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Todd A. Summers
01/14/98 01:22:32 PM

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To: Thomas Reilly/OMB/EOP

cc:
Subject: ONDCP Concerns About Needle Exchange

---------- Forwarded by Todd A. Summers/OPD/EOP on 01/14/98 01:22 PM ----------

Sandra Thurman 01/14/98 01:19:22 PM

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To: Todd A. Summers/OPD/EOP

cc:
Subject: ONDCP Concerns About Needle Exchange

---------- Forwarded by Sandra Thurman/OPD/EOP on 01/14/98 01:29 PM ----------

Sandra Thurman 01/14/98 01:06:50 PM

Record Type: Record

To: Jacob J. Lew/OMB/EOP, Joshua Gotbaum/OMB/EOP

cc: Bruce N. Reed/OPD/EOP, Christopher C. Jennings/OPD/EOP
Subject: ONDCP Concerns About Needle Exchange

ONDCP has objected to the proposed language in the FY99 budget relating to needle exchange (see below). The language proposed by OMB is thoroughly consistent with current Administration policy and public health science. ONDCP's assertion that OMB is proposing to "loosen" the criteria is factually incorrect and misleading; in reality, the criteria have remained the same since originally offered on the floor by Senator Hatch (1990). Making the change proposed by ONDCP would constitute a major shift in Administration policy and severely compromise the current authority of the Secretary.

Any change in Administration policy should be resolved by principals.

Janet L. Crist
01/14/98 11:01:23 AM

Record Type: Record

To: Jacob J. Lew/OMB/EOP@EOP, Joshua Gotbaum/OMB/EOP@EOP

cc: Daniel Schecter/ONDCP/EOP@EOP, Thomas Reilly/OMB/EOP@EOP

Subject: needle exchange

per discussion with General McCaffrey this am-- omb's proposed compromise language on needle exhcange is unacceptable. Specifically we object to changes that loosen the criteria for the use of federal funds--i.e. omb's language refers to "not encouraging" drrug use and ONDCP would retain "reducing the use of illegal drugs." We will have a letter to you shortly, and if need be, are prepared to take this to a principal's level discussion for resolution Janet Crist

MOTHERS' VOICES

United to end AIDS©

September 3, 1997

Barry R. McCaffrey
Director
Office of National Drug Control Policy
Executive Office of the President
750 17th Street, N.W.
Washington, DC 20503
Ph: 202-395-6700

165 West 46*th* Street
Suite 701
New York, NY 10036

telephone
212.730.2777
facsimile
212.730.4378
internet
http://www.mvoices.org

Dear General McCaffrey:

We are writing out of deep concern regarding a statement which was released by your office on August 20, 1997, in connection with a poll conducted by the Family Research Council on the issue of needle exchange. We would like to meet with you at your earliest convenience to begin a dialogue on this issue.

As mothers, and other individuals whose lives have been shattered by injection-related AIDS, we believe that the government must take every opportunity to stop the spread of HIV, and that access to clean needles in no way undermines the important goals of drug treatment to address addiction. The statement released by your office implies that easing Federal restrictions on supporting needle exchange programs would divert funds from drug treatment. Additionally, the statement seems to support the findings of the Family Research Council, which has conducted a seriously flawed poll, and released statements that we feel are dangerous and irresponsible (including the suggestion that drug dealers should be decapitated, as an answer to injection-related AIDS).

We applaud the efforts of the Office of Drug Control Policy to address the scourge of addiction in our communities. We appeal to you to support the use of HIV prevention dollars in the most effective ways, to stop the spread of HIV among injecting drug users, their partners and children. Living addicts can and do recover from their addiction. Dead addicts don't. Needle exchange has proven effective in reducing the spread of AIDS, and is sometimes the only way to reach some drug users in order to provide them with services, including drug treatment. Treatment policy and AIDS prevention policy should not be at odds, since the services provided are always complementary. We feel that the statement released by your office contributed to the general public's confusion about needle exchange, at a time when clarity is particularly important.

We would deeply appreciate the opportunity to discuss with you the role of needle exchange and AIDS prevention in the context of drug treatment, and to communicate the heartbreak which AIDS, in its finality, has caused us and our families, even as we struggle to address the issues of addiction. We would also like to include treatment professionals, AIDS prevention strategists, and researchers in the meeting, to provide you with the most updated information about the relationships between AIDS prevention and drug treatment.

We appeal to you, as American mothers, and in the interests of public health, to help us explain to the American public the crucial, proven importance of needle exchange. Every mother who has lost a child to injection-related AIDS, or who struggles with AIDS herself while trying to raise a family, understands that we must redouble our efforts to end addiction, as well as stop the spread of AIDS. We are committed to both goals, and we look forward to working with the Office of National Drug Control Policy in a unified way.

As you may know, there will be a demonstration in Washington on September 17. We would like to meet with you before then, in the hope of making progress on our mutual goals of reducing HIV infections and drug abuse.

We thank you for your attention, and look forward to your response.

C. Kurth

Ann Kurth
Executive Director
Mothers' Voices

for **The National Coalition to Save Lives Now!**

cc. Vice President Al Gore
Erskine Bowles, Chief of Staff to the President
Donna Shalala, Secretary, Health and Human Services
Donald Gips, Chief Domestic Policy Advisor to the Vice President
Toby Donnenfield, Office of the Vice President
Bruce Reed, Assistant to the President for Domestic Policy
Maria Echevestre, Special Assistant to the President, Director, Office of Public Liaison
Chris Jennings, Special Assistant to the President for Health Policy
Sandy Thurman, Director, White House Office of National AIDS Policy
Franklin Raines, Director, Office of Management and Budget
Josh Gotbaum, Executive Associate Director, OMB
William Corr, HHS Chief of Staff
Kevin Thurm, HHS Deputy Secretary
Marsha Martin, Special Assistant to the Secretary, HHS
Eric Goosby, Director of the HHS Office of HIV/AIDS Policy

MOTHERS' VOICES
United to end AIDS©

File Needles

September 5, 1997

Gen. Barry R. McCaffrey
Director
Office of National Drug Control Policy
Executive Office of the President
750 17th Street, N.W.
Washington, DC 20503
Ph: 202-395-6700

Dear General McCaffrey,

It was a pleasure to meet you yesterday in front of the Capitol after your informal address to the Army service members. As I mentioned, I am President of the Board of Directors of Mothers' Voices, a national AIDS prevention and research advocacy organization. We would like to meet with you to discuss the issues of HIV transmission and intravenous drug abuse.

We respect your work and the enthusiasm with which you are pursuing the fight against drugs, but are concerned about your recent statements regarding clean needle exchange programs. We have surveyed the available research, and believe that the scientific evidence shows that needle exchange programs are effective in reducing HIV infection without increasing drug abuse.

I realize that this is a very difficult issue, but as a representative of mothers who are personally affected by AIDS, as well as mothers of healthy children, I encourage you to reexamine your position on sterile needle exchange programs. Most clean needle programs offer addicts access to drug treatment programs and represent the only interaction with the public health system an IV drug abuser may have. Because they have proven effective, and do not increase the incidence of drug abuse, local jurisdictions should have the option of including needle exchange programs in their arsenal of weapons against the spread of AIDS.

I appreciate your interest, and look forward to hearing from you. Our Programs Director, Tony Davis will contact your scheduling secretary early next week to try to schedule a more formal meeting.

Sincerely,

Suzanne Benzer

Suzanne Benzer
President

SB/as/td

cc: Sandy Thurman, Director, White House Office of National AIDS Policy

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Clinton Drug Czar May Irk Allies but Gets T

By ELIZABETH DAERR
Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON — Inside the White House, no one wants to tangle with Drug Czar Barry McCaffrey.

Unlike many of his predecessors, the former four-star general has mastered the White House's Byzantine structure, finding ways to get things done. The latest example was his successful effort to get President Clinton in the 11th hour to kill a proposal for federal funding of needle-exchange programs for intravenous drug users, upsetting advocates of the plan including Health and Human Services Secretary Donna Shalala.

