use drugs? Will NEPs increase the number of discarded syringes in the community? Are NEPs effective in reducing the spread of HIV among IDUs? Do NEPs serve as a bridge to drug treatment and other social services?—some of the issues, especially those relating to the ethics of drug use, continue to be debated at the local level.

In local debates, questions about the legality of needle exchange, about the impact programs will have on the community and life within the community, and how to balance enforcing the law and protecting citizens with public health needs continue to surface. The following section discusses issues that have arisen at the local level as these questions have been discussed.

Legal Barriers

Central to the debate about needle-exchange programs is that the clients are participating in an illegal activity. Attitudes toward drug use often become a factor in debate at the local level and many have difficulty separating the need for HIV prevention measures from the idea that these measures may appear to condone or facilitate drug use. Policymakers fear that they will appear "soft on drugs" if they support programs.

In the minds of many activists, NEPs are a casualty of the "war on drugs." Needle exchange is just one part of

a larger approach to drug use called "harm reduction." Harm reduction is a set of strategies and tactics that encourage drug users to reduce the harm done to themselves and their communities by their licit and illicit substance use. Advocates of harm reduction contend that users should be provided access to the tools with which to become healthier and educated on how to protect their health. Their efforts to protect themselves, their families and their communities should be recognized and encouraged.

Central to the harm reduction approach is improving access to sterile injection equipment and encour-

aging IDUs to inject safely every time, even in settings where this can be difficult such as shooting galleries or on the street.

Beyond the ethical issues concerning illicit drug use are the logistics of operating a program that under state law is illegal. In some communities programs operate underground, with or without the support of local policymakers, health departments and law enforcement. Staff and clients of these programs risk arrest for their activities. Staff members have been arrested in New York, Massachusetts, California and other states.

The legal barriers have been removed in some communities, mostly as a result of significant lobbying efforts on the part of local officials, service providers, and needle exchange advocates. In New York, the State Legislature adopted a measure that allows organizations to apply for a waiver that exempts program staff and clients from prosecution for possessing syringes. In other states, such as Connecticut and Maryland, legislative action was also required before needle exchange programs could legally be established at the local level.

Other communities have taken a different approach in the face of opposition at the state level. In San Francisco, Mayor Frank Jordan declared a state of emergency that allowed the local government to support needle exchange even though California has a prescription law. The San Francisco Department of Health provides funds to Prevention Point, the local needle exchange program that for a long time operated illegally. Other programs in California continue to operate illegally.

Community Concerns

While many in a community may agree with the harm reduction aspects of needle exchange, when faced with the location of a program in their neighborhood they quickly adopt a NIMBY (not in my back yard) attitude. It is assumed that any program serving a large number of drug users will be disruptive and that increased crime, loitering, litter and other social ills will accompany the new program.

Generally, this has not been the case with existing programs. Sometimes, neighbors of syringe exchanges are not even aware of what is taking place. If sites are carefully chosen

and the community informed, most programs have found that community opposition is minimal at most and does not last.

Exchange staff also report that clients are very protective of programs and are unlikely to do anything that might jeopardize their access to clean syringes. Programs report incidents of unruly or threatening clients being told to leave or, if necessary, subdued by other clients.

While most consider the early stages of initiating a needle exchange the most contentious, new issues can arise as services are expanded, or not expanded, that can be disruptive to service provision and become a divisive force within the community. Even after programs are established, tensions can develop as a result of the controversial nature of needle exchange.

In some communities, organizations have complained when other organizations have come into their service area and distributed syringes. While supportive of syringe exchange in general, these organizations claim that it can be disruptive to their services when a new program suddenly arrives distributing syringes. Trust may not yet have been built between the incoming program and the community. This can lead to questions of why the service providers within the community had not informed them of the new services and were not involved with the new program.

Debate also continues on whether outreach workers should reflect the community in which they work—African Americans providing services to African Americans, Latinos providing services to Latinos, etc. Many syringe exchanges are initiated by AIDS activists of varying racial/ethnic backgrounds. As exchange programs have grown, there has been pressure in some commu-

nities for other organizations that are perceived as more racially and/or culturally sensitive to take over the operation. In some instances, these organizations have no interest in carrying out needle exchange. This can degenerate into an atmosphere where everyone is required to pick sides and may limit the effectiveness of the program in reaching those at risk.

