EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503
December 5, 1997

Dear Mr. Emanuel,

Want to share with you a copy of General McCaffrey's letter to Alan Leshner, Director of the National Institute on Drug Abuse, outlining our concerns about Federal funding for needle exchange programs.

Recently there has been discussion within the Administration about the possibility of lifting the statutory ban on the use of Federal funds for needle exchange programs (current HHS appropriations language mandates a total ban for 90 days, after which the Secretary of HHS may lift the ban if she determines needle exchange prevents HIV transmission, and does not encourage drug use). The Director wanted to make clear ONDCP's thinking on the issue, and in particular to make the case for additional targeted research to answer critical questions about the relationship between needle exchange programs, drug use, and HIV transmission.

The Director or I would be pleased to answer any questions you may have about the letter or the issue generally.

Sincerely,

Janet Crist
Chief of Staff

Mr. Rahm Emanuel
Senior Advisor to the President
The White House
Washington, DC 20500

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

December 4, 1997

Alan Leshner, PhD
Director
National Institute on Drug Abuse
5600 Fishers Lane
Rockville, Maryland 20857

Dear Dr. Leshner:

Last August 22, following your visit to discuss the research on needle exchange programs and its implications for drug policy, my Chief of Staff Janet Crist provided you with additional research questions which we believe would help to further inform federal policy on this important issue. Since our August discussion, we have become even more convinced that additional research is needed if we are to arrive at a federal policy that is humane, effective, and consistent with the goals and objectives of the *National Drug Control Strategy*. The research now underway does not address the questions we have outlined. Need to restate some of our concerns about Federal support for needle exchange programs, and to urge you and the national research community to seek answers to the questions we pose.

The drugs/AIDS nexus presents an enormous tragic challenge. The dramatic reduction in overall American drug use during the past 15 years (50 percent) is offset by increases in youth heroin and cocaine use and deterioration in youth attitudes toward drugs in general. Similarly, a general reduction in new AIDS cases masks increases among minority and female populations and among drug users, especially intravenous drug users, and their sexual partners and children.

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

Many health and law enforcement professionals are concerned about the narrow logic that would focus on needles or injecting drug use behavior as the essence of the problem. This perspective fails to take into account the complex human drug behavior involved. NIDA research demonstrates that drug addiction changes and trains the brain, creating a web of destructive and high risk behaviors. The resulting unemployment, crime, illness, social erosion, and frequently agonizing deaths flow from the compulsive behaviors associated with addiction, not just from the act of injecting. The provision of clean needles will not alone contain or alter this destructive lifestyle. Federal resources to provide a free 20 cent needle will not change the reckless, compulsive drug behavior that accompanies a $200 a day heroin, cocaine or methamphetamine habit. The only proven answer lies in effective drug treatment -- comprehensive in scope, intensive in application, and adequate in capacity.

The real challenge America faces is the more than 60 percent shortfall in drug treatment capacity for our 3.6 million addicted. Research sponsored by NIDA has shown that untreated opiate addicts die at a rate between 7 and 8 times higher than patients with similar characteristics in methadone programs. We also know that needle sharing rates have been reduced by more than two-thirds among injecting drug users during treatment. The positive role and record of drug treatment are clear. ONDCP strongly supports the outreach models developed by NIDA to bring injecting drug users into treatment. In particular, we must develop a greatly increased drug treatment capability for the drug dependent among the 1.6 million Americans currently behind bars at the local, state, and Federal levels.

SAMHSA's soon to be released report of findings from the Services Research Outcome Study (SROS) found significant and sustained reductions in drug use and criminal behavior following drug treatment. This is the first study of treatment outcomes to be based on a national probability sample, and its findings mirror other national treatment outcome studies, such as DATOS and NTIES.

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

SAMHSA'S National Treatment Improvement Evaluation Study (NTIES) determined extremely positive results for substance abuse treatment among predominately poor, inner-city populations. Use of illicit drugs dropped an average of 50

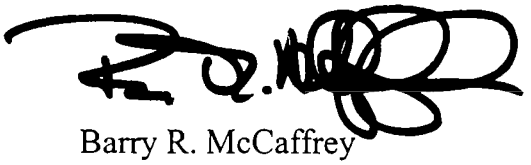
percent, drug selling by 78 percent, and arrests by 64 percent. Exchange of sex for money or drugs dropped by 56 percent, homelessness by 43 percent, and receipt of welfare income by 11 percent. Employment increased 19 percent.

Drug treatment has a solid record. It saves lives, reduces crime and health costs, and saves taxpayer money. Yet only enough capacity is available at this time to treat less than half of those in severe need. Methadone capacity is sufficient for only 25 percent of the estimated 600,000 American heroin addicts. Methadone regulation reforms, thankfully now being developed by HHS, will have a significant impact and have the strong support of ONDCP. However, more resources will be required for needed drug treatment capacity expansion. The requirement to increase drug treatment capacity should continue to be a key part of our Administration message until the shortfall has been remedied. In fiscal year 1998, the Congress under-funded the prevention and treatment block grant by $10 million. Congress must be persuaded to join us in supporting the critical role of drug treatment in the long-term *National Drug Control Strategy.*

We share a common view that our efforts to expand drug treatment must be based on a broader, consistent message of "no use." Visits to youth treatment programs around the country have made some things painfully clear to me. The importance of the drug prevention message we send to young Americans cannot be overstated. Heroin use has taken a terrible upward turn among our young people. We note recent press accounts of the deaths of 11 young people from heroin overdoses in a wealthy suburb of Dallas, Texas. Strongly agree that the message to our children must be an unambiguous "no use" message. If they should become ensnared by compulsive drug using behavior we should offer them a way out through drug treatment -- not a means to continue their addiction through needle exchange.

Clearly we need to know more about the treatment of compulsive drug behavior. A copy of our previous research questions on drug use and needle exchange programs is attached for consideration by your research team. ONDCP appreciates your outstanding leadership and contribution to the science base for drug abuse treatment and prevention.

Sincerely,



Barry R. McCaffrey
Director

Attachment
cc: Dr. Harold Varmus, Director, National Institutes of Health
Ms. Sandra Thurman, Director, Office of National AIDS Policy

August 21, 1997

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

February 3, 1998

Dear Mr. Emanuel: Rahm

Appreciate your continued support for and interest in ONDCP's Performance Measures of Effectiveness (PME) system. The PME system is the vehicle through which we will assess the Strategy's progress toward reducing drug use, availability, and consequences. It establishes desirable end states for the drug control community for 2002 and 2007 and represents an ambitious, but well-conceived undertaking by this Administration.

A key component of the PME system must be realistic annual targets. It is upon these that the annual assessment to gauge the drug control community's progress is based. Without them, the PME system can serve little purpose. As the enclosed package sent to Director Raines shows, annual performance targets are required by law, both expected and demanded by Congress, and necessary for adequate management of the President's comprehensive drug control program. At stake here are important public commitment issues and the overall solution to this nation's serious drug problems.

Design of the PME system is complete. It has passed through formal review within the Administration, and been modified in response to the input provided by the drug control Departments and agencies. We intend to formally release it with the 1998 Strategy and begin implementation. This includes the development during 1998 of realistic annual targets, done with full interagency involvement and consultation. These would be then reported on in the 1999 Strategy. These annual targets quantify our progress toward achieving the five and ten year targets that form the basis of the entire PME system and allow for any mid-course corrections needed to achieve these targets. Am requesting your support to ensure that realistic annual targets are included in the PME system. Look forward to working with you on this.

Respectfully,

Janet

Janet Crist
Chief of Staff

The Honorable Rahm Emanuel
Senior Advisor to the President
The White House
Washington, DC 20500

Enclosure

Personal

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

Strong —

January 30, 1998

Dear Mr. Raines:

Appreciate your continued cooperation and interest in ONDCP's system of Performance Measures of Effectiveness (PME). The PME system includes 111 performance targets, twelve of which establish desirable end states for the drug control community for 2002 and 2007 and represent an ambitious undertaking by this Administration.

The PME system has been developed, is in the final stages of review within the Administration, and is being implemented. Annual targets will be developed in calendar year 1998 and reported in the 1999 Strategy. These annual targets will supplement the five and ten year targets that form the basis of the system. As the enclosed documentation shows, legal, historical, and public commitment issues are at stake here.

PME is a measurement system by which we can assess the Strategy's progress toward reducing drug use, availability, and consequences. Annual assessment requires annual targets against which to gauge the drug control community's progress. Look forward to working with you on this.

Very respectfully,

Barry R. McCaffrey
Director

The Honorable Franklin D. Raines
Director
Office of Management and Budget
Old Executive Office Building
Washington, DC 20503

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

The Requirement for Annual Performance Targets

The current draft of the PME report says that ONDCP will prepare annual targets to correspond to the targets proposed for 2002 and 2007 in calendar year 1998. This document highlights the legal, historical, and public commitment issues involved.

- Legal: The law says that the Strategy shall "include comprehensive, research-based, long-range goals for reducing drug abuse and consequences of drug abuse" and "short-term measurable objectives which the Director determines may be realistically achieved in the 2-year period beginning on the date of submission of the strategy." With the requirement of an annual Strategy, it's only a matter of time before there are annual (short-term), measurable objectives (targets).

- Historical: The Strategy goals during the Bush Administration set targets for two and ten years. With the requirement of an annual strategy, targets were eventually established for each year. While these targets focused mostly on casual drug use and were not tied to agency performance, they did satisfy Congress' desire for measurement of the Strategy's overall performance. This discussion is only to show that ONDCP has had annual targets before and published them in its Strategies.

  The Clinton Administration dropped the need for annual targets and instead adopted goals that focused on change in key indicators. For example, one goal was to "reduce domestic drug-related crime and violence." Note that this goal does not identify "by how much" or "when" crime and violence should be reduced. Congress rejected outright the use of these types of goals. This is one reason why ONDCP is now building an PME system that contains annual, measurable targets.

- Public Commitment: A recent 5 January letter from Senator Hatch (attached) discussing the Strategy and performance measurement is probably the best, recent demonstration of Congress' interest in annual targets. In that letter, Senator Hatch requires annual targets to hold participating agencies accountable.

If targets only exist for 2002 and 2007, it will be difficult to comment annually on the Strategy's progress in attaining those goals. There are additional problems. Congress could claim that we are ignoring its intent to have ONDCP report on the performance of the Strategy. Dropping annual targets would run counter to the Administration's own reauthorization proposal for ONDCP that proposes the PME system and annual targets. Dropping annual targets runs counter to the GPRA theme, which is to have annual targets in agencies' own annual plans (drug control agencies are covered by GPRA).

ONDCP
January 30, 1998

ORRIN G. HATCH
UTAH

ROBERT L. DIBBLEE
ADMINISTRATIVE ASSISTANT

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United States Senate

WASHINGTON, DC 20510-4402

COMMITTEES:
JUDICIARY
FINANCE
INTELLIGENCE
INDIAN AFFAIRS
JOINT TAXATION

January 5, 1998

The Honorable Barry R. McCaffrey
Director
Office of National Drug Control Policy
Executive Office of The President
Washington, D.C 20500

Dear Director McCaffrey:

Thank you for your letter of October 21, 1997, concerning the 1998 National Drug Control Strategy. You have solicited my recommendations with respect to this strategy.

You have been a strong voice for responsible drug control policies. It is my opinion that such a voice must be immediately coupled with action, particularly focused on a youth drug abuse epidemic that continues to spiral out of control, as evidenced by the recently released *PRIDE* survey. As we continue to plan, propose, and evaluate new policies and procedures, the acceptance of illegal substance abuse by today's children continues to take root.

Notwithstanding your efforts to date, the Clinton Administration has presided over a youth drug epidemic that continues to spiral out of control. Consider that according to the latest *Monitoring the Future Study*:

- With respect to the use of any illicit drugs in the prior 12 months, since 1993 it has increased 56 percent among 8th graders, 52 percent among 10th graders, and 30 percent among 12th graders.

- With respect to use of marijuana use in the last 12 months, since 1993 it has increased 99 percent among 8th graders, 121 percent since 1992 for 10th graders, and 38 percent among 12th graders.

- Annual LSD use has increased 52 percent, 64 percent, and 29 percent among 8th, 10th, and 12th graders since 1993.

- Annual cocaine use has similarly increased 77 percent, 100 percent, and 49 percent among 8th, 10th, and 12th graders since 1993

- Annual heroin usage has increased 129 percent, 71 percent, and 100 percent for 8th, 10th, and 12th graders since 1993.