Barry McCaffrey

More battles lie ahead. The hard-charging drug czar has become a valuable political asset for Mr. Clinton as Republicans gear up to counter the president's antitobacco efforts by linking their tobacco proposals to tougher federal actions to combat increasing teenage drug-use. Heading into this fall's elections, Republicans plan to paint the White House, and Democrats, as soft on drugs. "This is an issue ripe for presidential leadership, and it is not getting it," declares Lamar Alexander, a likely GOP presidential candidate in 2000.

Mr. McCaffrey, who has gained credibility even among many Republicans, can help the White House blunt the GOP attack. But he has detractors. Colleagues dread confronting him, complaining he is too aggressive and unyielding. "He's iron-willed. Once he's made up his mind, he doesn't want to hear from anyone else," says District of Columbia Democratic delegate Eleanor Holmes Norton, who along with other Congressional Black Caucus members called for Mr. McCaffrey's resignation after he clashed with them in the needles fight. And critics say he will align with almost anyone, including foes of the administration, if they can help him accomplish his personal goals.

The Family Research Council, a group of social conservatives, led the successful fight against Clinton Surgeon General nominee Henry Foster and continues to battle the White House over a range of issues like late-term abortions. But almost daily, Robert Maginnis, the council's senior adviser on drug issues, talks with Mr. McCaffrey or his office, sharing polling data, strategy and other information.

In fact, after Mr. McCaffrey's big victory on the needle-exchange issue, the council received one of the letters of thanks that he sent out to those who supported him in the bitter dispute. "We scratch his back and, to certain extent, he helps us by keeping apprised of the issues," says Mr. Maginnis, who has known the drug czar for years.

The politically savvy Mr. McCaffrey is fully aware of his value, and aides say it allows him to play hardball. Indeed, Mr. Clinton seems to find his rough and tumble style refreshing. Recently word got back to the president that Mr. McCaffrey had been heavy-handed with colleagues. Mr. Clinton laughed it off, instructing his aides, "Someone has to grab the bull by the horns and get him out of the china closet."

Already, Mr. McCaffrey, who was named drug czar in 1996, has a long list of accomplishments, including increasing the budget for drug-prevention programs and gaining alliances with South American countries to combat the spread of illegal drugs. Now, at the top of his agenda is finding ways to curb the rise in teen drug-use; for instance, a 1997 study found that 20% of the nation's 10th graders smoked marijuana, up from just 9% five years earlier. He also wants to work with prison inmates to cut drug addiction and find an alternative to the ineffective drug-certification process supposed to curtail foreign nations from allowing drug production within their borders.

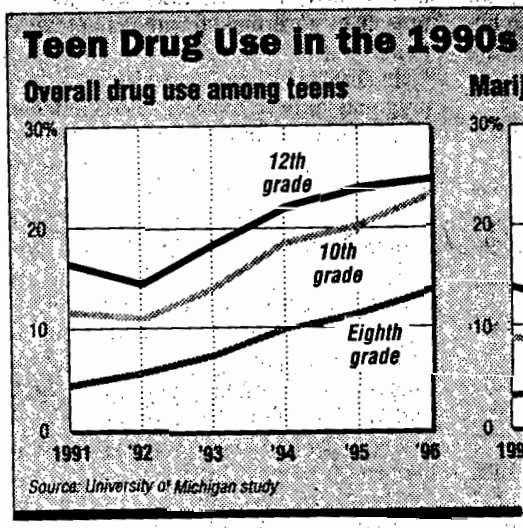
Unlike some past military leaders who worked in the White House, the former general has moved smoothly into his role. Mr. McCaffrey is applying what he learned in 32 years in the military as a commander of infantry forces in Vietnam, an administrator of two U.S. bases and a commanding general during the Persian Gulf War. "The interagency process of budgets, working with Congress and policy were things I have done year in and year out for the last decade," he says.

While Mr. McCaffrey has critics, he also has built a following who appreciate his no-nonsense style. "I can see why people followed him into battle," says Paul Begala, an adviser to the president.

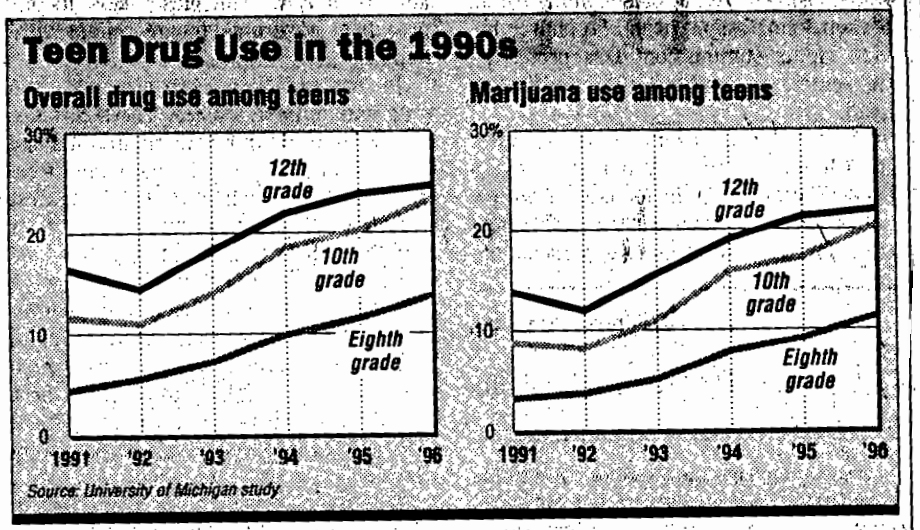
Mr. McCaffrey, 55 years old, is second-generation military and graduated from West Point. He was the youngest and most highly decorated four-star general in the Army. He proposed to his wife, Jill, when they met on a blind date while he was a West Point cadet. Of his three children, two also joined the military. It is a close-knit family, and Mr. McCaffrey's father persuaded him to take the job of drug czar. "If you think you can make a difference, get out and go take this on," his father advised him.

Dealing with political minefields is nothing compared to what Mr. McCaffrey endured in Vietnam; his iron will kept him alive. While commanding a platoon in 1969, he was hit from 15 feet away by machine gunnery that shoots bullets intended to pierce military vehicles. His left arm was hanging by "threads," is the way friends described it. But he wouldn't leave his men; he was evacuated for medical treatment only after passing out. There, doctors wanted to take his arm to save his life. He refused. In the end, it took two years and 17 operations, but he kept his arm.

Sometimes as drug czar, though, Mr. McCaffrey seems to singe his own team while on a mission. In the needle-exchange battle, Mr. McCaffrey reached out to Capitol Hill Republicans, encouraging them to blast the HHS proposal, which aimed to reduce AIDS by helping to provide clean needles to drug users. At the last minute, President Clinton decided to encourage local communities to engage in such programs, but, in a blow to advocates, not to provide federal funds for them. Backers of funding accuse the drug czar of being a



Allies but Gets Things Done



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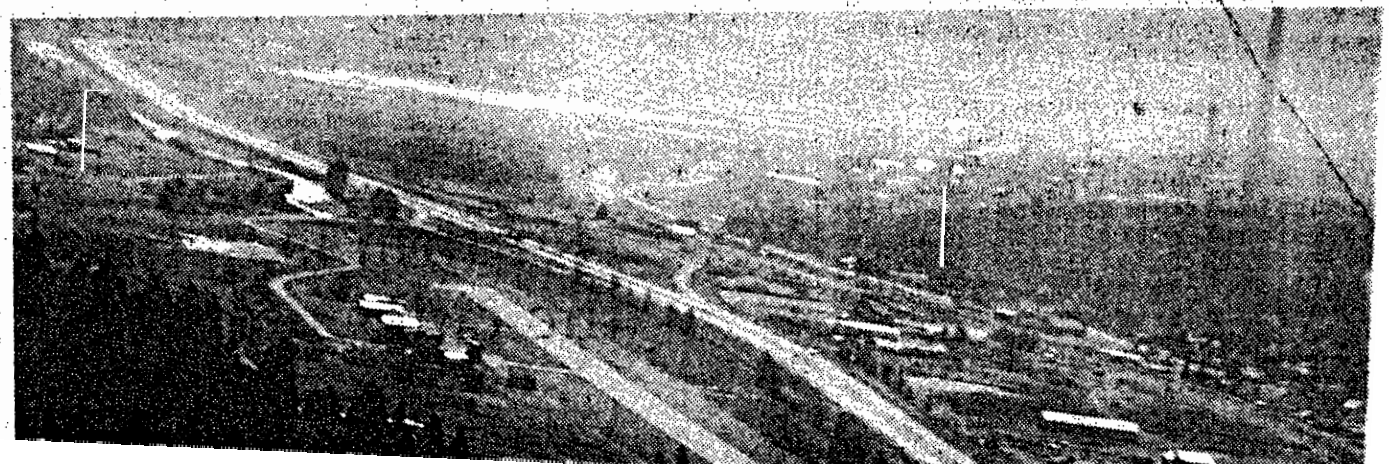
Mr. McCaffrey's staff bristles at any suggestion that he would mislead anyone. "It's unfair and unfounded," says Jim McDonough, the drug czar's director of strategy. Mr. McCaffrey insists he has no political affiliation and that his job is a bipartisan one. "When I go to the Congress, I don't go to Republicans and I don't go to Democrats, I go to see Orrin Hatch and Joseph Biden," he says of the Utah Republican and the Delaware Democrat.