When considering adopting needle exchange as an HIV prevention measure, communities should go beyond the basic questions and build consensus on operational questions such as who should conduct the program, where the services will be available, and future expansion of the program. This may prevent disagreements that may disrupt programs in the future.

Syringe Exchange and Law Enforcement

Needle-exchange programs do not need widespread support to operate, as some of the unauthorized programs demonstrate, but the level of community acceptance can make a difference in terms of the services programs can provide to their clients. The attitude of law enforcement within the community has perhaps the greatest impact on programs. With the majority of needle-exchange programs that operate illegally, minimal services are provided to clients because the "hit and run" nature of the exchange leaves little time to provide counseling or referral services. Both clients and staff are primarily concerned with exchanging syringes while avoiding arrest, and interaction that can build client trust, provide access to additional services and provide the kind of contact that supports behavior change is sacrificed.

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Being legally able to operate, however, does not guarantee perfect relations with the police. Even in communities where the mayor, police chief and health department have expressed support for syringe exchange, individual officers can "chill" exchange activities by intimidating staff and clients. Staff from existing legal pro-

grams emphasize the importance of maintaining open communications with law enforcement officials and educating police officers on an ongoing basis about the goals of syringe exchange and the role of the program in the community's HIV prevention efforts.

Some programs report individual officers being very supportive of their efforts—even taking the

program's cards in order to refer people to the exchange. Other programs report that occasional contact with police when they are exchanging syringes tends to allay fears among community members who may not be aware of the nature of the exchange. (Programs have reported community members calling the police on exchange sites because they thought that outreach workers were drug dealers.)

New Issues: Expanding and Improving Programs

As needle exchange has become more widely accepted as an HIV prevention measure and incorporated into the overall HIV prevention activities within some communities, new issues have arisen that have previously not been at the center of the debate.

Serving Younger Populations

Opponents of needle exchange frequently argue that programs will encourage people to begin using drugs—especially teenagers and young adults. While this has always been part of the debate at the local level it has not usually been a central issue. As programs have sought to expand their outreach, the question of whether programs should provide syringes to youths under 18 years old has arisen. The question of condoning drug use becomes much grayer when minors are involved.

Needle exchange programs have not been besieged with youths seeking to obtain needles. Injection drug use among teenagers is not the most prevalent form of drug abuse and, according to data collected on clients, most needle-exchange programs in the U.S. generally serve a group of clients with long histories of injection drug use. Youth will probably

never be the primary target population of needle exchange programs but there are IDUs who are minors who need access to sterile injection equipment and would probably benefit from the other services offered by exchanges.

Many legal programs, in an effort to minimize controversy, restrict participation in their program to adults. Unauthorized programs, however, usually do not have specific rules as to who can exchange syringes. They provide syringes to anyone.

In Santa Cruz, California, the unauthorized needle exchange has worked hard to reach younger drug users. Santa Cruz is a college town. Methamphetamine is readily available and the drug of choice of many younger users. The Santa Cruz exchange was able to reach younger users by recruiting teens and young adults (peers) as outreach workers. Younger users seem more comfortable exchanging syringes and being counseled by people their own age. The Santa Cruz exchange has also found that holding fundraisers that target young adults (events in bars

and night clubs) is also effective in reaching and providing education to younger adults.

Other programs, like Clean Needles Now (CNN) in Los Angeles, have also found a peer approach to be effective in reaching a younger drug-using population. Some clients exchange in a network of friends who may be unable or do not feel comfortable going to the exchange site. CNN works to support these informal exchanges by providing a one-for-one exchange of syringes with no limit on the number of syringes that can be exchanged. Participants can also pick up unlimited supplies (bleach, cotton, cookers, condoms, lubricant) and then redistribute them to their networks.