Similarly, the recently released PRIDE survey reflects a continued escalation in youth drug use. Perhaps even more troubling, like the *Monitoring the Future* study, PRIDE reports that not only is youth drug abuse continuing to rise, the age at which these children are using drugs is dropping. In fact, this survey reflected a continued increase in illicit drug use by children as young as the 6th grade.

I raise this concern in response to your assertion that, "ONDCP is also in the process of developing a performance measurement with which to gauge the success of the *National Drug Control Strategy* and its underlying programs." I am somewhat perplexed that your office is still merely "in the process" of developing such a system. It has been my understanding that your office has been working to establish and implement a performance measurement system for more than a year. I have made every effort to support you in this effort. Further, in your testimony before the Judiciary Committee on July 23, 1997, you testified:

> I will bring down to you by 1 October our first effort at developing performance measures of effectiveness at targets, at goals, and at outcomes. And we will put this into place to capture what we are achieving with your money in the year to come.

In your letter to me dated October 1, 1997, transmitting ONDCP's Strategic Plan for FY 1997 to 2002 you state, "At the heart of the plan is performance measurement...Will *[sic]* transmit to Congress in February 1998 the complete National Performance Measurement System."

I am concerned with the recurring delay we have experienced in obtaining and fully implementing your final performance measurement system. To date, no one from ONDCP has explained to me why a system to measure the effectiveness of federal drug control measures is not yet in place. For this reason, I request that a certification be made to this Congress that by January 1, 1998, the

Performance Measurement System has been fully implemented. I further request that, when transmitting the *1998 National Drug Control Strategy*, consistent with the "proposed end states" identified in your letter, you identify statistically through the use of this Performance Measurement System, the progress made in FY1997 towards the following objectives:

-Reduction of overall drug use by 50 percent;
-Reduction of youth drug use by 40 percent;
-Reduction of the amount of illegal drugs available for consumption by half.

In my view, the overriding goal of the 1998 strategy must be to reduce youthful drug use through a dramatic reduction in the availability of drugs in the United States, measured by the price and purity on the streets. The strategy must hold each participating agency to specifically defined targets, outline the quantifiable goals expected of each participant, and require annual progress reports by the agencies as to success in meeting these standards. Upon receipt of these reports, ONDCP should then provide Congress with an annual report as to the scarcity of drugs in America.

You have identified "long term goals" for your 10 year plan, yet section 1005(a)(2)(B) of the National Narcotics Control Leadership Act of 1988, still serves as the guiding principles for your office. That section requires that the drug strategy contain "short-term measurable objectives". I expect the 1998 Strategy to outline such objectives in the short term for each goal identified and to evaluate the effectiveness of the 1997 strategy using that same criteria. Accordingly, I have proposed for your consideration, some short-term measurable objectives related to each of your long term goals:

Goal 1:

The Administration has proposed a long term goal to, "Educate and enable America's youth to reject illegal drugs, as well as alcohol and tobacco." I propose a short term objective of over each of the next 4 years cause a 5 percent increase in perceived risk[1] for each drug typically used by America's youth to include marijuana, cocaine, LSD, and methamphetamine. In light of the staggering increase of youth drug use over the last five years, short term

definable reduction objectives must be established. I would strongly recommend establishing annual measurable objectives necessary to achieving your proposed end state of reducing youth drug use back to the 1992 level of 5.4 percent. By setting attainable short term objectives you provide far greater accountability to the American people and give your program agencies more specific objectives that can be achieved on an annual basis.

Goal 2:

The Administration has also proposed a long term goal to, "Increase the safety of America's citizens by substantially reducing drug-related crime and violence." Given this important and necessary goal, I was surprised to learn of the Administration's effort to resolve the cocaine powder versus crack sentencing disparity ratio issue by increasing the amount of crack a person must have in their possession in order to invoke mandatory minimum sentences under federal sentencing guidelines. While I am willing to consider greater parity in cocaine sentencing, I am not willing to consider any proposal that makes it easier and less costly for a dealer to peddle narcotics on America's streets.

I am also at a loss as to how the Administration believes it can accomplish this goal without a confirmed head of the Department of Justice's Criminal Division. This office has remained vacant for over 2 years.

I am also concerned over stagnating federal caseloads in the face of the ever increasing flow of drugs into this country. Established realistic short term goals must be outlined in the strategy. For instance, I would recommend a goal of increases in drug prosecutions nationwide of ten percent per year for the next 4 years. There is no chance of achieving this objective unless a refocus of effort and resources is made to law enforcement and interdiction agencies. A positive, step I believe, is your recent decertification of the Department of Defense budget on the basis that it needs to devote an additional $141 million for federal drug control. It is my hope that you will focus similar attention on other program agencies that are principally focused on "supply" related programs. As you well know, many of these agencies have seen their interdiction funding dwindle considerably as a percentage of their operating budgets. For example, it is my

understanding that only 9 percent of the FY 97 Coast Guard budget was for drug missions. This is down from 21 percent in FY 1991. The FY 1997 Customs budget was only 37 percent for drug interdiction, down from 45.5 percent in FY 1991.

Goal 3:

The Administration has proposed a long term goal to, "Reduce health and social costs of illegal drug use." A primary barometer for evaluating the effectiveness of strategies necessary to achieving this goal is to focus on reduction of emergency room admissions, which typically serve as the basis for determining the extent of hard core drug use. The Clinton Administration's cuts to enforcement and interdiction programs resulted in record emergency room admissions numbers. For instance between 1992 and 1996 cocaine-related emergencies rose 19 percent; heroin related episodes rose 58 percent; marijuana-related episodes increased 96 percent; and methamphetamine cases jumped 167 percent. Stated short term objectives at a minimum should be to reduce these admission levels to the 1992 level within 3 years. The only way that such an objective can be accomplished in my view, is to refocus the entire drug strategy back to interdiction and enforcement.

While we all recognize the importance of treatment programs, an effective treatment strategy, to meet the stated goal, must be focused on those who can most benefit by each dollar spent. For instance, a program that gives priority treatment to hard core drug addicts, who typically cycle through the treatment system several times over a period of years before getting off drugs, with most never even reaching that goal, may be imprudent. A 1994 study found that only 13 percent of heavy cocaine users who receive treatment are either non-users or light users at the end of that year. The study further found that 20 percent of heavy users continue to use drugs while in treatment.[2] The 1998 Strategy should reflect a shift away from giving priority treatment to hard core addicts, and instead favor treatment for those most salvageable--young people.

Goals 4 and 5:

The Administration has proposed as long term goals 4 and 5 to, "Shield America's air, land, and sea frontiers from the drug threat;" and "Break foreign and domestic drug sources of supply." Consistent with the above, it is my

belief that the 1998 strategy must recognize that the Administration's strategy emphasizing demand reduction, rather than interdiction, has not succeeded. In fact, matters have gotten worse. A renewed commitment to interdiction is vital, particularly if we wish to have any hope of achieving these long term goals The availability of drugs on the streets of America, particularly to our nation's youth, is at record levels. It will be quite difficult to change any attitudes concerning illegal drug use as long as such drugs are readily available in our schools and streets.

I am pleased to see that the 1998 Strategy will contain proposals for improving the effectiveness of federal efforts to prevent drug trafficking across the Southwest border. In fact, I would like to see considered in the 1998 strategy a comprehensive plan for the Southwest border, including an evaluation of the feasibility of increased operational involvement of the U.S. military in drug interdiction and eradication, expanded use of Legal Detachments (LEDETS) accompanying military units along the Southwest border, similar to Coast Guard LEDETS currently deployed with Navy ships in the transit zone, a strategy for reducing corruption along the border, and a concrete plan for improving intelligence coordination in this region.

The Strategy should also reflect any adjustments to the *National Methamphetamine Strategy* released by the President in April 1996, and provide a detailed quantifiable evaluation of this strategy in the almost 2 years since its implementation.

Further, the 1998 Strategy should address any and all source country initiatives, with an obvious focus upon Colombia, which I understand is seizing control of the international heroin market in addition to its cocaine trade, and Mexico, which I understand is sharing the market control of cocaine, and is serving as a major refinery location for methamphetamine. The strategy should also include empirical data concerning such matters as seizures, arrests, and prosecutions that reflect the effectiveness of each of the High Intensity Drug Trafficking Areas (HIDTA's). This data should be coupled with and substantiate the FY98 budget allocations for each respective HIDTA.

Assuming the effectiveness of a sound Southwest border

policy and a re-emphasis on transit zone interdiction, the 1998 Strategy should reflect a short term overall annual objective of increasing seizures by 10 percent. The best measurement of success of the 1998 Strategy is to examine the price and purity of these drugs on America's streets. As you know, drugs are cheaper and more available with greater purity. According to the DEA, since 1993, the retail price of cocaine has dropped more than 10 percent. The price of heroin has plummeted from $1,647 a gram in 1992, to $966 a gram in February 1996. At a minimum, a stated goal of the 1998 Strategy should include a short term objective of driving up the street value of heroin and cocaine by 20 percent per annum. As long as drugs are so cheap and readily available, we can never hope to regain control of our nation's streets.

The Strategy must also define the federal response to marijuana legalization initiatives as well as a concrete plan for domestic marijuana eradication. During the first four years of the Clinton Administration, there was a 59 percent reduction in cultivated plants destroyed.[3] Particularly with the growing momentum of marijuana "coops" that have resulted from state legalization initiatives, there is a growing need not only to address the legalization efforts themselves, but also to reenforce federal prohibitions against marijuana cultivation. The 1998 *Strategy* must outline a specific marijuana eradication program for dealing with this ever increasing problem.

Further, I know that you share my concern over the successful legalization initiatives for marijuana and other controlled substances, in both Arizona and California. These misguided legalization efforts must be met with a strong response. It is imperative that the 1998 Strategy address what can be done at the federal level to educate the public as to the true agenda of these groups, to clearly define the federal response to these initiatives in states such as Arizona and California, and to propose a strategy for confronting these legalization efforts across the nation.

Finally, I would like to emphasize the importance that I place on the funds appropriated for the youth anti-drug media campaign being used in a carefully targeted manner that ensures that the most is achieved with the money that has been allocated, rather than it being spent on

administrative overhead and related costs.

While this letter does not contain an exhaustive list of all drug control issues that I believe must be addressed in the 1998 National Drug Control Strategy, it does reflect particular areas I believe are essential in order for us to develop any type of meaningful drug control policy into the next century.

Sincerely,

Orrin G. Hatch
United States Senator

OGH:pmm

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

January 8, 1998

INFORMATION

MEMORANDUM FOR JOHN CARNEVALE, DIR., OPBR&E

FROM: CHUCK BLANCHARD, DIR., OLC (by Dave Shull)

SUBJECT: Underlying Presidential and Congressional Authority

PURPOSE: To provide reproducible copies, of the underlying Presidential and Congressional authorities for Director, ONDCP, to establish performance measurement objectives and to require Drug Program Agencies to provide information relating to compliance with such measures.

DISCUSSION:

General Congressional authority is in our authorization language, specifically under the Director's responsibilities and powers enumerated in 21 USC 1502 (b and d). That language, with emphasis to highlight appropriate wording, is reproduced at Tabs A and B.

Additionally, statutory language appearing in 21 U.S.C. 1504 (a and b) and 21 U.S.C. 1507 provides authority. Highlighted versions of those statutes appear at Tabs C,D and E.

Our Presidential authority, appropriately highlighted, is at Tab F.

Attachments
Tab A - 21 U.S.C. 1502(b)
Tab B - 21 U.S.C. 1502(d)
Tab C - 21 U.S.C. 1504(a)
Tab D - 21 U.S.C. 1504(b)
Tab E - 21 U.S.C. 1507
Tab F - E.O. 12880, as amended by E.O. 13008

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

A

Divider Title: _____

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

Excerpt from ONDCP AUTHORIZING STATUTE
21 U.S.C. 1502(b)

§ 1502. Appointment and duties of Director, Deputy Directors, and Associate Director...