But the drug czar lets it be known he doesn't appreciate others meddling in his issues. One of his frequent lines is, "Stay in your own lane." That is military jargon relating to advancing tanks. They must remain in parallel formations — if they stray out of their lanes, they will shoot each other or hit the wrong target. In McCaffrey's domestic world, it translates to: You do your job, I'll do mine.



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

April 23, 1998

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

Dear Ms. Thurman: Sandy —

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

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

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

Sincerely,

Barry R. McCaffrey
Director

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

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

Why We Said No to ~~Needle~~ Federal Funding of Needle

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

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

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

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

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

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

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

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

Barry R. McCaffrey
Director

THE WHITE HOUSE

WASHINGTON

April 28, 1998

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

Dear Mr. McCaffrey: Barry -

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

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

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

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

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

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

Sincerely yours,

Sandra L. Thurman
Director
Office of National AIDS Policy

The New York Times

Founded in 1851

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The Politics of Needles and AIDS

By Julie Bruneau and Martin T. Schechter

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

As the authors of the Canadian studies, we must point out that these officials have misinterpreted our research. True, we found that addicts who took part in needle exchange programs in Vancouver and Montreal had higher H.I.V. infection rates than addicts who did not. That's not surprising. Because these programs are in inner-city neighborhoods, they serve users who are at greatest risk of infection. Those who didn't accept free needles often didn't need them since they could afford to buy syringes in drugstores. They also were less likely to engage in the riskiest activities.

Canadian findings are distorted.

Also, needle-exchange programs must be tailored to local conditions. For example, in Montreal and Vancouver, cocaine injection is a major source of H.I.V. transmission. Some users inject the drug up to 40 times a day. At that rate, we have calculated that the two cities we studied would each need 10 million clean needles a year to prevent the re-use of syringes. Currently, the Vancouver program exchanges two million syringes annually, and Montreal, half a million.

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

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

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

Personal

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503
February 12, 1998

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

Dear Mr. President:

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

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

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

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

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

Very respectfully,

Barry R. McCaffrey
Director

Needle Exchange

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

- **Drug treatment and outreach are the most effective means to prevent HIV.** We need to improve outreach to addicts and get them into drug treatment and HIV prevention programs.

- **Science, not ideology, should drive drug policy.** ONDCP is aware of the views of many eminent scientists that needle exchange programs can be effective in the short-term in reducing HIV transmission. However, needle exchange programs may pose a risk of increased levels of drug abuse (and therefore HIV) in the longer run. We have questions about the research and want to have a continuing dialogue with Secretary Shalala and Dr. Varmus.

- **ONDCP continues to have serious concerns about whether NEPs would contribute to higher drug use levels in the community.** This concern was raised in an Institute of Medicine report. There are still significant concerns on the part of many communities.

- **Continued drug use is dangerous.** There are real dangers in continued drug use by addicts in terms of crime in the community, the addict's own health and well-being, and potential transmission of the virus through risky sexual behaviors.

- **A mixed message is risky.** A Federal policy that demonstrated acceptance of needles exchanges by paying for them could have an impact on public perception regarding drug use. We do know that youth attitudes (i.e., risk perception, social disapproval) have a strong correlation with drug use.

- **Lifting the ban provides Congress the opportunity to add even more restrictive language to authorizing and appropriations bills, and it could hurt drug treatment funding.**

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

April 10, 1998

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

Dear Ms. Thurman: Sandy

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

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

- **The science is uncertain.** It would be imprudent to take a key policy step on the basis of yet uncertain and insufficient evidence.

- **The public health risks outweigh benefits.** Each day, over 8,000 young people will try an illegal drug for the first time. Heroin use rates are up among youth. While perhaps eight persons contract HIV directly or indirectly from dirty needles, 352 start using heroin each day, and more than 4,000 die each year from heroin/morphine-related causes (the number one drug-related cause of death). Even assuming that needle exchange programs can further accelerate the already declining rate of HIV transmission, the risk that such programs might encourage a higher rate of heroin use clearly outweighs any potential benefit.

- **Treatment should be our priority.** Our fundamental moral obligation is to provide treatment for those addicted to drugs. Needle exchange programs should not be funded instead of treatment.

- **Federal dollars are not required.** State and local governments and the private sector can already fund NEPs.

- **Federal support of NEPs may undercut AIDS research, prevention and treatment.** If federal funds are allocated to NEPs, those who oppose AIDS research, treatment and prevention programs may argue why provide millions of federal dollars for these HIV/AIDS programs when the answer lies in a twenty-cents needle?

- **Federal support of NEPs may undermine other drug-control programs.** The use of taxpayer dollars to support needle exchange programs is a lightning rod issue. The President's *National Drug Control Strategy* is increasingly gaining support and making a difference. An Administration decision to alter course on NEPs and spend federal monies to buy drug paraphernalia could seriously undermine our ability to continue to carry out effective drug policies that enjoy bipartisan support.

- **Supporting NEPs will send the wrong message to our children.** By handing out needles we encourage drug use. Such a message would be inconsistent with the tenor of our national youth-oriented anti-drug campaign.

- **NEPs place disadvantaged neighborhoods at greater risk.** NEPs are normally located in impoverished neighborhoods. These programs attract addicts from surrounding areas and result in a concentration of criminal activity.

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

Sincerely,

James R. McDonough
Director, Strategy

Enlosure
Vancouver Needle Exchange
Trip Report

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

April 6, 1998

INFORMATION
MEMORANDUM FOR THE DIRECTOR

THROUGH: THE DEPUTY DIRECTOR

FROM: STRATEGY (D.B. DES ROCHES)

SUBJECT: Vancouver Needle Exchange Trip Report

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

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

3. **OBSERVATIONS -- FACTS:**

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

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

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

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

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

4. **OBSERVATIONS--STATEMENTS:**

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

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

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

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

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

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

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

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

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

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

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

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

4. **OBSERVATIONS-- REPORTER NOTES:**

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

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

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

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

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

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

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

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

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

meeting on the day of our departure.

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

5. CONCLUSIONS:

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

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

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

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

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

ENCLOSURES:

TAB 1 Trip Schedule
TAB 2 Crime Maps

March 30, 1998

INFORMATION
MEMORANDUM FOR THE DEPUTY DIRECTOR

FROM: **STRATEGY (D.B. DES ROCHES)**

SUBJECT: Vancouver Trip

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

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

3. **SCHEDULE:**

April 2, 1998

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

April 2, 1998

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

1200 Meeting with USCS SAC, POE Blaine, Washington

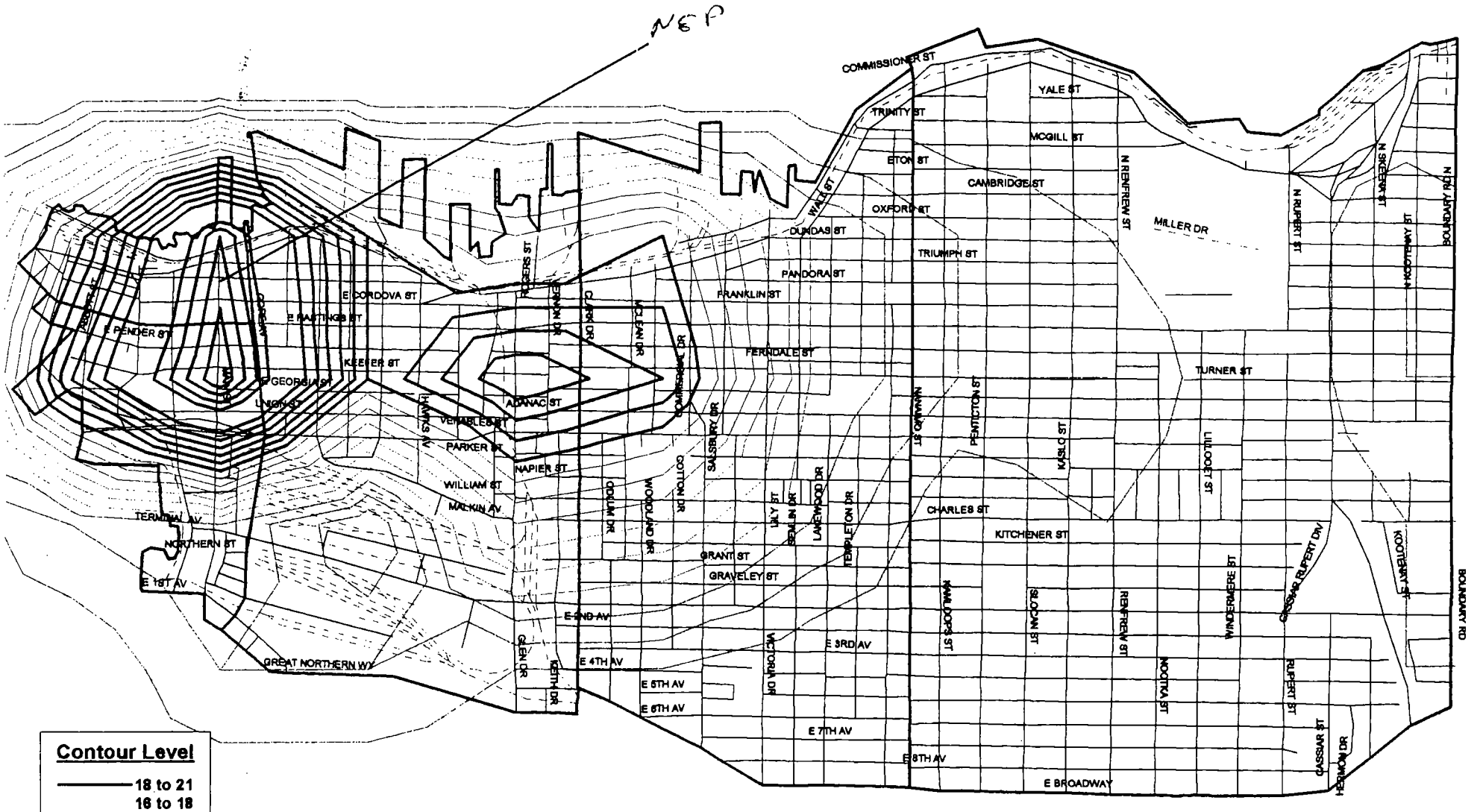
1500 Meeting with BC Provincial Coroner, (604) 660-7739

ENCLOSURES:

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

Patrol District Two
Commercial Break & Enter

Mar15th. To Mar 29th., 1998



Contour Level

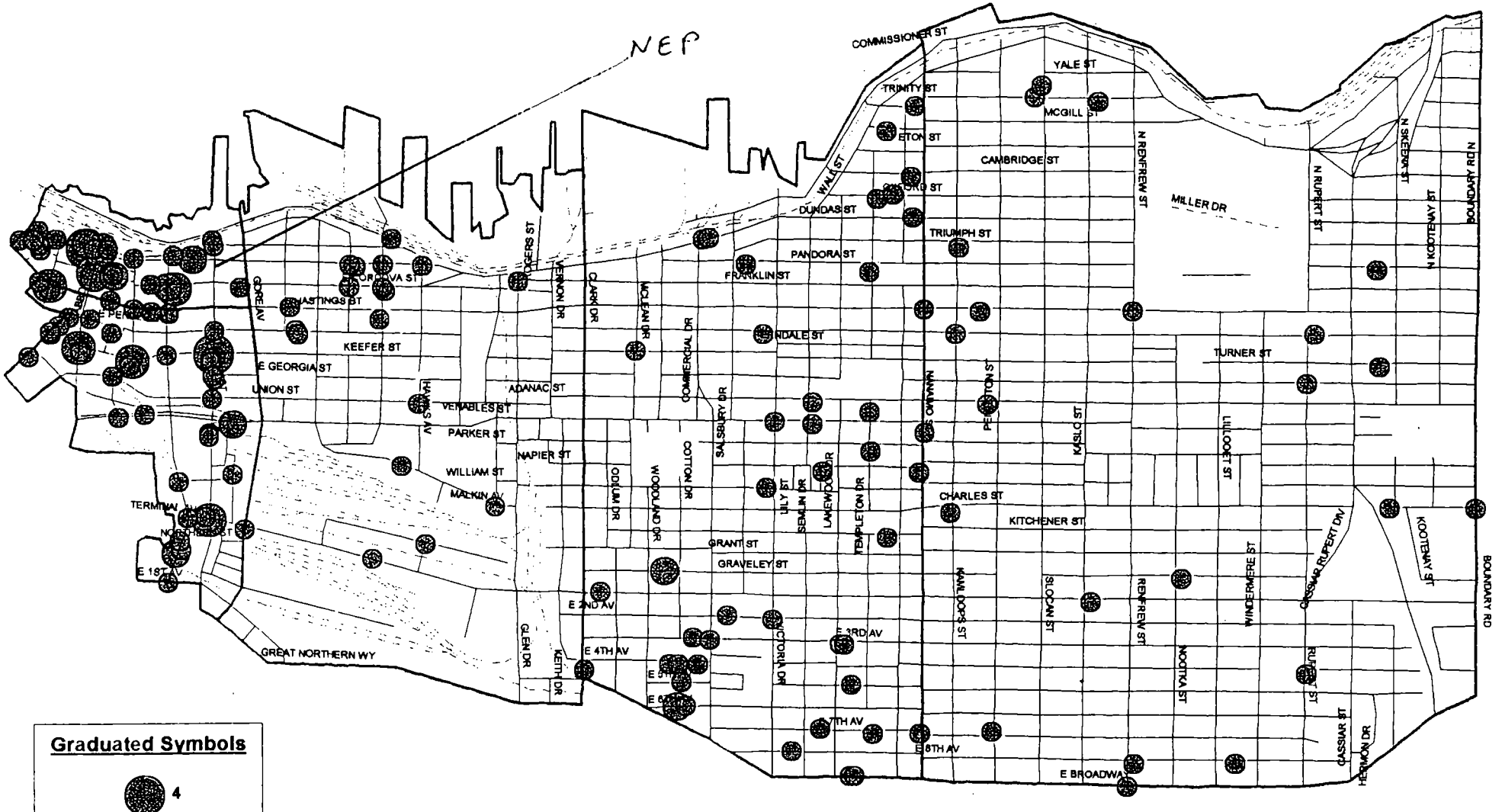
———	18 to 21
	16 to 18
———	13 to 16
———	10 to 13
- - - - -	7 to 10
	4 to 7
· · · · ·	1 to 4

65 Incidents In 45 Separate Locations
62 Incidents In Previous 2-Week Map

Vancouver Police Department
Crime Analysis Unit

Patrol District Two
Theft From Auto

Mar15th. To Mar 29th., 1998



Graduated Symbols

4

2

1

182 Incidents In 153 Separate Locations
219 Incidents In Previous 2-Week Map

Vancouver Police Department
Crime Analysis Unit

January 21, 1998

Health Division

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

Route to: Richard Turman
Barry Clendenin
Kevin Cichetti

Subject: **1998 Drug Control Strategy**

From: Barbara Menard

ACTION:
Decision_____
Signature_____
Comment _____
As requested XXX
Information_____

Phone: 202/395-4929
Fax: 202/395-7840
Room: NEOB #7001
Barbara_A._Menard@oa.eop.gov

Needed By:
Date:_____
Time:_____
Copies to:

HD Chron, HPS Chron

Post this Document on HD Intranet? NO

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

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

- **Statistics**. ONDCP cites specific "use" statistics throughout this document. Although the statistics cited seem to agree with the general use patterns with which we are familiar, we cannot confirm that all of the statistics are accurate and agree with the most recent data. On this confirmation, we defer to HHS and the OPDIVS responsible for gathering and reporting such data.