Programs run by health departments or receiving funds from health departments may have more rigid regulations concerning the age of clients. Many have policies stating that they will not exchange syringes with anyone

under 18 years of age. However, clients are rarely asked their age. If they are, they do not have to present documentation.

Some organizations have sought to avoid potential controversies relating to working with younger populations by collaborating with other service providers. The StreetWorks Project of Victim Services/Travelers Aid, an organization in New York City serving homeless youth under 24 years old, is an official site of the Lower East Side Needle Exchange (an organization that does have a waiver from the state which allows it to conduct needle exchange). As a satellite site of Lower East Side, StreetWorks did not have to apply to the state for a waiver to exchange needles. Any StreetWorks client can obtain syringes during closed-door counseling sessions with their assigned counselor. StreetWorks does not distinguish between clients who are over 18 or under 18 years old.

While there may not be a large population of youths using heroin, cocaine and other illegal injection drugs, advocates of needle exchange argue that youths do need access to sterile injection equipment. Many exchange programs report that steroid use among young men has created an at-risk population that is usually not considered in the debate on syringe exchange. The injection of vitamins is also practiced, especially in the Latino community. Advocates of needle exchange contend that the "just say no" approach has not been effective in deterring youths from using drugs and that, because these children have not heeded what they were told, it does not follow that they should face infection with HIV. Obviously, this debate will continue in communities.

Delivery and Home Visits

The growing community acceptance of needle exchange has enabled programs to expand their services. The original needle-exchange "models" that rely on street outreach or clients coming to fixed sites are not applicable for every community, especially suburban and rural communities. Some programs, such as Pt. Defiance AIDS Project in Tacoma, Washington, The Works in Boulder, Colorado, and several underground programs in Northern California deliver syringes to agreed upon locations or clients' homes. Clients call the exchange (some programs use pagers) to arrange the delivery.

Home delivery appeals to clients for several reasons. Clients do not need to risk arrest by carrying syringes to and from the exchange site. Home visits also eliminate many of the barriers that prevent people from accessing services: lack of transportation, lack of childcare, inconvenient hours of operation, and fear of "the system." Fear of the system is an especially large issue for women with children who fear that if the authorities are aware of their drug use their children may be removed from their custody.

Home visits also provide an opportunity for more intensive HIV prevention counseling. Exchanges on the street take place very quickly and clients may not initiate communication with outreach workers. At the client's home, outreach workers can discuss risk reduction at length and also assist the client with referrals to additional services (HIV counseling and testing, drug treatment, support services).

Program staff like the approach as well. There is less of a need to do street outreach in inclement weather

and home visits allow the program to provide its service while maintaining a lower profile in the community. Staff also contend that home visits may be safer than street outreach. Staff of one program explained their clients are very protective of outreach workers because they are grateful for the service they provide. Programs offering home delivery stress the importance of building and maintaining client trust in order to gain access to clients' homes.

Unlimited Syringes?

One of the major issues as many communities have addressed needle exchange is whether the programs will increase the number of discarded syringes in the community. To avoid increasing the number of syringes in circulation most needle exchanges maintain a one-for-one exchange—clients must bring in a used syringe to get a new sterile one. Some programs have caps on the number of syringes they will exchange and others have no limit.

Some needle exchange advocates argue that it is unethical to deny anyone a sterile syringe if they ask for one. One outreach worker with an underground exchange that recently became legal said it will be hard to conform to new regulations requiring strict one-for-one exchange since occasionally clients come without a used syringe. When the exchange was operating illegally with less regulation, outreach workers at their own discretion provided syringes to clients who did not have one to exchange.

Some also argue that limits on the number of syringes that can be exchanged prevent people from collecting for others and then providing them with clean needles. (Some exchanges have found that men exchange for their female partners since women tend to be reluctant to

come to exchanges). Others contend that it is important for drug users to come to the exchange so they can receive risk-reduction information and learn about additional services, such as HIV counseling and testing, drug treatment or medical care, that are available through the exchange.

Some exchanges have found that providing a two-for-one exchange up to five syringes has been well received by clients. One program reports that this practice is especially popular among younger clients who may not know of other sources of syringes because of their limited experience with injection drug use.