(b) **Responsibilities**

The Director shall ---

(1) establish policies, objectives, and priorities for the National Drug Control Program;

(2) **annually promulgate the National Drug Control Strategy** in accordance with section 1504 of this title;

(3) **coordinate and oversee the implementation by National Drug Control Program agencies of the policies, objectives, and priorities established under the National Drug Control Strategy**;

(4) make such recommendations to the President as the Director determines are appropriate regarding --

(A) changes in the organization, management, and budgets of Federal departments and agencies engaged in drug enforcement; and

(B) the allocation of personnel to and within such departments and agencies; to implement the policies, priorities, and objectives established under paragraph (1) and the National Drug Control Strategy;

(5) consult with and assist State and local governments with respect to their relations with the National Drug Control Program agencies;

(6) **appear before duly constituted committees and subcommittees of the House of Representatives and of the Senate to represent the drug policies of the executive branch**;

(7) **notify any National Drug Control Program agency if its policies are not in compliance with the responsibilities of such agency under the National Drug Control Strategy and transmit a copy of each such notification to the President**; and

(8) provide, by July 1 of each year, budget recommendations to the heads of departments and agencies with responsibilities under the National Drug Control Program, which recommendations shall apply to the second following fiscal year and address funding priorities developed in the annual National Drug Control Strategy.

(Emphasis Added)

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

Excerpt from ONDCP AUTHORIZING STATUTE
21 U.S.C. 1502(d)

§ 1502. Appointment and duties of Director, Deputy Directors, and Associate Director...

(d) **Powers of Director**

In carrying out the responsibilities established under subsection (b) of this section, the **Director may--**

(1) select, appoint, employ, and fix compensation of up to 75 and such additional officers and employees as may be necessary to carry out the functions of the Office of National Drug Control Policy under this title;

(2) request the head of a department or agency or program to place department, agency, or program personnel who are engaged in drug control activities on temporary detail to another department or agency in order to implement the National Drug Control Strategy, and the head of the department or agency shall comply with such a request;

(3) use for administrative purposes, on a reimbursable basis, the available services, equipment, personnel, and facilities of Federal, State, and local agencies;

(4) procure the services of experts and consultants in accordance with section 3109 of Title 5, relating to appointments in the Federal Service, at rates of compensation for individuals not to exceed the daily equivalent of the rate of pay payable for GS-18 of the General Schedule under section 5332 of Title 5;

(5) accept and use donations of property from Federal, State, and local government agencies;

(6) use the mails in the same manner as any other department or agency of the executive branch;

(7) **monitor implementation of the National Drug Control Program, including--**

(A) **conducting program and performance audits and evaluations; and**

(B) **requesting assistance from the Inspector General of the relevant agency in such audits and evaluations;**

(8) except to the extent that the Director's authority under this paragraph is limited in an annual appropriations Act, transfer funds appropriated to a National Drug Control Program agency account to a different National Drug Control Program agency account in an amount that does not exceed 2 percent of the amount appropriated to either account, upon advance approval of the Committees on Appropriations of each House of Congress; and

(9) in order to ensure compliance with the National Drug Control Program, issue to the head of a National Drug Control Program agency a funds control notice described in subsection (f) of this section.

(Emphasis Added)

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

Excerpt from ONDCP AUTHORIZING STATUTE
21 U.S.C. 1504(a)

§ 1504. Development and submission of National Drug Control Strategy

(a) **Development and Submission of the National Drug Control Strategy**

(1) Not later than 180 days after the first Director is confirmed by the Senate, and not later than February 1 of each year thereafter, the **President shall submit to the Congress a National Drug Control Strategy.** Any part of such strategy that involves information properly classified under criteria established by an Executive order shall be presented to the Congress separately.

(2) **The National Drug Control Strategy submitted under paragraph (1) shall--**

(A) **include comprehensive, research-based, long-range goals for reducing drug abuse and the consequences of drug abuse in the United States;**

(B) **include short-term *measurable objectives* which the Director determines may be realistically achieved in the 2-year period beginning on the date of the submission of the strategy;**

(C) describe the balance between resources devoted to supply reduction and demand reduction; and

(D) review State and local drug control activities to ensure that the United States pursues well-coordinated and effective drug control at all levels of government.

(3) (A) **In developing the National Drug Control Strategy, the Director shall consult with--**

(i) **the heads of the National Drug Control Program agencies;**

(ii) **the Congress;**

(iii) State and local officials;

(iv) private citizens with experience and expertise in demand reduction; and

(v) private citizens with experience and expertise in supply reduction.

(B) At the time the President submits the National Drug Control Strategy to the Congress, the Director shall transmit a report to the Congress indicating the persons consulted under this paragraph.

(4) **The Director shall include with each National Drug Control Strategy an evaluation**

of the effectiveness of Federal Drug control during the preceding year. The evaluation shall include an assessment of Federal drug control efforts, including--

(A) **assessment, of the reduction of drug use**, including estimates of drug prevalence and frequency of use as measured by national, State, and local surveys of illicit drug use and by other special studies of--

(i) high-risk populations, including school dropouts, the homeless and transient, arrestees, parolees, and probationers, and juvenile delinquents; and

(ii) drug use in the workplace and the productivity lost by such use;

(B) **assessment of the reduction of drug availability**, as measured by--

(i) the quantities of cocaine, heroin, and marijuana available for consumption in the United States;

(ii) the amount of cocaine and heroin entering the United States;

(iii) the number of hectares of poppy and coca cultivated and destroyed;

(iv) the number of metric tons of heroin and cocaine seized;

(v) the number of cocaine processing labs destroyed;

(vi) changes in the price and purity of heroin and cocaine;

(vii) the amount and type of controlled substances diverted from legitimate retail and wholesale sources; and

(viii) the effectiveness of Federal technology programs at improving drug detection capabilities at United States ports of entry;

(C) **assessment of the reduction of the consequences of drug use and availability**, which shall include estimation of--

(i) burdens drug users placed on hospital emergency rooms in the United States, such as the quantity of drug-related services provided;

(ii) the annual national health care costs of drug use, including costs associated with people becoming infected with the human immunodeficiency virus and other communicable diseases as a result of drug use;

(iii) the extent of drug-related crime and criminal activity; and

(iv) the contribution of drugs to the underground economy, as measured by the retail value of drugs sold in the United States; and

(D) determination of the status of drug treatment in the United States, by assessing--

(i) public and private treatment capacity within each State, including information on the number of treatment slots available in relation to the number actually used, including data on intravenous drug users and pregnant women;

(ii) the extent, within each State, to which treatment is available, on demand, to intravenous drug users and pregnant women;

(iii) the number of drug users the Director estimates could benefit from treatment; and

(iv) the success of drug treatment programs, including an assessment of the effectiveness of the mechanisms in place federally, and within each State, to determine the relative quality of substance abuse treatment programs, the qualifications of treatment personnel, and the mechanism by which patients are admitted to the most appropriate and cost effective treatment setting.

(5) **The Director shall include with the National Drug Control Strategy** required to be submitted not later than February 1, 1995, and with every second such strategy submitted thereafter-

(A) **an assessment of the quality of current drug use measurement instruments and techniques to measure supply reduction and demand reduction activities;**

(B) **an assessment of the adequacy of the coverage of existing national drug use measurement instruments and techniques** to measure the casual drug user population and groups at-risk for drug use;

(C) **an assessment of the actions the Director shall take to correct any deficiencies and limitations identified pursuant to subparagraphs (A) and (B)**; and

(D) **identification of the specific factors that restrict the availability of treatment services to those seeking it** and proposed administrative or legislative remedies to make treatment available to those individuals.

(6) **Federal agencies responsible for the collection or estimation of drug-related information required by the Director shall cooperate with the Director, to the fullest extent possible,** to enable the Director to satisfy the requirements of sections 4 and 5[1].

(7) **With each National Drug Control Strategy, the Director shall report to the President and the Congress on the Director's assessment of drug use and availability in the United States,** including an estimate of the effectiveness of interdiction, treatment, prevention, law enforcement, and international programs under the National Drug Control Strategy in effect in the preceding year in reducing drug use and availability.

(Emphasis Added)

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

Excerpt from ONDCP AUTHORIZING STATUTE
21 U.S.C. 1504(b)

§ 1504. Development and submission of National Drug Control Strategy

(b) Goals, objectives, and priorities

Each National Drug Control Strategy shall include--

(1) **a complete list of goals, objectives, and priorities for supply reduction and for demand reduction;**

(2) private sector initiatives and cooperative efforts between the Federal Government and State and local governments for drug control;

(3) **3-year projections for program and budget priorities and achievable projections for reductions of drug availability and usage;**

(4) a complete assessment of how the budget proposal transmitted under section 1502(c) of this title is intended to implement the strategy and whether the funding levels contained in such proposal are sufficient to implement such strategy;

(5) designation of areas of the United States as high intensity drug trafficking areas in accordance with subsection (c) of this section; and

(6) a plan for improving the compatibility of automated information and communication systems to provide Federal agencies with timely and accurate information for purposes of this subtitle.

(Emphasis Added)

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

Excerpt from ONDCP AUTHORIZING STATUTE
21 U.S.C. 1507

§ 1507. Definitions

As used in this subtitle--

(1) the term "drug" has the same meaning as the term "controlled substance" has in section 802(6) of this title;

(2) the term **"drug control" means *any activity* conducted by a National Drug Control Program agency involving supply reduction or demand reduction**;

(3) the term "supply reduction" means any enforcement activity of a program conducted by a National Drug Control Program agency that is intended to reduce the supply or use of drugs in the United States and abroad, including--

(A) international drug control;

(B) foreign and domestic drug enforcement intelligence;

(C) interdiction; and

(D) domestic drug law enforcement, including law enforcement directed at drug users;

(4) the term "demand reduction: means any activity conducted by a National Drug Control Program agency, other than an enforcement activity, that is intended to reduce the demand for drugs, including--

(A) drug abuse education;

(B) prevention;

(C) treatment;

(D) research; and

(E) rehabilitation;

(5) the term "National Drug Control Program" means programs, policies, and activities undertaken by National Drug Control Program agencies pursuant to the responsibilities of such agencies under the National Drug Control Strategy;

(6) the term "National Drug Control Program agency" means any department or agency and all dedicated units thereof, with responsibilities under the National Drug Control Strategy, as designated--

(A) jointly by the Director and the head of the department or agency; or

(B) by the President;

(7) the term "Director" means the Director of National Drug Control Policy; and

(8) the term "National Drug Control Strategy' means a strategy developed and submitted to the Congress under section 1504 of this title.

(Emphasis Added)

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Divider Title: _____

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

EXECUTIVE ORDER 12880
(as amended by Executive Order 13008)

National Drug Control Program

The Office of National Drug Control Policy has the lead responsibility within the Executive Office of the President to establish policies, priorities, and objectives for the Nation's drug control program, with the goal of reducing the production, availability, and use of illegal drugs. All lawful and reasonable means must be used to ensure that the United States has a comprehensive and effective National Drug Control Strategy.

Therefore, by the authority vested in me as President by the Constitution and the laws of the United States of America, including the National Narcotics Leadership Act of 1988, as amended (21 U.S.C. 1501 *et seq.*), and in order to provide for the effective management of the drug abuse policies of the United States, it is hereby ordered as follows:

Section 1. GENERAL PROVISIONS.

(a) Because the United States considers the operations of international criminal narcotics syndicates as a national security threat requiring an extraordinary and coordinated response by the civilian and military agencies involved in national security, the Director of the Office of National Drug Control Policy (Director), in his role as the principal adviser to the National Security Council on national drug control policy (50 U.S.C. 402(f)), shall provide drug policy guidance and direction in the development of related national security programs.

(b) The Director shall provide oversight and direction for all international counternarcotics policy development and implementation, in coordination with other concerned Cabinet members, as appropriated.

(c) An interagency Working Group (IWG) on international counternarcotics policy, chaired by the Office of National Drug Control Policy, shall develop and ensure coordinated implementation of an international counternarcotics policy. The IWG shall report its activities and differences of views among agencies to the Director for review, mediation, and resolution with concerned Cabinet members, and if necessary, by the President.

(d) A coordinator for drug interdiction shall be designated by the Director to ensure that assets dedicated by Federal drug program agencies for interdiction are sufficient and that their use is properly integrated and optimized. The coordinator shall ensure that interdiction efforts and priorities are consistent with overall U.S. international counternarcotics policy.

(e) The Director shall examine the number and structure of command/control and drug intelligence centers operated by drug control program agencies involved in international counter-narcotics and suggest improvements to the current structure for consideration by the President and concerned members of the Cabinet.

(f) The Director, utilizing the services of the Drugs and Crime Data Center and Department of Justice Clearinghouse, shall assist in coordinating and enhancing the dissemination of statistics and studies relating to anti-drug abuse policy.