- **Use of the term "gateway drug."** At several points in the document, alcohol, tobacco and marijuana are referred to as "gateway drugs." We recommend that this phrase be removed, given that it is the official position of the National Institute on Drug Abuse (NIDA) that, although there is a strong *correlation* between the use of alcohol, tobacco & marijuana and the use of other illicit substances, *causality* has not yet been proven. Again, we defer to HHS on this issue.

- **Treatment gap.** ONDCP continues to cite the statistic that the current treatment gap is 3.6 million users. Upon closer examination, however, it becomes clear that this number refers to *all* of the substance abusers in the United States who could possibly benefit from treatment and are not currently receiving it. This calculation does not take into

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

- **Needle Exchange Programs (NEPs).** There is currently much debate within the Administration regarding NEPs and the presentation of the Administration's position on such programs in the FY 1999 Budget. In the 1998 Strategy, however, ONDCP has chosen to take a hard stand against NEPs, and suggest that the Administration not support certification of the use of Federal funds for NEPs in the future. Given that this remains a very contentious issue on which many parties need to be consulted before a policy is presented, **we recommend that the *Strategy* not address the issue of NEPs at all, and we are bracketing all text referring to NEPs in Chapters Two and Four. In an effort to maintain maximum flexibility for the President and the Secretary of Health and Human Services on this issue, all language referring to NEPs currently in the strategy must be removed.**

- **Editing.** In its current form, the Strategy contains many grammatical, structural and spelling errors. It seems as if the draft has not yet received even basic proofreading, including correction of spelling, spacing and grammar mistakes. While OMB staff appreciate the opportunity to review the *Strategy* for content and agreement with the Administration's policies, we do not have the staff or the time to focus on basic editing of the document. Given that the *Strategy* is a Presidential document that garners much public and press attention, [and that editorial errors in last year's document were recently pointed out in the *Washington Post*), we recommend that ONDCP have the document reviewed by a professional editor prior to final publication.

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

Q/A Bergman *continued*

assignment?

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

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

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

WEDNESDAY JULY 2

Reducing Drug Use and Its Consequences in America

Gen. Barry McCaffrey

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

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

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

Heart of the Matter

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

Gen. Barry McCaffrey

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

It is a nightmare. But it has gotten a lot better. Over the last 15 years, drug abuse has declined by 50 percent. America got sick of it in the 1970s. We got organized, as usual, from the bottom up. Some 4000 community coalitions sprung up all over the country to bring together teachers, business leaders, health professionals, and law enforcement officials to address the problem. And it did get better. Cocaine use is down by 75 percent, and casual use of cocaine is down from 6 million Americans to about 1.4 million. These numbers are ambiguous at best, but what's not arguable is that cocaine use has plummeted.

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

Continued on page 12

Commonwealth Club of California
1997 Business Council

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

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Oracle Corporation
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SERENA Software International
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Hellman & Friedman
Hitachi Data Systems
The Industrial Bank of Japan, Ltd.
Levi Strauss & Company
Solectron

McCaffrey *continued*

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

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

Some of us won't make it; we're not going to defeat the enemy in the war on drugs. We have an incredible 6 percent of the population abusing drugs—20 million Americans (down from 25 million). Another 3.6 million are addicted and are causing tremendous damage. What do we do about them? That has been the principal failure of the national drug strategy in the last 20 years.

Testing and Treatment

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

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

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

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

Conceptual Framework

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

1. Motivate American youth to reject illegal drugs, alcohol, and tobacco.

2. Protect Americans from crime associated with drug abuse.

3. Protect Americans from the health and social cost of drug abuse.

4. Provide a sensible defense of our land, air, and sea borders. We're not going

continued on page 13

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

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

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

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

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

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

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

Q & A / BARRY MCCAFFREY

Answers to Questions from the Floor

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

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

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

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

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

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

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

Q. Is the drug trade corrupting our financial system?

A. One of the few bits of magic I've seen in the last 15 months is the Financial Enforcement Center, a Department of Treasury task force outside of Washington, D.C. It uses a giant bank of computers to pull together information from foreign governments, U.S. Bank Secrecy Act reports, and commercial databases to detect suspicious transactions and money laundering. This is giant enterprise. We're talking about $49 billion a year—boxcars of hundred-dollar bills that somehow get into legal business. We've had tremendous successes, such as Project El Dorado in New York City. We're going to go after "cybercash," credit card movement of money. These are sophisticated people. They have access to very advanced legal advice; they have no respect for national sovereignty boundaries. This is an international problem, and it's going to require a cooperative solution. We're well on our way. Our hemisphere partners are passing legislation that allows them to deal with money laundering, illegal enrichment, conspiracy, witness protec-

continued on page 14

THE 66TH ANNUAL COMMONWEALTH CLUB BOOK AWARDS

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

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

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

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

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

Awards Endowment *continued*

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

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

Michael Ondaatje, author of *The English Patient*, was this year's Martha Heasley Cox lecturer at San Jose State University. Other prominent authors in the Cox lecture series, established in 1983, have included Toni Morrison, Paul Theroux, and Maxine Hong Kingston.

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

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

McCaffrey *continued*

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

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

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

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

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

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

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

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

Continued on page 15

McCaffrey *continued*

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

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

Q. What about needle exchange programs?

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

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

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

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

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

THE WHITE HOUSE

WASHINGTON

April 13, 1998

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

RE: Needle Exchange Correspondence Dated April 10, 1998

Dear Mr. McDonough:

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

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

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

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

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

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

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

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

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

Allowing state and local communities the option to use their HIV prevention funds for needle exchange programs in no way undermines our drug-control program.
Hypodermic syringes are not the cause of illegal injection drug use any more than matches are the cause of illegal marijuana use. However, the sharing of hypodermic syringes is directly contributing to the spread of deadly blood-borne diseases in this country. Needle exchange programs quite simply allow for the exchange of used syringes for clean ones, not handing them out on the street corner. Moreover, the scientific studies clearly show that NEPs are reaching hard-core drug users that are otherwise unreachable and offer our best and perhaps only chance of encouraging their acceptance of drug treatment.

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

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

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

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

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

Sincerely,

Sandra L. Thurman
Director
Office of National AIDS Policy

cc: Erskine Bowles
Rahm Emanuel
Bruce Reed

DRAFT

April 13, 1998

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

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The science is clear and convincing.
It is stated that, "the science is uncertain" and "insufficient." I strongly disagree. Nevertheless, I thought we had agreed to let the world renowned scientists at the NIH make these "scientific determinations." Dr. Varmus, the Director of the NIH, recently reconfirmed before Congress that the science was adequate to support a certification by the Secretary that needle exchange programs reduce HIV infection without encouraging illegal drug use. ~~Your office~~ ONDCP continues to cite studies of NEPs done in Montreal and Vancouver as evidence that they don't work. We have ~~challenged you on~~ expressed our concern regarding the manner in which those studies have been cited, and have been subsequently joined (in an op-ed in the *New York Times*) by the authors of those studies. While both show a higher incidence of HIV infection among participants in the NEPs than the general population, it is because these programs specifically target those at highest risk for HIV infection. Even among this population, the Vancouver NEP now shows a reduction in HIV infection. Arguing the adequacy of the science in opposition to virtually every major medical and public health organization and journal weakens the credibility of this Administration.

Public health benefits outweigh the risks.
We know that HIV transmission rates are <u>not</u> declining but rather growing most rapidly among injection drug users, their partners, and their children. While AIDS treatments are becoming more effective, an AIDS diagnosis is still a death sentence in 1998. According to the scientists, NEPs reduce HIV infections without encouraging illegal drug use. Therefore, the public health benefits clearly outweigh any theoretical risks. As for drug prevention, I agree that more needs to be done. This means that an effective HIV prevention strategy with no deleterious effect on

drug use should be an option for those health officials who deem it to be appropriate.