Transitioning from Underground Status

The transition from underground exchange to legal program has been difficult in some communities. One complicating factor has been a fear that some organizations will rush to establish an exchange program once legal barriers have been eliminated and funds are available. The existing and formerly underground programs often feel they have legitimate claims since they initiated efforts, have developed outreach networks, risked arrest, and worked hard to raise money to support their efforts. More established organizations may claim that they have a better developed infrastructure, are more capable of administering a program, and are in a better position to provide clients with services in addition to needle exchange.

Some underground exchanges are not interested in being integrated into a legal program. When the New Haven Health Department initiated a needle exchange program in November 1990, the individuals who were operating the underground program continued to distribute syringes. Many who are involved in operating underground programs

believe that legal efforts carried out by health departments or more established organizations may be less effective because of the problems drug users have in accessing these organizations. Since these organizations are part of "the system," they may appear to be less "user friendly" because they have to adhere more closely to regulations and may collect more information from clients for evaluation purposes. Underground exchange usually is carried out much more informally.

Ongoing Shortage of Drug Treatment

Implicit in any discussion of needle exchange is drug treatment. Often debated is the question of whether resources devoted to needle exchange would be better spent on providing and promoting drug treatment. Needle-exchange programs have been found to be very effective in referring clients to drug treatment. While some programs have arrangements that give their clients priority access to drug treatment, most all programs have been faced with turning down clients who ask for treatment because there is no space available.

While the primary goal of needle exchange is to prevent the spread of HIV among injection drug users, their sexual partners, and their unborn children, many strongly support the role of programs as bridges to drug treatment and other services. According to the report *The Public Health Impact of Needle Exchange Programs in the United States and Abroad*, the annual cost for funding an average needle-exchange program, about \$169,000, would support about 60 methadone-maintenance slots for one year. The estimated lifetime cost of treating a person with HIV is \$119,000. If programs prevent two people from becoming infected with HIV per year, they have more than paid for themselves.

Supporters of needle exchange are quick to point out that it is possible to recover from drug use (stop using) but there is no cure for HIV. Needle-exchange programs are not draining a significant amount of money from drug treatment and they can help keep people healthy until they are ready and able to enter drug treatment.

Conclusion

The debate concerning needle exchange is not over. In fact, in many communities it has not even begun and discussions between needle exchange supporters, policymakers and local health departments have yet to take place. In all likelihood, the debate concerning needle exchange will be the first step in a long process of exploring options for further reducing the spread of HIV among drug users. These options include making syringes more accessible to drug users through pharmacies or other distribution points and by developing and making available non-reusable syringes.

HIV has made tragic and irreversible inroads into the drug-using population but communities now have enough information about the efficacy and impact of needle exchange to consider it as an option in their HIV prevention efforts. Communities need to work together to address issues concerning needle exchange that may relate to local conditions. The development of programs can be facilitated by open discussions involving needle exchange advocates, policymakers, local health departments, law enforcement, service providers, and potential clients. Communities must also advocate at the state and national level for the removal of legal barriers that will enable the adoption of effective HIV prevention measures targeting injection drug users. □

USCM Surveys Local Health Departments on Needle Exchange

In April 1994, the U.S. Conference of Mayors conducted a survey to determine the barriers that exist to the establishment of needle exchange programs at the local level. It was designed to allow health departments to comment on the need for needle exchange and efforts to initiate programs within their communities. A total of 170 (28.6%) health departments responded out of the 594 surveyed.

The Debate over Needle Exchange

The survey asked health departments to comment on the arguments for and against needle exchange discussed in their communities. When asked to identify arguments against needle exchange that have surfaced in debate, respondents said that opponents expressed fear of condoning drug use and an increase of discarded needles. Another typical comment was that there was a lack of conclusive evidence supporting needle exchange as a useful tool in the fight against AIDS. Some health departments indicated a fear that a "drug paraphernalia" exchange program would divert attention away from the need for treatment. They were concerned that it would be breaking the law and condoning the use of drugs while not addressing what they saw as a need for rehabilitation and treatment.