(g) **The Director shall provide advice to agencies regarding ways to achieve efficiencies in spending and improvements to interagency cooperation** that could enhance the delivery of drug control treatment and prevention services to the public. **The Director may request agencies to provide studies, information, and analyses in support of this order.**

Section 2. GOALS, DIRECTION, DUTIES AND RESPONSIBILITIES WITH RESPECT TO THE NATIONAL DRUG CONTROL PROGRAM.

(a) *Budget Matters.*

(1) In addition to the budgetary authorities and responsibilities provided to the Director by statute, 21 U.S.C. 1502, for those agency budget requests that are not certified as adequate to implement the objectives of the National Drug Control Strategy, the Director shall include in such certifications initiatives or funding levels that would make such requests adequate.

(2) The Director shall provide, by July 1 of each year, budget recommendations to the heads of departments and agencies with responsibilities under the National Drug Control Program. The recommendations shall apply to the second following fiscal year and address funding priorities developed in the annual National Drug Control Strategy.

(b) ***Measurement of National Drug Control Strategy Outcome.***

(1) **The National Drug Control Strategy shall include long-range goals for reducing drug use and the consequences of drug use in the United States, including burdens on hospital emergency rooms, drug use among arrestees, the extent of drug-related crime, high school dropout rates, the number of infants exposed annually to illicit drugs in utero, national drug abuse treatment capacity, and the annual national health care costs of drug use.**

(2) **The National Drug Control Strategy shall also include an assessment of the quality of techniques and instruments to measure current drug use and supply and demand reduction activities, and the adequacy of the coverage of existing national drug use instruments and techniques to measure the total illicit drug user population and groups at-risk for drug use.**

(3) **The Director shall coordinate an effort among the relevant drug control program agencies to assess the quality, access, management, effectiveness, and standards of accountability of drug abuse treatment, prevention, education, and other demand reduction activities.**

(c) *Provisions of Reports.* **To the extent permitted by law, heads of departments and agencies with responsibilities under the National Drug Control Program shall make available to the Office of National Drug Control Policy, appropriate statistics, studies, and reports, pertaining to Federal drug abuse control.**

WILLIAM J. CLINTON

THE WHITE HOUSE,
November 16, 1993,
as amended on June 3, 1996

(Emphasis Added)

Needle exchanges facilitated abuse, drug officials find

Lack of treatment hurt Vancouver program

Barry McCaffrey, director of the Office of National Drug Control Policy, used the data in this April 6 "Vancouver Needle Exchange Trip Report" to oppose the Clinton administration's push to lift the ban on federal funding for needle-exchange programs. The report was compiled by Dr. Hoover Adger, deputy director; D.B. Des Roches, special assistant for strategy; and Jane Sanville of the Office for Demand Reduction.

Observations – facts

A. The Vancouver Needle Exchange Program (NEP) is one of the largest in the world — it has distributed over 1 million needles annually for the last 10 years, and close to 2.5 million needles last year alone.

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

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

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

E. The highest rates of property crime in Vancouver are within two blocks of the needle exchange.

Statements

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

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

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

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

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

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

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

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

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

J. The Vancouver Police stated that there was a 24-hour drug market and similar open drug injection activity in the area immediately adjacent to the needle exchange. During a drive-around with a detective from the Vancouver Drug Squad, we observed multiple instances of drug users injecting and purchasing drugs. A one-block-long alley typically had three or four people injecting, preparing to inject or moving from injecting drugs.

Reporter notes

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

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

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

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

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

C. The academics who studied the NEP seemed extremely concerned by the increase in HIV among NEP participants, and devoted much of our time together to explaining how NEP frequent users were a much more marginalized and at-risk segment of society than were infrequent NEP users.

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

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

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

Conclusions

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

1). Absent any mandate for drug treatment, NEPs will focus on what they can afford and do best — exchange needles.

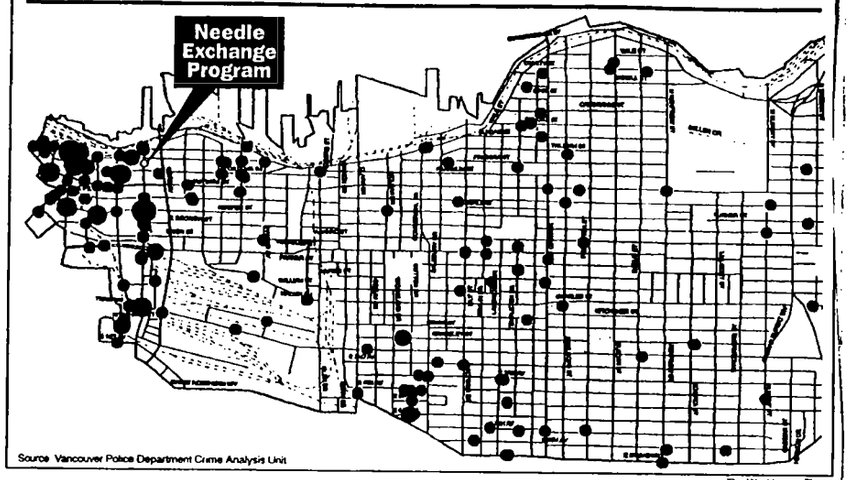
2). Once the NEP was instituted, there seemed to be no imperative for the establishment or expansion of drug treatment. All interviewees stated that NEP was not a "silver bullet," but reality suggests that it is treated as such:

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

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

FREE NEEDLES AND CRIME RATES

A map of downtown Vancouver prepared by the city's police department shows soaring rates for thefts from automobiles in the neighborhoods near the city's needle-exchange program. For the two-week period ending March 29, the largest dots, clustered near the site of the program, denote four or more incidents of robberies from cars.



Source: Vancouver Police Department Crime Analysis Unit

The Washington Times

The Washington Times
TUESDAY, APRIL 28, 1998

IQ, not environment, strongest income factor

By Cheryl Wetzstein
THE WASHINGTON TIMES

Innate intelligence largely determines how much money people earn because environmental and social factors do not dramatically change intellect possessed at birth, according to social scientist Charles Murray.

"For many years now, too many scholars on left and right alike have pretended they live in a Lake Woebegon world where everyone can be above average," Mr. Murray writes in a new report titled "Income Inequality and IQ."

"It is time for policy analysts to stop avoiding the reality of human inequality, a reality that neither equalization of opportunity nor a freer market will circumvent."

Mr. Murray, a Bradley fellow at the American Enterprise Institute and author of the controversial book "The Bell Curve: Intelligence and Class Structure in American Life," yesterday discussed findings from his study of young adult siblings.

The 2,859 sibling pairs Mr. Murray studied were raised in the same home with the same parents but had different intelligence quotients, known as IQs. He found that siblings with high IQs tended to go to college and earn high wages: "Very bright" siblings, with IQs above 120, earned a median of $33,500 — $11,500 more than their "normal" siblings, whose IQs ranged between 90 and 109.

"Normal" siblings earned a median of $9,750 more than their "very dull" siblings, whose IQs were less than 80 and had median earnings of $7,500.

Mr. Murray also wondered what would happen to siblings if the very best social advantages were introduced. He applied his question to a "utopian" sample of siblings — ones who spent 14 years in an intact family with median earnings of $50,000 a year.

Mr. Murray found that the "utopian" siblings' earnings remained stratified by IQ and were only slightly higher than their counterparts in the general study.

The one exception was the "very dull" siblings — those who grew up in ideal settings earned 47 percent more than those who did not.

Some at the American Enterprise Institute briefing yesterday took issue with the author's conclusions. Panelist Gary Burtless, a Brookings Institution senior fellow, found Mr. Murray "too pessimistic" about the impact social and educational programs make in people's lives.

Decades of research show that IQs can be lifted through education and social programs, and therefore change the way "rewards" are distributed, said Mr. Burtless. Society should not hesitate to continue to give opportunities to the disadvantaged, he and others in the audience argued.

"Without enlightened public policy, some of our brightest kids will never see the light of day," said Claudia Pharis, chief of staff for Rep. Chaka Fattah, Pennsylvania Democrat.

Wheelchair seating gets sight boost

From page B7

By Michael J. Sniffen
ASSOCIATED PRESS

The nation's largest architectural firm agreed to design new stadiums and arenas so spectators in wheelchairs still have a full view when other fans stand up, the Justice Department announced yesterday.

The agreement settles a lawsuit filed by the Justice Department in October 1996 charging that the Ellerbe Becket firm had violated the Americans with Disabilities Act with its designs of Washington's MCI Center as well as arenas in Boston; Buffalo, N.Y.; Cleveland; Philadelphia; and Portland, Ore.

The agreement was approved by the U.S. District Court in Minneapolis on Friday.

The disabilities law requires that stadiums and arenas built after Jan. 26, 1993, provide seating for wheelchair users that allows lines of sight to the floor or field that are comparable to those that other spectators have. When fans stand during exciting parts of a game, wheelchair users often are blocked from seeing the event.

The government said that six Ellerbe Becket arenas, all built after the law took effect, did not provide wheelchair users a line of sight over standing spectators. In addition to MCI Center, the other arenas are the Fleet Center in Boston, the Marine Midland Arena in Buffalo, the Gund Arena in Cleveland, the Corestates Arena in Philadelphia and the Rose Garden in Portland.

The government had sought a fine and an order requiring the company to stop violating the law; it settled for an agreement by the firm to design future sites along guidelines that the government said will meet the law's requirements.

Ellerbe Becket maintained it was complying with the act all along.

"Now people with disabilities will be able to see what they are paying for," said Acting Assistant Attorney General Bill Lann Lee, head of the civil rights division. "Equal opportunity means more than just being able to attend an event; it also means the opportunity to watch it."

Individuals with disabilities and disability advocacy groups have filed lawsuits against several of the same arenas, seeking to force the owners of the arenas to modify the wheelchair seating.

In Washington, the Paralyzed Veterans of America prevailed in a lawsuit against the MCI Center, and several modifications have been made to wheelchair seating there. In Portland, a U.S. District Court ruled that wheelchair locations in the Rose Garden were not required to provide lines of sight over standing spectators. Private lawsuits are still pending in Boston, Philadelphia and Buffalo.

Ellerbe, which is based in Minneapolis, agreed to take into account the likelihood that some spectators will stand for part or all of events such as basketball games and rock concerts and to design wheelchair seating so its occupants can still see when others stand.

The agreement includes detailed measurements for the average heights of standing spectators and the average height of a person in a wheelchair to be used in calculating sight lines for wheelchair users that the Justice Department said would be comparable to those for other spectators.

see **ARENAS,** *page B8*

The Washington Times
TUESDAY, APRIL 28, 1998

Prominent Republicans Who Support Needle Exchange Programs To Fight The Spread of AIDS

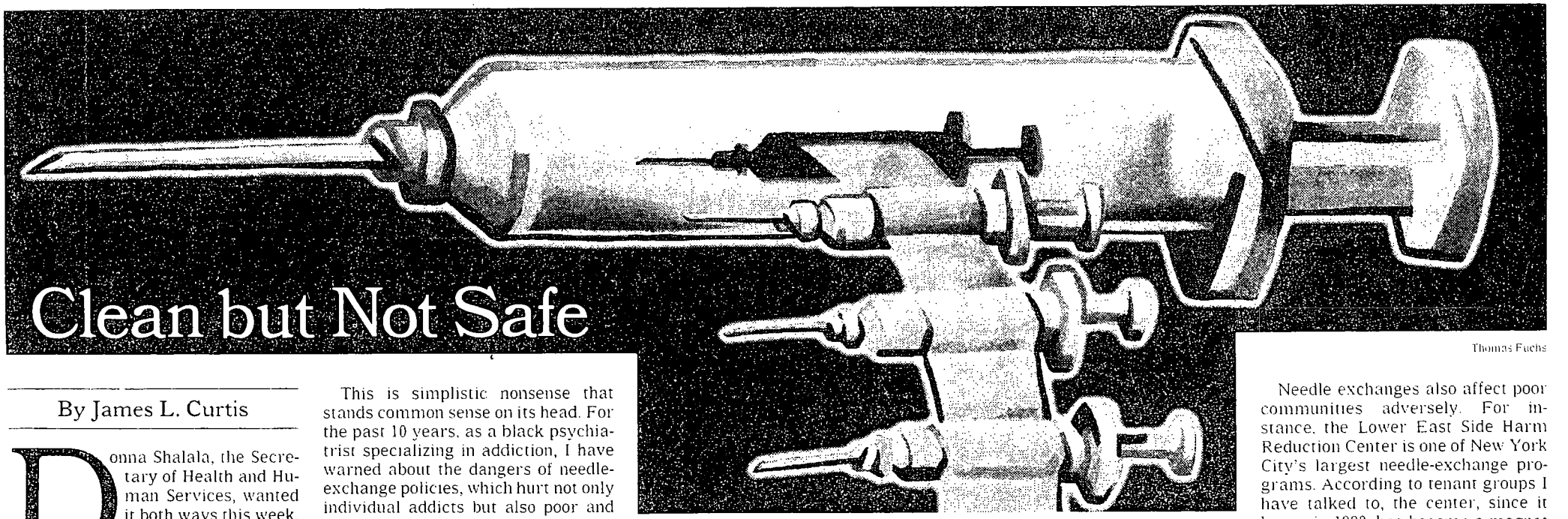
C. Everett Koop Says Needle Exchange Studies Show "Good Results"
C. Everett Koop, former Surgeon General under the Reagan Administration, supporting state regulation of needle exchange: "Every study that's been done has been done chiefly abroad, not in this country, and they all show good results. No increased use of drugs and a reduction in AIDS." While Surgeon General, Koop said if needle exchange "will contain the epidemic, you've got to be for it." [ABC This Week, 8/24/97; Chicago Tribune, 3/6/88]