Needle exchange and drug treatment are wholly compatible and mutually supporting.
I agree that "needle exchange programs should not be funded instead of treatment." This has never been under consideration by this Administration. Quite the contrary, we have joined ONDCP in emphasizing the critical importance of increasing drug treatment services. The Congressional funding restriction currently under review by this Administration is for funds currently available to states and localities for HIV prevention, not drug treatment. We will continue to work with your office to support more drug treatment funding.

Federal funding, and the federal imprimatur on the science, are absolutely critical.
State and local governments are demanding the option to use their federal HIV prevention funds for needle exchange programs. Certifying that needle exchange programs are efficacious in reducing the spread of HIV without encouraging illegal drug use ~~(and thereby releasing federal funds)~~ is a critical message~~s~~ to those state and local communities struggling with this issue. They have a right to leadership on this issue, as difficult as it may be. It is our responsibility to provide that leadership.

Congress will not abandon its investment in AIDS care, research, and prevention because needle exchange programs are funded.
We are not aware of any Member of Congress that has even suggested that AIDS funding for care, research, and prevention be reduced or abandoned in order to fund needle exchange programs. Congress understands, as I am sure you do, that needle exchange is an important but single strategy that must be seen as part of a comprehensive plan designed to deal with two complex epidemics.

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

Allowing state and local communities the option to use their HIV prevention funds for needle exchange programs in no way undermines our drug-control program.
Hypodermic syringes are not the cause of illegal injection drug use any more than matches are the cause of illegal marijuana use. However, the sharing of hypodermic syringes is directly contributing to the spread of deadly blood-borne diseases in this country. Needle exchange programs quite simply allow for the exchange of used syringes for clean ones, not handing them out on the street corner. Moreover, the scientific studies clearly show that NEPs are reaching hard-core drug users that are otherwise unreachable and offer our best and perhaps only chance of encouraging their acceptance of drug treatment.

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These communities are already in crisis not because of NEPs, but because of drugs, crime, poverty, violence, and AIDS. In these communities, NEPs are often the only link people have for a way out of the cycle of addiction and crime.

To argue that NEPs "attract addicts from surrounding areas" is an argument for supporting their expansion, not limiting them. An increased number of programs will help serve addicts in their own communities. Only because the programs are scarce--a result of the restriction on federal funding--are drug users forced to travel to different communities to get clean needles. It is certainly also true, as your staff observed in Vancouver, that it is the ready availability of illegal drugs that attracts addicts, not needles.

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

Sincerely,

Sandra L. Thurman
Director
Office of National AIDS Policy

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Director, Strategy
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Washington, DC 20503

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To argue that NEPs "attract addicts from surrounding areas" is an argument for supporting their expansion, not limiting them. ~~An increased number of programs will help serve addicts in their own communities~~. Only because the programs are scarce ~~a result of the restriction on federal funding~~ are drug users forced to travel to different communities to get clean needles. It is certainly also true, as your staff observed in Vancouver, that it is the ready availability of illegal drugs that attracts addicts, not needles.

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Sincerely,

Sandra L. Thurman
Director
Office of National AIDS Policy

Again, NEPs do not relate the need for drug treatment, health care workers, HIV, and AIDS services. But in many cases, they provide an opportunity for a range of successful interventions.

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

April 10, 1998

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

Dear Ms. Thurman: Sandy

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

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

- **The science is uncertain.** It would be imprudent to take a key policy step on the basis of yet uncertain and insufficient evidence.

- **The public health risks outweigh benefits.** Each day, over 8,000 young people will try an illegal drug for the first time. Heroin use rates are up among youth. While perhaps eight persons contract HIV directly or indirectly from dirty needles, 352 start using heroin each day, and more than 4,000 die each year from heroin/morphine-related causes (the number one drug-related cause of death). Even assuming that needle exchange programs can further accelerate the already declining rate of HIV transmission, the risk that such programs might encourage a higher rate of heroin use clearly outweighs any potential benefit.

- **Treatment should be our priority.** Our fundamental moral obligation is to provide treatment for those addicted to drugs. Needle exchange programs should not be funded instead of treatment.

- **Federal dollars are not required.** State and local governments and the private sector can already fund NEPs.

- **Federal support of NEPs may undercut AIDS research, prevention and treatment.** If federal funds are allocated to NEPs, those who oppose AIDS research, treatment and prevention programs may argue why provide millions of federal dollars for these HIV/AIDS programs when the answer lies in a twenty-cents needle?

- **Federal support of NEPs may undermine other drug-control programs.** The use of taxpayer dollars to support needle exchange programs is a lightning rod issue. The President's *National Drug Control Strategy* is increasingly gaining support and making a difference. An Administration decision to alter course on NEPs and spend federal monies to buy drug paraphernalia could seriously undermine our ability to continue to carry out effective drug policies that enjoy bipartisan support.

- **Supporting NEPs will send the wrong message to our children.** By handing out needles we encourage drug use. Such a message would be inconsistent with the tenor of our national youth-oriented anti-drug campaign.

- **NEPs place disadvantaged neighborhoods at greater risk.** NEPs are normally located in impoverished neighborhoods. These programs attract addicts from surrounding areas and result in a concentration of criminal activity.

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

Sincerely,

James R. McDonough
Director, Strategy

Enlosure
Vancouver Needle Exchange
Trip Report

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

April 6, 1998

INFORMATION
MEMORANDUM FOR THE DIRECTOR

THROUGH: THE DEPUTY DIRECTOR

FROM: STRATEGY (D.B. DES ROCHES)

SUBJECT: Vancouver Needle Exchange Trip Report

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

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

3. **OBSERVATIONS -- FACTS:**

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

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

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

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

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

4. **OBSERVATIONS--STATEMENTS:**

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

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

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

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

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

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

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

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

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

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

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

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

4. OBSERVATIONS-- REPORTER NOTES:

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

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

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

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

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

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

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

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

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

meeting on the day of our departure.

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

5. CONCLUSIONS:

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

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

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

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

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

ENCLOSURES:

TAB 1 Trip Schedule
TAB 2 Crime Maps

March 30, 1998

INFORMATION
MEMORANDUM FOR THE DEPUTY DIRECTOR

FROM: **STRATEGY (D.B. DES ROCHES)**

SUBJECT: Vancouver Trip

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

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

3. **SCHEDULE:**

April 2, 1998

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

April 2, 1998

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

1200 Meeting with USCS SAC, POE Blaine, Washington

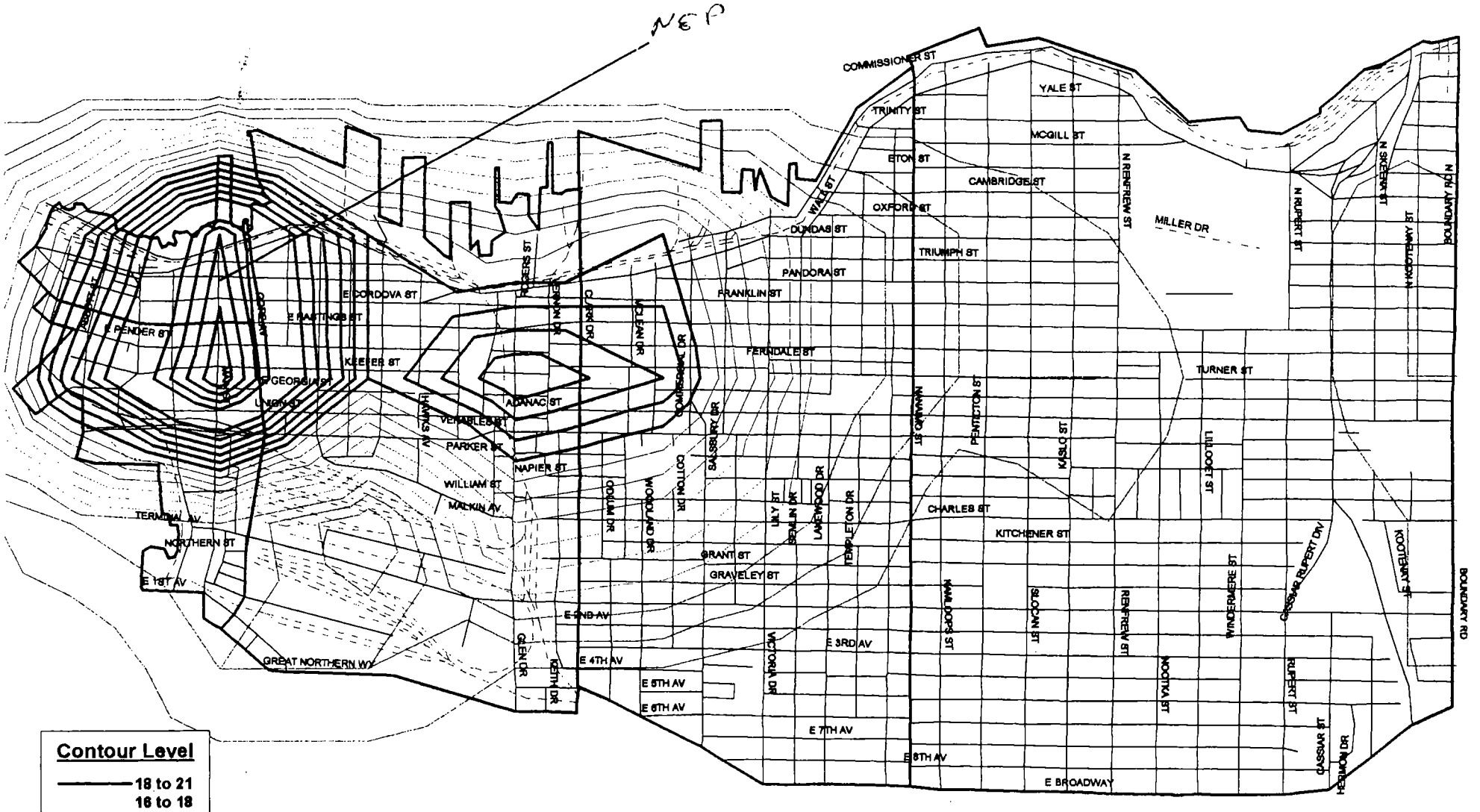
1500 Meeting with BC Provincial Coroner, (604) 660-7739

ENCLOSURES:

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

Patrol District Two
Commercial Break & Enter

Mar15th. To Mar 29th., 1998



Contour Level

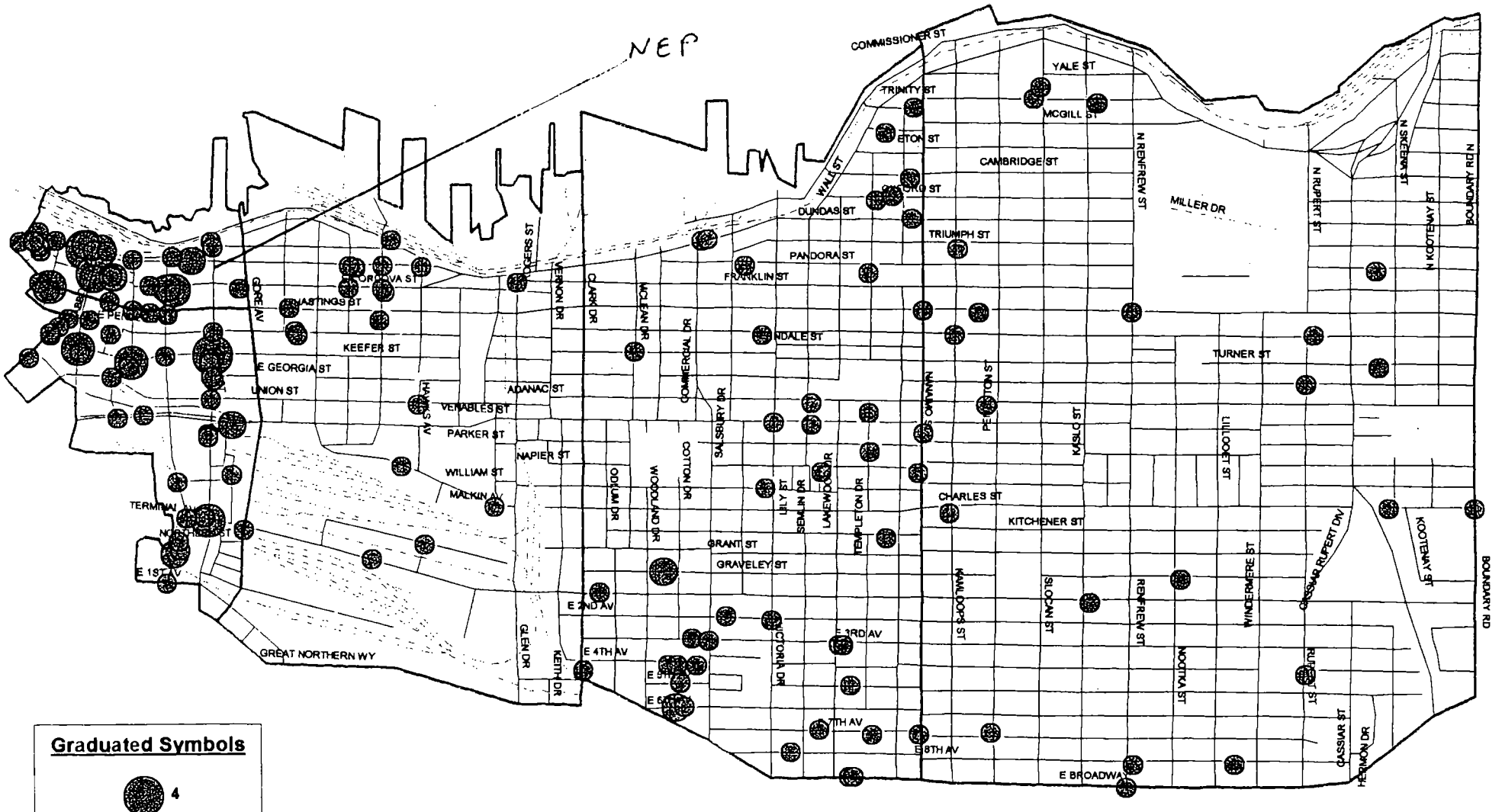
18 to 21	
16 to 18	
13 to 16	
10 to 13	
7 to 10	
4 to 7	
1 to 4	

65 Incidents In 45 Separate Locations
62 Incidents In Previous 2-Week Map

Vancouver Police Department
Crime Analysis Unit

Patrol District Two
Theft From Auto

Mar15th. To Mar 29th., 1998



Graduated Symbols

4
2
1

182 Incidents In 153 Separate Locations
219 Incidents In Previous 2-Week Map

Vancouver Police Department
Crime Analysis Unit

THE WHITE HOUSE

WASHINGTON

MEMORANDUM FOR JAMES R. McDONOUGH

From: Sandra L. Thurman
Director, Office of National AIDS Policy
(202) 632-1090

Date: March 19, 1998

Re: **Draft Joint Statement**

I am attaching a revised draft of a joint statement between myself and ONDCP Director McAffrey. I have taken the liberty of shortening the statement, and offering a perspective that is more balanced in its tone and reflective of the conversation of March 17.

Please let me know what comments you have. Thanks very much!

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

FOR IMMEDIATE RELEASE
March 19, 1998

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

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

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

As for needle exchange, Congress has given the Secretary Health and Human Services the statutory authority to allow state and local health officials to use federal HIV prevention funding for needle exchange programs if she determines that such programs: (1) reduce the transmission of HIV infection; and (2) do not encourage the use of drugs. The Office of National Drug Control Policy and the Office of National AIDS Policy remain dedicated to working with Secretary Shalala, and to supporting her efforts to ensure that public health policy is guided by sound science.

THE WHITE HOUSE

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105TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPORT
105–390

MAKING APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1998, AND FOR OTHER PURPOSES

NOVEMBER 7, 1997.—Ordered to be printed

Mr. LIVINGSTON, from the committee on conference, submitted the following

CONFERENCE REPORT

[To accompany H.R. 2264]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2264) "making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 1998, and for other purposes", having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate, and agree to the same with an amendment, as follows:

In lieu of the matter stricken and inserted by said amendment, insert:

That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 1998, and for other purposes, namely:

TITLE I—DEPARTMENT OF LABOR

EMPLOYMENT AND TRAINING ADMINISTRATION

TRAINING AND EMPLOYMENT SERVICES

For necessary expenses of the Job Training Partnership Act, as amended, including the purchase and hire of passenger motor vehicles, the construction, alteration, and repair of buildings and other facilities, and the purchase of real property for training centers as

bills allowing the Social Security Administration to use unexpended fiscal year 1997 funds for fiscal year 1998 activities.