When asked to identify what arguments had surfaced in favor of needle exchange, respondents said that exchange programs would help decrease the spread of HIV. They also indicated that an exchange program could provide access to IDUs. Some health departments felt that with increased access, they could probably increase the opportunity for outreach and education. This could result in an increase in the number of IDUs seeking drug treatment.

Health departments with a small number of AIDS cases tended not to respond to all of the questions. Departments with larger caseloads, however, provided more information. Those with smaller numbers generally felt that their jurisdiction did not have a problem and that there was no need for needle exchange. They often said that their jurisdiction did not have a large number of IDUs based on the small number of AIDS cases attributed to injection drug use.

— continued on page 8 —

Needle Exchange Survey

Total Number of Respondents = 170

What was the cumulative number of reported AIDS cases in your jurisdiction as of the month ending December 1993?

Number of Cases	% of Respondents
1-200	54% (91)
201-400	14% (24)
401-500	3% (5)
501-1000	14% (24)
1001+	15% (26)

Total = 170

What percentage of these cases identified injection drug use as the transmission mode?

% of Cases	% of Respondents
<1%	6% (8)
1% - 10%	17% (23)
10% - 20%	29% (38)
20% - 30%	22% (29)
30% - 40%	12% (16)
>40%	14% (19)

Total = 133

The remaining responses were either 'unknown' or incomplete.

What percentage of IDUs in your community are estimated to be infected with HIV?

% in community	% of Respondents
<1%	5% (3)
1% - 10%	43% (26)
11%- 20%	18% (11)
21%-30%	20% (12)
31%- 40%	3% (2)
41%+	10% (6)

Total = 60

The remaining responses were 'unknown'. Many health departments that responded did not have statistics available.

Does your jurisdiction have a needle exchange program (either legal or underground)?

no =	153 (90%)
yes =	13 (8%)
unknown or n/a =	4 (2%)

Total = 170

Where do IDUs get their needles in your community? (Respondents identified all applicable sources.)

street	107
pharmacy	60
legal exchange programs	7
illegal exchange programs	18
don't know	61
other	20

Total Number who responded = 165

Of those 60 health departments that indicated the pharmacy as source for their needles, all named the streets as an additional source. Some 'other' sources for needles are veterinarians, diabetics who sell their needles, and theft. One health department with over 2,000 cases of AIDS as a result of injection drug use said that they are aware of at least three separate illicit needle markets operating in their city.

Has needle exchange been proposed in your community?

no =	117 (69%)
yes =	48 (28%)
unknown or n/a =	5 (3%)

Total = 170

Are there currently legal barriers to needle exchange programs in your jurisdiction?

no = 60 (35%)
yes = 76 (45%)
unknown or n/a = 34 (20%)

Total = 170

Although 44.7% said that their state had some sort of paraphernalia law, many also said that needles could be purchased from pharmacies (35.3%). Some states have provisions for diabetics to purchase needles without a prescription, so IDUs can attempt to get syringes by posing as diabetics.

If your community does have a needle exchange program what has been the estimated number of clients since the program's inception?

Of the health departments that responded, the average number of clients served was 42. Seattle-King County Health Department had served the largest number of clients at 5000+.

If your community does not have a needle exchange program, please specify the HIV prevention programs targeting IDUs.

The majority said that the method of HIV prevention was community outreach and education programs. These programs generally included information and instructions on bleaching. Community-based organizations primarily carry out the street outreach efforts. Programs in drug treatment facilities and prisons were also mentioned. HIV counseling and testing services also target IDUs in many communities.

If your community has considered needle exchange, who is/was involved in the debate over proposed needle exchange programs in your jurisdiction? (indicate all applicable)

elected officials = 39
health departments = 51
community-based organizations = 44
churches = 17
police = 33
media = 19
drug treatment facilities = 33
others = 26
(i.e. private citizens' groups, universities, and/or state agencies)

Total Number who responded= 126

Were HIV prevention measures other than needle exchange proposed to prevent the spread of HIV among IDUs as a result of discussions about needle exchange?

no = 45 (26%)
yes = 75 (44%)
unknown or n/a = 50 (29%)

Total = 170

Forty-four percent (44.1%) of the respondents said that their jurisdiction had implemented some sort of street outreach and prevention program that targeted IDUs. The programs generally included education on bleaching procedures as well as education on the potential risks of contracting the HIV virus through contaminated needles.