Representative Ganske Says We Can't "Close the Door" on Needle Exchange
According to U.S. Representative Greg Ganske (R-IA), "we will never win the fight against AIDS unless we stop its spread through shared needles...It would be wrong to close the door on federal involvement in the projects...I urge my colleagues to think of the thousands of children who get AIDS because the parents got HIV from a dirty needle." [The Herald-Sun, 9/14/97]

Representative Morella Says Needle Exchange Reduced HIV Cases in Baltimore
According to *AIDS Policy and Law*: "Representative Constance Morella, R-Md., said Baltimore City's needle-exchange program has been associated with a 40 percent reduction in new HIV cases. Researchers there found no evidence that the swaps led to increased drug use." [AIDS Policy and Law, 10/3/97]

Mayor Riordan Says Needle Exchange Needed to Prevent "Extraordinary Loss of Life"
Los Angeles Mayor Richard Riordan (R) said needle exchange programs are needed to prevent "extraordinary loss of life" to AIDS. He encouraged the police department, the city attorney's office and the police commission "to immediately create and implement proper procedures to avoid needless investigations of needle exchange programs." Government studies "have shown that effective needle exchange programs help reduce HIV transmission," according to Riordan. [San Diego Union-Tribune, 11/20/94; Reuters, 9/7/94]

16 Republican Representatives Voted Not to Ban Needle Exchange
On September 11, 1997, 16 Republican Representatives voted against an amendment offered by Representative J. Dennis Hastert (R-IL) to prohibit federal funding for any needle exchange program. The Hastert Amendment was part of a larger Labor, HHS, Education, and related agencies appropriations bill (HR 2264). Here are the 16 Republicans who voted not to ban needle exchange: Nancy Johnson (R-CT), Chris Shays (R-CT), Jim Kolbe (R-AZ), Tom Campbell (R-CA), William Thomas (R-CA), Steve Horn (R-CA), Bill Young (R-AL), Mark Foley (R-FL), Jim Leach (R-IA), Greg Ganske (R-IA), Jim McCrery (R-LA), John Cooksey (R-LA), Constance Morella (R-MD), Rodney Frelinghuysen (R-NJ), Amory Houghton Jr. (R-NY), and James Greenwood (R-PA). [Congressional Record, 9/11/97]



Clean but Not Safe

Thomas Fuchs

By James L. Curtis

Donna Shalala, the Secretary of Health and Human Services, wanted it both ways this week. She announced that Federal money would not be used for programs that distribute clean needles to addicts. But she offered only a halfhearted defense of that decision, even stating that while the Clinton Administration would not finance such programs, it supported them in theory.

Ms. Shalala should have defended the Administration's decision vigorously. Instead, she chose to placate AIDS activists, who insist that giving free needles to addicts is a cheap and easy way to prevent H.I.V. infection.

James L. Curtis is a professor of psychiatry at Columbia University's medical school and the director of psychiatry at Harlem Hospital.

This is simplistic nonsense that stands common sense on its head. For the past 10 years, as a black psychiatrist specializing in addiction, I have warned about the dangers of needle-exchange policies, which hurt not only individual addicts but also poor and minority communities.

There is no evidence that such programs work. Take a look at the way many of them are conducted in the United States. An addict is enrolled anonymously, without being given an H.I.V. test to determine whether he or she is already infected. The addict is given a coded identification card exempting him or her from arrest for carrying drug paraphernalia. There is no strict accounting of how many needles are given out or returned.

How can such an effort prove it is preventing the spread of H.I.V. if the participants are anonymous and if they aren't tested for the virus before and after entering the program?

Studies in Montreal and Vancouver did systematically test participants in needle-exchange programs. And the studies found that those addicts who took part in such exchanges were two to three times more likely to become infected with H.I.V. than those who did not participate. They also found that almost half the addicts frequently shared needles with others anyway.

This was unwelcome news to the AIDS establishment. For almost two years, the Montreal study was not reported in scientific journals. After the study finally appeared last year in a medical journal, two of the researchers, Julie Bruneau and Martin T. Schechter, said that their results had been misinterpreted. The results, they said, needed to be seen in the context of H.I.V. rates in other inner-city neighborhoods. They even suggested that maybe the number of needles given out in Vancouver should be raised to 10 million from 2 million.

Free needles don't help drug addicts.

Needle-exchange programs are reckless experiments. Clearly there is more than a minimal risk of contracting the virus. And addicts already infected with H.I.V., or infected while in the program, are not given antiretroviral medications, which we know combats the virus in its earliest stages.

Needle exchanges also affect poor communities adversely. For instance, the Lower East Side Harm Reduction Center is one of New York City's largest needle-exchange programs. According to tenant groups I have talked to, the center, since it began in 1992, has become a magnet not only for addicts but for dealers as well. Used needles, syringes and crack vials litter the sidewalk. Tenants who live next door to the center complain that the police don't arrest addicts who hang out near it, even though they are openly buying drugs and injecting them.

The indisputable fact is that needle exchanges merely help addicts continue to use drugs. It's not unlike giving an alcoholic a clean Scotch tumbler to prevent meningitis. Drug addicts suffer from a serious disease requiring comprehensive treatment, sometimes under compulsion. Ultimately, that's the best way to reduce H.I.V. infection among this group. What addicts don't need is the lure of free needles. □

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Monday, April 20, 1998

Contact: HHS Press Office
(202) 690-6343

RESEARCH SHOWS NEEDLE EXCHANGE PROGRAMS REDUCE HIV INFECTIONS WITHOUT INCREASING DRUG USE

HHS Secretary Donna E. Shalala announced today that based on the findings of extensive scientific research, she has determined that needle exchange programs can be an effective part of a comprehensive strategy to reduce the incidence of HIV transmission and do not encourage the use of illegal drugs.

Under the terms of Public Law 105-78, the Secretary of HHS is authorized to determine that such programs reduce the transmission of the human immunodeficiency virus (HIV) and do not encourage the use of illegal drugs. The act's restriction on federal funding, however, has not been lifted.

"This nation is fighting two deadly epidemics -- AIDS and drug abuse. They are robbing us of far too many of our citizens and weakening our future," said Secretary Shalala. "A meticulous scientific review has now proven that needle exchange programs can reduce the transmission of HIV and save lives without losing ground in the battle against illegal drugs. It offers communities that decide to pursue needle exchange programs yet another weapon in their fight against AIDS."

While the use of federal funds continues to be restricted, and criteria for their use have not been established, Secretary Shalala emphasized that needle exchange programs that have been successful have had the strong support of their communities, including appropriate state and local public health officials. The science reveals that successful needle exchange programs refer participants to drug counseling and treatment as well as necessary medical services, and make needles available on a replacement basis only.

The Administration has decided that the best course at this time is to have local communities which choose to implement their own programs use their own dollars to fund needle exchange programs, and to communicate what has been learned from the science so that communities can construct the most successful programs possible to reduce the transmission of HIV, while not encouraging illegal drug use.

Since the AIDS epidemic began in 1981, injection drug use has played an increasing role in the spread of HIV and AIDS, accounting for more than 60 percent of AIDS cases in certain areas in 1995. To date, nearly 40 percent of the 652,000 cases of AIDS reported in the U.S. have been linked to injection drug use. More than 70 percent

- More -

of HIV infections among women of childbearing age are related either directly or indirectly to injection drug use. And more than 75 pecnet of babies diagnosed with HIV/AIDS were infected as a direct or indirect result of injection drug use by a parent.

Communities' use of needle exchange programs has increased throughout the epidemic. According to data reported to the Centers for Disease Control and Prevention, communities in 28 states and one U.S. territory currently operate needle exchange programs, supported by state, local, or private funds. Many of these programs provide a direct linkage to drug treatment and counseling as well as needed medical services.

Since 1989, the use of federal funds for needle exchange programs has been restricted by the Congress. Funding has, however, been authorized by the Congress to conduct research into the efficacy of such programs as a public health intervention to reduce transmission of HIV and to examine the impact of such programs on drug use. The federal government has supported numerous studies of the effectiveness of needle exchange programs in reducing the transmission of HIV among injection drug users, their spouses or sexual partners, and their children. Many of these studies also examined whether or not needle exchange programs encourage the use of illegal drugs.

In February 1997, Secretary Shalala reported to Congress that a review of scientific studies indicated that needle exchange programs "can be an effective component of a comprehensive strategy to prevent HIV and other blood borne infectious diseases in communities that choose to include them." She also directed the Department's scientific agencies to continue to review research findings regarding the effect of needle exchange programs on illegal drug use. The scientific evidence indicates that needle exchange programs do not encourage illegal drug use and can, in fact, be part of a comprehensive public health strategy to reduce drug use through effective referrals to drug treatment and counseling.

"An exhaustive review of the science in this area indicates that needle exchange programs can be an effective component of the global effort to end the epidemic of HIV disease," said Harold Varmus, M.D., Director of the National Institutes of Health. NIH has funded much of the research into the effectiveness of needle exchange programs and their impact on drug use. "Recent findings have strengthened the scientific evidence that needle exchange programs do not encourage the use of illegal drugs," Dr. Varmus said. Specifically, he cited:

- In March 1997, the National Institutes of Health published the Consensus Development Statement on Interventions to Prevent HIV Risk Behaviors. That report concluded that needle exchange programs "show a reduction in risk behaviors as high as 80 percent in injecting drug users, with estimates of a 30 percent or greater reduction of HIV." The panel also concluded that the preponderance of evidence shows either a decrease in injection drug use among participants or no changes in their current levels of drug use.

- An October 1997, study of needle exchange programs in Baltimore, Md., indicated that needle exchange programs that are closely linked to or integrated with drug treatment programs have high levels of retention in drug treatment. A 1998 NIH Consensus Conference report on the effectiveness of treatment for heroin addiction found that drug treatment programs can assist heroin users in halting their drug use.

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Note: HHS press releases are available on the World Wide Web at: http://www.hhs.gov.

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

April 20, 1998

Contact: HHS Press Office
(202) 690-6343

NEEDLE EXCHANGE PROGRAMS: PART OF A COMPREHENSIVE HIV PREVENTION STRATEGY

Overview: Since 1981, injection drug use has played an increasing role in the spread of HIV and AIDS, accounting for more than 60% of AIDS cases in certain areas in 1995. To date, nearly 40% of the 652,000 cases of AIDS reported in the U.S. have been linked to injection drug use. More than 70% of HIV infections among women of childbearing age are related either directly or indirectly to injection drug use. And more than 75 percent of babies diagnosed with HIV/AIDS were infected as a direct or indirect result of injection drug use by a parent.

To protect individuals from infection with HIV and other blood-borne infections, several communities have established needle or syringe exchange programs. In communities that choose to use them, needle exchange programs are a form of public health intervention to reduce the transmission of the human immunodeficiency virus (HIV) among drug users, their sex partners, and their children. They provide new, sterile syringes in exchange for used, contaminated syringes. Many needle exchange programs also provide drug users with a referral to drug counseling and treatment, medical services, and provide risk reduction information.