Were any of these programs implemented?

no = 30 (18%)
yes = 67 (39%)
unknown or n/a = 73 (43%)

Total = 170

Since in many jurisdictions the outreach and education targeting IDUs are implemented by CBOs, the health departments were not always aware of the programs in operation.

The Changing Face of Needle Exchange Programs

Early needle exchange programs, carried out mainly by activists, had but a single purpose—to distribute sterile needles to reduce the spread of HIV. The provision of additional services (educational and referral) was hampered by the threat of arrest and limited resources. As needle exchange has been adopted by some communities as part of their HIV prevention efforts, services have been augmented and modified and become more responsive to the needs of the target population.

Needle exchange has long been debated in New York City. A short-lived city-run program was halted in 1990. Legally-sanctioned services were not resumed until 1992 when state law was changed to allow community-based organizations to carry out services if they obtain a legal waiver from the state. Five programs now operate in New York City, tailoring services to the needs of their clients. Programs have sought to collaborate with other organizations to build referral networks and reach new clients. One example of such a collaboration is between the Streetwork Project of Victim Services and the Lower East Side Harm Reduction Center (LESHRC). The Streetwork Project is a LESHRC site and provides needle exchange under LESHRC's waiver.

The Streetwork Project

The Streetwork Project is a program of Victim Services (formerly Victim Services/Travelers Aid). Streetwork's clients are chronically homeless youth who are part of the street culture of Times Square. Through both outreach and drop-in services, Streetwork seeks to break through loneliness and fear and communicate to clients a concern for their lives and a belief in their potential. Streetwork provides food, shower facilities, medical and social service referral, and a variety of support groups to clients. Clients are assigned to counselors who assist them in determining and meeting their needs. Each year, Streetwork reaches about 3,500 youth on the street and 300 youths receive counseling at the drop-in center each month. Streetwork receives city, state, federal and private funds.

Providing Services to Drug Using Clients

A grant from the U.S. Department of Health and Human Services in 1991 allowed Streetwork to develop

a program to serve drug using clients. Initially, an abstinence model was adopted and clients were encouraged to work toward abstinence through the 12-step approach or detox followed by residential or day treatment programs.

Only a small percentage of clients sought these services. Streetwork found that most drug users were neither interested in nor ready to accept an abstinence-based program. Some clients attempted to abstain from drugs but many failed because they were not motivated to make the abstinence-based model work for them. Other clients avoided discussing or lied about their drug use.

In order to be more responsive to the needs of clients, Streetwork moved toward a harm reduction model. The program is based on engagement—accepting clients as they are and designing a program that will keep them engaged. Streetwork's harm reduction philosophy states:

If a drug user is neither ready nor willing to abstain from drugs, it is best to minimize the harmful conse-

quences of their drug-taking behavior, and not to banish them to the black market and the drug sub-culture. Clients are not required to first give up drugs before they are offered services.

The Harm Reduction Protocol

Streetwork's harm reduction services are provided both on the streets and at the drop-in center. Outreach workers encounter drug using clients on the streets, sometimes while they are high, in the process of getting high, or dealing or turning tricks to get money to get high. It is necessary for outreach workers to be non-judgmental so as not to alienate or drive away clients or potential clients. Outreach workers offer information, counseling, referrals, buttons and palm cards with information about Streetwork, and encourage youths to take advantage of the services offered at Streetwork's drop-in center.

At the drop-in center, Streetwork provides showers, meals, and an opportunity for clients to change their clothes. These simple services can provide clients a sense of well-being

that contributes to an attitude more receptive to harm reduction services. Counselors use a holistic approach when working with clients. Harm reduction is integrated into a range of issues such as homelessness, childhood physical and sexual abuse, HIV infection or risk and drug addiction. Counselors work to build consistent, non-judgmental relationships with clients and encourage them to start reducing the harm drugs cause and to work toward specific goals. Streetwork also integrates harm reduction and substance use counseling into support groups.

Needle Exchange Integrated into Existing Services

Most needle exchange programs stand alone. While they provide services other than needle exchange, needle exchange is their main focus and the service that draws clients to them. It has been relatively rare for service providers to integrate needle

exchange into existing services. In order legally to exchange syringes, Streetwork became a site of LESHRC, an organization that already had obtained a waiver to exempt it from the state's prescription law. Streetwork's goals in providing needle exchange are to assist clients in staying healthy, to collect and dispose of used syringes that can pose a threat to the public, and to build stronger relationships with clients by communicating that they are concerned about their health.

A One-to-One Relationship

Needles are only available to clients through their assigned counselor. As a site of LESHRC, Streetwork enrolls clients and collects data according to LESHRC's procedures. Clients are given ID cards and enrolled in a log. Every subsequent exchange is recorded in the log. The ID cards identify clients as participants in the program and exempt them from prosecution for possession of drug paraphernalia.

Streetwork's counseling staff all receive drug information and counseling training and a special orientation and training in harm reduction philosophy and techniques. Each new client is taught safer injecting techniques by the counselor at the time of enrollment. Clients are taught to disinfect syringes since even with a needle exchange program available, sharing may occur. Each time the client exchanges, counselors question clients about their experiences in order to build on the existing relationship and further assess the client's needs. The protocol is fairly flexible and counselors frequently must use their own judgement in working with clients to ensure that the goals of the program are achieved. □

Streetwork Project of Victim Services

545 8th Avenue, 22nd Floor
New York, NY 10018

Stacey Rubin, Director of
Harm Reduction

Client Profile

- 69% are from New York City with the rest being primarily from New York suburbs
- 38% are Hispanic, 35% are African American, 25% are white, and 2% are of other ethnic origins
- 53% are male and 47% are female
- 29% are parents
- 87% report involvement with drugs
- 73% report having engaged in prostitution
- 33% have psychiatric histories
- 57% have spent time in foster or group homes
- 47% report sexual abuse
- 42% are lesbian, gay or bisexual
- 79% have been arrested or incarcerated

HIV Capsule Report, Paula M. Jones, editor, an official publication of the USCM AIDS/HIV Program, published by The United States Conference of Mayors, with support from the U.S. Department of Health and Human Services under grant #U62/CCU300609-11. J. Thomas Cochran, Executive Director; Byron J. Harris, Assistant Executive Director; Roger Dahl, Director, Office of Program Development and Technical Assistance; Richard C. Johnson, Director of Health Programs. Any opinions expressed herein do not necessarily reflect the policies of the U.S. Department of Health and Human Services. This issue was prepared by Paula M. Jones and edited by Larry Tate, Staff Associate. The survey of local health departments was conducted and written by Crystal D. Swann, Staff Associate.

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Resources

U.S. Centers for Disease Control and Prevention
National AIDS Clearinghouse/NAC Online
P.O. Box 6003
Rockville MD 20849-6003
800/458-5231
301/738-6616 (Fax)

The Clearinghouse has several databases of HIV/AIDS organizations and educational materials. NAC Online gives users access to these databases, including the North American Syringe Exchange Network, in addition to access to the AIDS Clinical Trials Information Database, the AIDS Daily Summary, Morbidity and Mortality Weekly Reports, HIV/AIDS Surveillance Report, current funding opportunities, and information on upcoming meetings and conferences, both domestic and international.

National Clearinghouse for Alcohol and Drug Information
P.O. Box 2345
Rockville, MD 20847-2345
800/729-6686
800/487-4889 (TDD)

Information on resources and organizations, electronic database, and a variety of publications and monographs, including National Institute on Drug Abuse publications.

Publications from USCM

Needle Exchange in New Haven, AIDS Information Exchange (March 1992).
Needle Exchange: Public Health and Politics, HIV Capsule Report (March 1992).

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