Under the terms of Public Law 105-78, federal funds to support needle exchange programs were conditioned on a determination by the Secretary of Health and Human Services that such programs reduce the transmission of the human immunodeficiency virus (HIV) and do not encourage the use of illegal drugs. The Secretary has made that determination. The Act's restriction on federal funding, however, has not been lifted.

The Administration has decided that the best course at this time is to have local communities which choose to implement their own programs use their own dollars to fund needle exchange programs, and to communicate what has been learned from the science so that communities can construct the most successful programs possible to reduce the transmission of HIV, while not encouraging illegal drug use.

In a February 1997 report to Congress, Health and Human Services Secretary Donna E. Shalala reported that a review of the findings of scientific research indicated that needle exchange programs "can be an effective component of a comprehensive strategy to prevent HIV and other blood borne infectious diseases in communities that choose to include them."

On April 20, 1998, Secretary Shalala announced that a review of research findings indicated that needle exchange programs also "do not encourage the use of illegal drugs."

FEDERAL RESEARCH ON NEEDLE EXCHANGE

While Congress has restricted the use of federal funds for needle exchange programs since 1989, lawmakers have authorized funding for research into the efficacy of needle exchange programs as a public health intervention to reduce the transmission of HIV and to examine the impact of such programs on drug use. The federal government has supported and will continue to support research into the effectiveness of needle exchange programs.

Effect of Needle Exchange Programs on HIV Transmission

Three major expert reviews of the scientific literature on needle exchange programs conclude that such programs can be an effective component of a comprehensive community-based HIV prevention effort. Additionally, needle exchange programs can provide a pathway for linking injection drug users to other important services such as risk reduction counseling, drug treatment, and support services. The reviews include:

- *Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy,* United States General Accounting Office, March 1993, is an extensive review of U.S. and international data looking at the effects of needle exchange programs. It estimated that a needle exchange program in New Haven, Connecticut, had led to a 33% reduction in HIV infection rates among drug users in that city.

- *The Public-Health Impact of Needle Exchange Programs in the United States and Abroad,* prepared by the University of California, San Francisco, September 1993, reported that needle exchange programs served as an important bridge to other health services, particularly drug counseling and treatment. It also found that needle exchange programs reached a group of injecting drug users with long histories of drug use and limited exposure to drug treatment.

- *Preventing HIV Transmission: The Role of Sterile Needles and Bleach,* National Research Council and Institute of Medicine, September 1995, concluded that needle exchange programs have beneficial effects on reducing behaviors such as multi-person reuse of syringes. It estimated a reduction in risk behaviors of 80% and reductions in HIV transmission of 30% or greater.

Based on that scientific evidence, in February 1997, Secretary Shalala reported to Congress that a review of scientific findings indicated that needle exchange programs "can be an effective component of a comprehensive strategy to prevent HIV and other blood borne infectious diseases in communities that choose to include them." She also directed the Department's scientific agencies to continue to review research findings regarding the effect of needle exchange programs on illegal drug use.

Impact of Needle Exchange Programs on Drug Use

Extensive research indicates that needle exchange programs do not encourage illegal drug use and can, in fact, reduce drug use through effective referrals to drug treatment and counseling. Several recent studies strengthen the conclusion that needle exchange programs do not encourage the use of illegal drugs. They include:

- In March, 1997, the National Institutes of Health published the Consensus Development Statement on Interventions to Prevent HIV Risk Behaviors. That report concluded that needle exchange programs "show a reduction in risk behaviors as high as 80% in injecting drug users, with estimates of a 30% or greater reduction of HIV." The panel also concluded that the preponderance of evidence shows either a decrease in injection drug use among participants or no changes in their current levels of drug use.

- An October 1997, study of needle exchange programs in Baltimore, Maryland, (Brooner et al., Abstract presented to the American Public Health Association, October 1997) reported that needle exchange programs that are closely linked to or integrated with drug treatment programs actually reduce the incidence of drug use with high levels of retention in drug treatment. A 1998 NIH Consensus Conference report on the effectiveness of treatment for heroin addiction found that drug treatment programs can assist heroin users in halting their drug use.

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ARAPAHOE COUNTY SHERIFF'S OFFICE

5686 S. Court Place
Littleton, Colorado 80120-1200

FAX TRANSMITTAL SHEET

To: JOSE CERDA Date: April 20, 1998

OFFICE OF DOMESTIC POLICY Time: 8:50 a.m.

From: PATRICK J. SULLIVAN, JR. SHERIFF

FROM:	FAX (303)		Phone (303)
XX	734-5144	Sheriff's Administration.....	734-5102

Total number of pages 3, including this page.

Remarks:

ARAPAHOE COUNTY SHERIFF'S OFFICE

5686 S. Court Pl. • Littleton, Colorado 80120-1200

PATRICK J. SULLIVAN JR., SHERIFF (303) 795-4711

PLEASE DELIVER THE FOLLOWING PAGES TO:
NAME: News Editors/News Directors
FROM: Sheriff Patrick J. Sullivan, Jr.
DATE: April 17, 1998
TIME: 3:15 p.m.
Total number of pages 1, including this page.

IF YOU DO NOT RECEIVE ALL PAGES, PLEASE CALL BACK AS SOON AS POSSIBLE. PHONE (303) 795-4702

M E D I A R E L E A S E

NSA OPPOSES FEDERAL TAX DOLLARS FOR NEEDLE EXCHANGE

THE NATIONAL SHERIFFS' ASSOCIATION (NSA), THE NATIONAL ASSOCIATION OF THE 3,096 LOCALLY ELECTED COUNTY SHERIFFS, IS DEEPLY CONCERNED ABOUT RECENT PROPOSALS TO USE FEDERAL FUNDS TO DISTRIBUTE CLEAN NEEDLES TO DRUG ABUSERS. **"THE NATIONAL SHERIFFS' ASSOCIATION ADAMANTLY OPPOSES THE USE OF TAXPAYER FUNDS FOR ANY NEEDLE EXCHANGE PROGRAMS FOR DRUG ADDICTS,"** STATED SHERIFF PAT J. SULLIVAN, JR., ARAPAHOE COUNTY, COLORADO; CHAIRMAN, CONGRESSIONAL AFFAIRS COMMITTEE, NSA.

FEDERAL AUTHORITIES SHOULD NOT CONDONE DRUG ABUSE. IT IS A CRIMINAL ACTIVITY. SUPPLYING DRUG ABUSERS WITH CLEAN NEEDLES UNDER THE GUISE OF PREVENTING INFECTIOUS DISEASE IS LUDICROUS. DRUG ABUSE IS A DISEASE AND ADDICTS REQUIRE PROPER TREATMENT, NOT THE ABILITY TO SUSTAIN THEIR ADDICTION THROUGH NEEDLE EXCHANGE. UNDER A FEDERALLY-FUNDED AND APPROVED NEEDLE EXCHANGE PROGRAM, THE GOVERNMENT WOULD SEND THE MESSAGE TO THOUSANDS OF ABUSERS THAT USING DRUGS IS OKAY AS LONG AS YOU HAVE A CLEAN NEEDLE. **"THIS IS CONTRARY TO THE OVERALL DRUG CONTROL STRATEGY AND IS COUNTER TO STATE AND LOCAL EFFORTS TO REDUCE DRUG ABUSE AND DRUG ADDICTION. IN OUR VIEW, THE PROPER FEDERAL ROLE IS PREVENTION AND TREATMENT, NOT DISTRIBUTION OF HYPODERMIC NEEDLES FOR THE INJECTION OF ILLEGAL DRUGS,"** SAID SHERIFF PAT J. SULLIVAN, JR.

FOR ADDITIONAL INFORMATION, CONTACT SHERIFF PAT J. SULLIVAN, JR., 303-734-5101 OR DEAN KEUTER, DIRECTOR OF CONGRESSIONAL AFFAIRS, NSA, 1-800-424-7827.

** END **

FROM :

ARAPAHOE COUNTY SHERIFF'S OFFICE
5686 S. Court Pl. • Littleton, Colorado 80120-1200
PATRICK J. SULLIVAN JR., SHERIFF (303) 795-4711

April 17, 1998

The Honorable William J. Clinton
President of the United States
White House
1600 Pennsylvania Avenue
Washington, D.C. 20502

Dear President Clinton:

I am writing today because the National Sheriffs' Association (NSA) is deeply concerned about recent proposals to use federal funds to distribute clean needles to drug abusers. The National Sheriffs' Association adamantly opposes the use of taxpayer funds for any needle exchange programs for drug addicts.

Federal authorities should not condone drug abuse. It is a criminal activity. Supplying drug abusers with clean needles under the guise of preventing infectious disease is ludicrous. Drug abuse is a disease and addicts require proper treatment, not the ability to sustain their addiction through needle exchange. Under a federally-funded and approved needle exchange program, the government would send the message to thousands of abusers that using drugs is okay as long as you have a clean needle. This is contrary to the overall drug control strategy and is counter to the efforts of the War on Drugs. In our view, the proper federal role is prevention and treatment, not distribution of hypodermic needles for the injection of illegal drugs.

We look forward to working with you to resolve this issue and commend you for your efforts to reduce drug abuse in America.

Sincerely,

Patrick J. Sullivan, Jr.
Sheriff

Chairman, Congressional Affairs Committee, NSA

The Washington Post

DATE: 4-21-98
PAGE: A-1

Clinton Supports Needle Exchanges But Not Funding

By Amy Goldstein
Washington Post Staff Writer

The Clinton administration declared yesterday that needle exchange programs can help curb the AIDS epidemic without fostering the use of illegal drugs, but refused to allow federal money to be spent on the controversial approach.

The continued ban on federal funds stunned leading AIDS researchers and many activists, who had long believed that government money would begin flowing as soon as the administration determined there is enough scientific evidence to show that needle exchange programs work.

But by divorcing the science from the matter of subsidies, the administration found a way to surmount lingering disagreements among President Clinton's top advisers over one of the most contentious public health questions they have confronted.

Needle exchanges have become a lightning rod in the debate over how the nation will combat the AIDS epidemic, now that it is well into its second decade. The programs, which have sprung up in more than 100 cities across the country, including Washington and Baltimore, attempt to slow the spread of HIV by giving clean syringes to intravenous drug users, thus lessening the sharing of needles that contain residue of tainted blood.

Advocates of the programs say such a strategy is increasingly important as the epidemic has veered more heavily into populations of drug users and their sex partners and children. Such drug-related cases account for nearly one-third of the more than 600,000 AIDS cases reported in the United States since the epidemic began. The proportion is substantially higher among people who have been infected in recent years and particularly in the nation's large cities.

But the strategy also has a large army of critics, including many conservatives and President Clinton's drug policy chief, Barry McCaffrey, who contend that it tacitly condones the use of illegal drugs since it puts the government in the business of handing out free needles.

Administration sources said yesterday that Secretary of Health and Human Services Donna E. Shalala preferred to begin allowing certain needle exchange programs to qualify for federal aid, even though such a decision would have touched off a fight with Congress that even some Democratic leaders had warned would be foolhardy. "She knew this would be tough, but she was willing to defend it on the Hill," said one administration official close to the discussions.

But Sunday night, while flying back to Washington from a South American trip, Clinton decided in favor of a second alternative Shalala had proposed: leaving the ban in place while announcing that needle exchanges were scientifically sound. His decision ended an agonizing debate among his senior aides.

Yesterday, Shalala said that, even without the subsidies, the administration's decision that needle exchanges have scientific merit will galvanize syringe programs at the state and local level by sending a signal that the federal government endorses the efforts. "This is another life-saving intervention, which requires a careful local design," she said at a news briefing, surrounding the director of the National Institutes of Health, the acting director of the Centers for Disease Control and Prevention, the surgeon general, and other top federal health officials.

In the Washington area, the District and Baltimore operate needle exchange programs with local funds. The Maryland General Assembly this year decided to allow a similar program to begin in Prince George's County, but defeated a measure that would have allowed exchanges statewide. There are no needle exchanges in Virginia.

Shalala's announcement, in effect, answered the second of a pair of questions Congress posed several years ago. Congress said that federal money could be spent on needle exchanges only if research conclusively established that they met two criteria.

Last year, Shalala told Congress the administration was satisfied that the programs met one of those criteria—determining that the programs do indeed diminish the spread of HIV. Until yesterday, the administration had said it remained uncertain on the question of whether exchanges inadvertently contribute to increased drug use, despite six major reviews of the research literature, including one by NIH last year, that found they do not.

Shalala's announcement was derided immediately by major AIDS organizations. "It is like saying, 'We acknowledge the world is not flat, but we are not going to give Columbus the money for the ships,'" said Daniel Zingale, executive director of AIDS Action.

"It's helpful to get the scientific obstacles out of the way once and for all," said Peter Lurie, a University of Michigan AIDS researcher, "but absent the federal funding, it's unlikely the programs will expand to meet the tremendous need."

But the political dangers of expressing support for the programs, much less allowing federal money to be used for them, were quickly evident. Determining that the programs work "is an intolerable message that it's time to accept drug use as a way of life," said Sen. John D. Ashcroft (Mo.), one of several congressional Republicans who denounced the administration's decision. Sen. Paul Coverdell (R-Ga.), introduced a bill yesterday that would prevent the HHS secretary from ever lifting the ban.

Staff Writer John F. Harris contributed to this report.

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USA TODAY

DATE: 4-21-98

PAGE: 1

Jury: Abortion foes guilty of conspiracy

By Carrie Hedges
USA TODAY

A jury in Chicago put anti-abortion groups in the same category as mobsters Monday, ruling they violated federal racketeering laws by conspiring to close abortion clinics through violence nationwide.

The ruling, which critics say could endanger free speech, may cost the movement millions of dollars.

"We knew there was a conspiracy of violence against us, but finally a jury believed us," said Susan Hill, president of the National Women's Health Organization, which represents 900 clinics.

She predicted hundreds of clinics will file for damages as a result of the ruling. A lawyer for an Alabama clinic, hit by a deadly bombing in January, said within hours of the verdict that the clinic would try to collect under the ruling.

The lawsuit, filed by the National Organization for Women, was the first nationwide class action suit to use the Racketeer Influenced and Corrupt Organizations Law, or RICO, against the anti-abortion movement.

That law, passed in 1970, has been used primarily as a weapon against organized crime. But jurors in this case found that anti-abortion activists Joseph Scheidler, Timothy Murphy and Andrew Scholberg engaged in 21 acts of extortion, including threats of physical violence, to shut down clinics.

They ruled that Operation Rescue and the Pro-Life Action League played a role.

The defendants were ordered to pay $85,962 in damages, which will be tripled under RICO. It will go to clinics in Milwaukee and Wilmington, Del., to cover the costs of increased security after they became targets of violence.

"They want to bankrupt us," said Scheidler, head of the Pro-Life Action League.

Critics warned that the verdict could affect other groups like environmentalists, labor unions and civil rights activists.

"The decision in this case effectively equates freedom of speech with racketeering," said Cardinal Francis George of the Chicago Archdiocese.

Defense lawyers said the verdict will be appealed.

The plaintiffs convinced the jury that extortion can include taking someone's constitutional rights through threats and intimidation, Hill said.

But G. Robert Blakey, a Notre Dame University law professor who drafted the anti-racketeering law, said the verdict abused the law's intent and was never supposed to apply to demonstrators.

"This is intended to scare the hell out of all demonstrators," he said.

NOW filed the suit in 1986 because the abortion groups went beyond picketing, spokeswoman Karen Johnson said.

The New York Times

DATE: 4-21-98

PAGE: A-1

PRESIDENT DECIDES AGAINST FINANCING NEEDLE PROGRAMS

BITTER INTERNAL DEBATE

Ban Stays, Even as Scientists Cite Chance to Stem Spread of AIDS Among Addicts

By SHERYL GAY STOLBERG

WASHINGTON, April 20 — After a bitter internal debate, the Clinton Administration today declined to lift a nine-year-old ban on Federal financing for programs to distribute clean needles to drug addicts, even as the Government's top scientists certified that such programs did not encourage drug abuse and could save lives by reducing the spread of AIDS.

The decision, announced by Donna E. Shalala, the Secretary of Health and Human Services, was immediately denounced by public health experts and advocates for people with AIDS, who had been told in recent days that the ban was about to be lifted.

The announcement has no practical effect; it simply means that state and local governments, which receive block grants from Washington for AIDS prevention efforts, remain barred from using that money for needle exchange. But the decision is of huge significance to advocates for people with AIDS, who have viewed it as a test of the Administration's commitment to reducing the spread of the disease.

"At best this is hypocrisy," said Dr. R. Scott Hitt, chairman of the President's Advisory Council on H.I.V. and AIDS, which last month issued a vote of "no confidence" in the Administration. "At worst, it's a lie. And no matter what, it's immoral."

Many Administration officials strongly supported lifting the ban and were disappointed with the final decision. But the position taken by Gen. Barry R. McCaffrey, the Administration's director of national drug policy, was that lifting the ban would send the wrong message to the nation's children. One official called that issue "an important consideration" for Mr. Clinton.

The announcement came after a week of negotiations between Dr. Shalala's staff and the White House, according to three Administration officials familiar with the talks. Dr. Shalala had been pressing to rescind the ban, with some restrictions, and was prepared to defend that decision on Capitol Hill, knowing it was bound to be controversial.

But his advisers feared a political disaster for Mr. Clinton and worried that Republicans might push through legislation stripping Federal money from groupsthat provide free needles, even though the money was used for other purposes.

"Any Republican could have offered a resolution and we almost certainly would have lost," said one of the officials, all of whom spoke on the condition of anonymity. "We don't have the votes for this in an election year."

To further complicate matters, General McCaffrey had been in an open debate on the issue with Sandra L. Thurman, the White House director of national AIDS policy, who had argued strenuously that the ban should be lifted. Ms. Thurman made no public comment about the decision today.

The ban dates to 1989, when Congress declared that no Federal money could be spent to support clean-needle programs until the Government could provide scientific evidence that such programs both reduced the spread of H.I.V., the virus that causes AIDS, and did not encourage drug use. The two prong test was difficult to meet.

In February, the Administration certified that needle exchange reduced the spread of AIDS, but it took until today for officials to provide evidence that the programs did not promote drug use. With that evidence in hand, the Administration was free to begin drafting guidelines

In a bitter debate, political concerns prevail.

for how Federal money might be spent for needle-exchange programs. Although Dr. Shalala's staff had come up with such guidelines, the President declined to endorse them, officials said.

Over the last decade, needle exchange programs have cropped up across the country; today there are about 100 in more than 20 states. Many operate on a shoestring budget, with private or local money.

In many states, needle exchange remains illegal, but law-enforcement officers look the other way and allow the programs to continue. Public health experts had been hoping a release of Federal money would have legitimized these programs. (In New York, officials can grant permission for certain needle exchange programs to operate.)

"There are states that for years have hidden behind Federal opposition to needle exchange to justify their own inaction," said Dr. Peter Lurie, who in 1993, while teaching at the University of California at San Francisco, published the first Government-financed survey of the effectiveness of needle exchange programs.

Federal officials have estimated that each day, 33 people are infected with the AIDS virus as a result of intravenous drug use, a figure that includes drug abusers, their partners and their children.

Intravenous drug use is also responsible for most of the growth in the spread of AIDS, particularly among the poor and minorities. Dr. David Satcher, the Surgeon General, said today that 40 percent of new AIDS infections in the United States are either directly or indirectly attributed to infection with contaminated needles; among women and children, the figure is 75 percent.

Dr. Lurie, who works as a research associate at Public Citizen, a Washington advocacy group specializing in public health issues, estimated today that had the Government paid for needle exchange programs, 17,000 lives could have been saved in Mr. Clinton's terms in office.

"It is frustrating in the extreme," he said, "to see political considerations take precedence over public health ones, particularly when a huge cost in human life is predictable."

The decision clearly made the Government's top scientists uncomfortable. At the news conference announcing it, Dr. Shalala was flanked by many of them, including Dr. Satcher and Dr. Harold Varmus, director of the National Institutes of Health.

Most shifted uncomfortably in their seats as reporters peppered Dr. Shalala with questions about the Administration's decision, although none publicly disagreed with it.

Cont'd

Dr. Shalala declined to discuss the internal debate between her office and the White House, or even her recommendations to the President, but said the Administration hoped that its pronouncement would spur state and local governments to pay for the programs on their own. In defending the decision not to release Federal money, she said studies showed that needle exchange programs worked best when they were carefully designed within local communities.

"We are sending the message that the senior scientists of this Government, in conjunction with a number of scientists around the world," have concluded that these needle exchange programs do reduce H.I.V. transmission and do not encourage drug use, she said.

Dr. Varmus said a review of the scientific literature, provided "increasingly strong evidence" that needle exchange programs can be an effective means of bringing addicts in for treatment.

He cited a Baltimore study of nearly 3,000 addicts, which found that the needle exchange program dramatically reduced the sharing of tainted needles and that half the participants in the program entered treatment.

As expected, today's decision prompted a flurry of announcements from Congress. Senator John Ashcroft, Republican of Missouri, called the Administration's position "an intolerable message that it's time to accept drug use as a way of life."

But Representative Nancy Pelosi, Democrat of California, complained that the Administration had missed an opportunity to save lives. "It defies logic," she said, "to determine a program's efficacy and then not fund the program, especially in the middle of an epidemic."

The Washington Times

DATE: 4/21/98

PAGE: A1

Free needles OK, but no funds

White House lays costs on localities

By Paul Bedard
THE WASHINGTON TIMES

The Clinton administration yesterday endorsed providing free needles to drug abusers to fight the spread of AIDS but stopped short of funding the programs, bowing to opposition from the president's drug-policy office and Republican critics.

The middle-ground decision by the Department of Health and Human Services infuriated AIDS activists who had expected immediate federal funding and GOP lawmakers who saw it as the first step to eventual federal funding of the programs.

"This has all the markings of a policy that was going to go forward by lifting the federal funding ban and then, 'Whoops, they caught us,' " said a knowledgeable administration official. "This was an 11th-hour reversal."

The Washington Times reported Friday that the administration was expected to meet congressional requirements to lift the funding ban by certifying that free needles do not boost drug use and HIV infections.

Republican lawmakers, saying they were acting to support the president's drug-policy office, vowed to kill the plan by passing legislation to permanently bar federal funding for free needles.

As a result, Donna Shalala, secretary of health and human services, stopped short of calling for federal funding in her statement yesterday.

"A meticulous scientific review has now proven that needle-exchange programs can reduce the transmission of HIV and save lives without losing ground in the battle against illegal drugs," Miss Shalala said in a statement.

But, she added, "the administration has decided that the best course at this time is to have local communities which choose to implement their own programs use their own dollars to fund needle exchange programs."

Miss Shalala said "we had to make a choice. It was a decision. It was a decision to leave it to local communities."

Eighty-eight communities have free needle programs. The goal is to reduce needle sharing by drug addicts. Needle sharing is a major cause of AIDS in women and children.

AIDS activists were disappointed that the ban on federal funding of needle-exchange programs will not be lifted but said they hope to use the Shalala statement to help local communities broaden their programs.

"It's like saying the world is not flat but not funding Columbus' voyage," said Daniel Zingale of the activist group AIDS Action. He said his group would help local communities use the HHS statement to fight opponents to funding needle-exchange programs.

"It's politics rather than public science," added Winnie Stachelberg of the Human Rights Campaign, the nation's largest homosexual lobby. "Local communities have been scraping together programs for the last several years, but it's clear federal funds are needed."

Wayne Turner of the AIDS Coalition to Unleash Power, or ACT-UP, said: "Clinton pulled another 'Slick Willie.' We're outraged. They aren't even doing the little we thought they'd be doing."

Sandra Thurman, director of the president's AIDS office, has been pressuring the president to lift the funding ban. She has argued that scientific reports show free needles to drug addicts do not promote drug use or AIDS.

But two days before the White House was expected to give HHS and the AIDS office the green light to lift the funding ban, the president's Office of National Drug Control Policy provided The Times with a report showing that drug use and cases of infection with HIV, which causes AIDS, jumped in Vancouver, British Columbia, the city with the world's largest free-needle program.

HHS officials would not comment on the drug policy office's study of the Vancouver program, which also reported higher crime where free needles were distributed.

Officials associated with the office said scientific studies do not support Miss Shalala's statement. They cited Dr. Mitchell S. Rosenthal, head of New York's Phoenix House treatment center, who wrote to the office condemning needle exchanges.

"There is no consistent evidence that the availability of needle exchange reduces the transmission of the HIV virus among IV drug users," Dr. Rosenthal wrote to Barry McCaffrey, director of the White House drug-policy office. "Nor is there evidence that needle exchange programs are necessary to reduce the spread of HIV through needle exchange."

He and others backed Gen. McCaffrey's efforts to spend tax dollars on drug treatment programs — not free needles so that drug addicts, some infected with HIV, do not share dirty needles.

Administration officials suggested that Miss Shalala's statement was universally endorsed throughout the administration, but Gen. McCaffrey's office continued to fight it and was not consulted by Miss Shalala. For example, Miss Shalala's statement was not provided to the White House drug-policy office.

In an effort to downplay the internal White House struggle, Clinton aides said the opposition to needle-exchange programs was led by GOP leaders, but Republicans said they were simply following Gen. McCaffrey's lead.

Sen. John Ashcroft, Missouri Republican, warned: "The secretary's decision to endorse needles on demand opens the door wide to a subsequent decision to fund needle exchanges with the hard-earned money of American taxpayers."

"Secretary Shalala's decision today to forbid federal funding for drug needle exchange programs comes to me with great relief, however I am distressed at her seemingly continued support for such programs," said Rep. Gerald B.H. Solomon, New York Republican.

The Washington Post

DATE: 4-21-98
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Nichols Refuses Offer Of Leniency for Leads

His Lawyer Assails Tactics of U.S. Judge

From News Services

DENVER, April 20—Terry L. Nichols today rejected an offer of leniency in exchange for information about the Oklahoma City bombing, saying it would jeopardize him if he is tried in Oklahoma.

In a motion filed in U.S. District Court, Nichols said his constitutional right to silence is violated by the federal offer since his comments could help a state prosecution that could lead to the death penalty.

He did say, however, that he would review thousands of pages of government leads that point to another participant in the bombing.

"He could go through these . . . documents to see if any of them provide meaningful information, which, together with his knowledge, would help answer the court's questions," Nichols's attorney Michael Tigar said in the filing.

Last month, U.S. District Judge Richard P. Matsch told Nichols he will sentence him to life in prison unless Nichols helps resolve lingering questions about the April 19, 1995, bombing that killed 168 people and injured hundreds more.

Co-defendant Timothy J. McVeigh was sentenced to death.

Matsch delayed Nichols's sentencing after an unexpected dispute arose over restitution to victims.

In a separate U.S. District Court filing today, Tigar argued that Nichols's assets and future earnings potential make the $14.5 million restitution demand ludicrous.

Tigar called the demand an effort "to impose additional punishment, this time on Mr. Nichols' innocent (and indigent) wife and young children."

A lawyer for Nichols's wife said she had visited a state social services agency to apply for welfare benefits.

Nichols promised that he would never profit from the crime.

"Anybody who thinks I would for a second think of profiting from this or any tragedy, does not know me," he said in a two-page affidavit signed in the prison cell where he is awaiting sentencing.

He said that if he ever sold his story or wrote a book about the bombing, all proceeds would benefit survivors through a trust fund.

Nichols was convicted in a federal trial Dec. 23 of conspiracy and eight counts of involuntary manslaughter, but the jury deadlocked on whether to impose the death penalty, which leaves his sentence to Matsch. The maximum he can receive is life in prison without parole.

NATIONAL DISTRICT ATTORNEYS ASSOCIATION
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Office of the President

March 24, 1998

The Honorable Barry R. McCaffrey
Director, Office of National Drug Control Policy
750 17th Street, NW
Washington, DC 20006

Dear General McCaffrey:

On behalf of the local prosecutors, I want to provide our strong support for your public opposition to efforts to institute and federally fund ill conceived and misguided needle exchange programs. In our collective experience drug abusers do not, and will not, take into consideration public health needs as they are consumed in seeking and using their next "fix." Sharing drugs is a part of the culture of illegal drug use and thoughts of individual or communal health needs is not an active concern within that world.

Moreover, the funds used for supporting such a program dilute the public monies available for prevention, diversion and treatment programs; inculcates a belief that drug use is "OK" since it's publicly funded; and further undermines the national effort to significantly reduce drug abuse by providing support for some of our worst drug abusers.

In 1990 the Board of Directors of the National District Attorneys Association adopted a Resolution "Opposing Needle Exchange Experimentation." I have attached a copy for your consideration.

Your concern and efforts in this area are well taken and I assure you of our utmost support.

Regards,

William L. Murphy
District Attorney, Richmond County (Staten Island), New York
President, National District Attorneys Association

NATIONAL DISTRICT ATTORNEYS ASSOCIATION
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OFFICIAL POLICY POSITION

Opposing Needle Exchange Experimentation

WHEREAS, a number of jurisdictions have or are considering experimentation with needle exchange programs; and

WHEREAS, proponents of needle exchange experimentation argue that permitting addicts to trade dirty for clean needles will reduce the transmission of HIV through shared needles; and

WHEREAS, this argument contains several faulty and unsupported assumptions such as:

- incorrectly assuming that addicts share needles because clean needles are unavailable. America's police and prosecutors have learned through interviews of addicts and seizures from addicts that needle sharing occurs as part of the drug culture even when addicts have unused needles readily available. Addicts often share the drugs contained in a single syringe and view needle sharing as an expression of trust with one another.

- incorrectly assuming that a needle exchange experiment will make needles more available. Insulin needles are commonly available and inexpensive. Several jurisdictions which have experimented with needle exchange have failed to show any benefit from the experiment, few addicts have exchanged needles, and no decrease in the spread of HIV has been established.

• incorrectly assuming that the only harm to be avoided in the transmission of HIV and ignores that drug usage, particularly during pregnancy, causes permanent and even fatal effects on users and infants; and

WHEREAS, needle exchange experiments, to the extent they are successful, encourage addicts to continue illegal drug usage and are inconsistent with providing for education, enforcement, and treatment.

THEREFORE, BE IT RESOLVED, that the NDAA condemns needle exchange experiments as being supported only by faulty and unsupported assumptions which ignore the realities of drug usage.

BE IT FURTHER RESOLVED that NDAA condemns needle exchange experiments as tolerating and even encouraging illegal drug usage.

BE IT FURTHER RESOLVED that NDAA supports drug education, aggressive enforcement and readily available treatment as the most effective combination to eliminate the host of evils caused by the illegal use of drugs.

(Adopted by the NDAA Board of Directors in February, 1990)

MEMORANDUM TO THE PRESIDENT

FROM: Bruce Reed, Assistant to the President for Domestic Policy
Sandra Thurman, National AIDS Policy Coordinator

SUBJECT: U.S. Conference of Mayors Needle Exchange Resolution

This memorandum will provide you a quick overview of the U.S. Conference of Mayors resolution on needle exchange programs, and the politics of this issue in Congress, public health community and AIDS advocacy groups.

USCM Resolution The FY 1997 Appropriations bill maintains the prohibition on federal funding of needle exchange unless the Secretary of HHS determines that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs. Mayor Willie Brown of San Francisco is sponsoring a resolution at the USCM meeting (see attached) calling on Secretary Shalala to exercise her waiver authority and permit state and local public health officials to use federal funds for needle exchange as one component of a comprehensive HIV prevention strategy. The resolution will be considered in Subcommittee on June 21, and put forward to the full membership on June 24. There has been no visible opposition to the resolution to date.

Other mainstream public health and state government groups (National Governor's Association, Association of State and Territorial Health Officers, National Black Caucus of State Legislatures) support removing the federal funding restrictions in favor of state/local flexibility to design HIV prevention strategies that respond to the characteristics of the HIV epidemic in their jurisdiction.

Department of Health and Human Services HHS sent a report to Congress in February 1997 which included the statement that "Overall these studies indicate that needle exchange programs can have an impact on bringing difficult to reach populations into systems of care that offer drug dependency services, mental health, medical and support services. These studies also indicate that needle exchange programs can be an effective component of a comprehensive strategy to prevent HIV and other blood borne infectious diseases in communities that choose to include them." The Department has not acted on the funding restrictions, but is internally moving towards a position that would allow grantees to use federal funds if certain conditions are met. The Department has not yet sent clear signals on its intentions, or the best timing for possible action.

Congress Six Republican members of the House L/HHS Appropriations Subcommittee have indicated their intent to offer an amendment repealing the authority of Secretary Shalala to waive the prohibition on federal funding for needle exchange. The House mark-up is scheduled for the week of July 7. Subcommittee Chair Porter (R-IL) has high regard for NIH's scientific position, but clearly would need tangible support from HHS and the public health community to defeat such an amendment. On the Senate side, Sen. Specter chairs the L/HHS Subcommittee and he has come to generally support needle exchange programs-- Philadelphia has one of the largest. Both he and Sen. Harkin (ranking Member) would be inclined to leave the waiver language as is

and avoid difficult votes on this issue. If HHS were to lift the ban, staff are not sure how the votes would fall.

Community The AIDS advocacy community is pushing vigorously to have the federal ban on needle exchange funding lifted. The community has recognized that a lot of political work needs to be done in Congress prior to removing the funding restrictions, so that a worse outcome is not realized with a flat ban on funding in lieu of the Secretary's waiver authority. They are perfectly willing to do some "heavy lifting"to insure a positive outcome. Now that there's a clear sign that the House Subcommittee will consider an amendment for a flat ban, there is heightened interest in having HHS remove the funding restrictions and aggressively defend the science behind its action on the Hill.

To that end, some groups are trying to place press questions on needle exchange to you in conjunction with the USCM resolution on needle exchange.....

Recommendation:

* Indicate support for local flexibility in these matters (in keeping with the NGA, ASTHO, AMA positions)

* HHS has been meeting with AIDS advocacy groups,scientists, members of Congress, and others to determine the best course of action. Ask the Secretary to report their progress and plans to you ASAP.

* Acknowledge HHS is engaged in an internal discussion around developing strategies that would counter the dominant role intravenous drug use is playing in the transmission of HIV.

* The Federal role must always be in deference to local control.

DRAFT
June 17, 1997 (5:16pm)

TALKING POINTS ON NEEDLE EXCHANGE

Injection drug use plays a major role in continuing the spread of the AIDS epidemic.

- 50% of new infections are from injection drug users, their partners, and children (these are occuring in the 96 largest metropolitan areas)
- 1/3 of all AIDS cases to date are associated with injection drug use
- injection drug use is the leading factor for current spread of the epidemic in the United States, including among women and children

The science supports the efficacy of needle exchange in reducing the transmission of HIV without promoting illegal drug use.

- there have been 3 major reviews (NIH, CDC, NAS) of over 100 programs
- these reviews report overwhelming evidence that needle exchange programs can have a positive impact on curbing the spread of HIV among users, their partners, and children
- found no evidence that needle exchange programs increase drug use by program participants or in the communities in which programs are located
- Yale University study, for example, estimated a 33 percent reduction in new HIV infections in the New Haven, Connecticut program

Local communities and public health officials should be supported if they decide to utilize needle exchange programs in AIDS prevention campaigns.

- needle exchange will be available to--not imposed upon--local communities as part of comprehensive HIV prevention strategies
- mayors and city councils, including those in Boston, San Francisco, New York, Los Angeles and New Haven, have approved needle exchange programs

Needle exchange programs will provide a pathway to medical and drug treatment as well as addiction recovery services.

- they should be closely linked to drug treatment, HIV counseling and testing, and prevention education
- the hope offered by the new AIDS treatments can be used as a powerful incentive to program users to get off and stay off illegal drugs

Needle exchange programs have been endorsed as a component of comprehensive HIV prevention strategies by numerous national organizations, including:

- American Medical Association
- National Association of County and City Health Officials
- American Public Health Association
- American Nurses Association
- Association of State and Territorial Health Officers
- National Alliance of State and Territorial AIDS Directors

Capsule quotation from report by Secretary Shalala to Congress:

"Needle exchange programs can have an impact on bringing difficult to reach populations into systems of care that offer drug dependency services, mental health, medical and support services. These studies also indicate that needle exchange programs can be an effective component of a comprehensive strategy to prevent HIV and other blood-borne infectious diseases in communities that choose to include them."

* Background Note

I believe that the Administration and Congress should follow the science on needle exchange, which supports their use as part of a comprehensive HIV prevention strategy. However, neither Congress nor the Office of National Drug Control Policy are on the program at this point. A premature decision to lift the ban on the use of federal funds for needle exchange could be counterproductive at this point (as happend with the gays in the military and HIV immigration restriction issues). We need to do our homework with Congress and other members of the Administration for this to work.