The conference agreement includes a provision proposed by the House and not included in the Senate bill requiring the Secretary of the Treasury to reimburse the trust funds from general revenues for expenditures related to union activities performed on official time. The conferees request that Social Security coordinate with the government-wide reporting effort which will be undertaken by the Office of Personnel Management in consultation with the Office of Management and Budget as required by Public Law 105–61.

The conferees support the Social Security Administration's unique, cooperative training program for Administrative Law Judges which is recognized by State Bar Associations for continuing legal education credits. The conferees encourage the Office of Hearings and Appeals to continue this training program and to expand financial support to enable greater ALJ participation.

OFFICE OF INSPECTOR GENERAL

(INCLUDING TRANSFER OF FUNDS)

The conference agreement provides $48,424,000 for the Office of Inspector General through a combination of general revenues and limitations on trust fund transfers instead of $52,424,000 as proposed by the House and $37,354,000 as proposed by the Senate.

TITLE V—GENERAL PROVISIONS

DISTRIBUTION OF STERILE NEEDLES

Both the House and Senate bills contained restrictions on the use of federal funds for the distribution of sterile needles for the injection of any illegal drug (section 505). The Senate bill repeated language from previous appropriations bills allowing the Secretary to waive the prohibition if she determined that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs. The House bill removed the Secretary's authority over this issue.

The conference agreement includes the House language prohibiting the use of federal funds for carrying out any program for the distribution of sterile needles or syringes for the injection of any illegal drug. This provision is consistent with the goal of discouraging illegal drug use and not increasing the number of needles and syringes in communities.

The conference agreement also includes bill language limiting the use of federal funds for sterile needle and syringe exchange projects until March 31, 1998. After that date such projects may proceed if (1) the Secretary of Health and Human Services determines that exchange projects are effective in preventing the spread of HIV and do not encourage the use of illegal drugs; and (2) the project is operated in accordance with criteria established by the Secretary for preventing the spread of HIV and for ensuring that the project does not encourage the use of illegal drugs. This provision is consistent with the goal of allowing the Secretary maximum authority to protect public health while not increasing the overall number of needles and syringes in communities.

With respect to the first criteria, the conferees expect the Secretary to make a determination based on a review of the relevant science. If the Secretary makes the necessary determination, then the conferees expect the Secretary to require the chief public health officer of the State or political subdivision proposing to use federal funds for exchange projects to notify the Secretary that, at a minimum, all of the following conditions are met: (1) a program for preventing HIV transmission is operating in the community; (2) the State or local health officer has determined that an exchange project is likely to be an effective component of such a prevention program; (3) the exchange project provides referrals for treatment of drug abuse and for other appropriate health and social services; (4) such project provides information on reducing the risk of transmission of HIV; (5) the project complies with established standards for the disposal of hazardous medical waste; and (6) the State or local health officer agrees that, as needs are identified by the Secretary, the officer will collaborate with federally supported programs of research and evaluation that relate to exchange projects.

It is hoped that the delay in implementation of the provision with regard to exchange projects will allow the authorizing committees sufficient time to conduct a complete review and evaluation of the scientific evidence, as well as any conditions proposed by the Secretary, and consider the need for legislation with regard to these programs. It is the intent of the conferees that the Appropriations Committees refrain from further restrictions on the Secretary's authority over exchange after March 31, 1998.

TECHNICAL

The conference agreement inserts the word "the" before the word "Departments" in section 516 as proposed by the House.

SALARIES AND EXPENSES REDUCTION

The conference agreement deletes section 517 of the Senate bill that would have reduced salaries and expenses appropriations for all agencies in the bill by a total of $75,500,000 to be allocated by the Office of Management and Budget. The House had no similar provision.

TEAMSTERS ELECTION

The conference agreement includes a general provision (section 518) proposed by the House that prohibits the use of funds in this Act for the election of officers of the International Brotherhood of Teamsters. The conference agreement deletes section 106 of the Senate bill which included a related provision. The conferees are aware that the U.S. District Court is currently supervising the election of IBT officers pursuant to a consent decree between the IBT and the Department of Justice. This consent decree provided, in part, a Federal government option to order supervision of the 1996 election at government expense. While the Department of Labor contributed a portion of the funding to assist the Department of Justice in financing the 1996 election supervision expenses, it is the understanding of the conferees that the cost to rerun this election is expected to be significantly less than the original elec-

THE WHITE HOUSE

WASHINGTON

March 24, 1998

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

Dear Mr. McCaffrey: Barry,

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

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

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

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

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

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

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

Very truly yours,

Sandra L. Thurman
Director
Office of National AIDS Policy

cc: Secretary Donna Shalala
Sylvia Mathews
Rahm Emanuel
Bruce Reed

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

March 23, 1998

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

Dear Mister Bowles: Erskine —

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

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

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

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

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

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

- ***The Role of Science***

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

Very Respectfully,

Barry R. McCaffrey

LETTERS

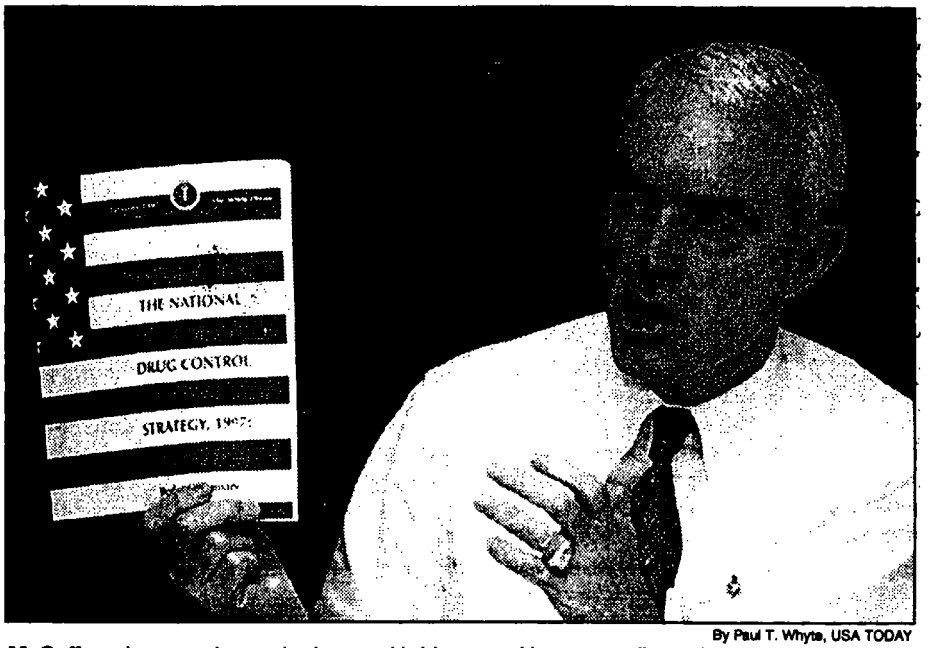
Drug addiction is health problem, not moral issue

Anti-drug czar Barry McCaffrey says providing syringe exchanges to intravenous drug users sends "the wrong message" ("Needle exchanges still stir debate," News, Thursday).

Drug use is a public health problem, not a moral issue. Those who treat it as a question of morality are making a big mistake. Using his philosophy, the message becomes, "You use drugs, therefore you are a bad person and deserve the diseases you contract from your drug use." However, sooner or later, people who don't use intravenous drugs will also be infected with these diseases. Then what's the message?

Here's my message: Grab a clue and blow this "drug war" to smithereens.

Linda S. Collins
Merriam, Kan.



By Paul T. Whyte, USA TODAY

McCaffrey: Letter writers take issue with his opposition to needle exchange programs.

Syringe exchange is effective

"We're all concerned about the AIDS epidemic," said Family Research Council's Robert Maginnis. He's obviously not sufficiently concerned to advocate for the one program known throughout the world to prevent the spread of AIDS among and from drug injectors: syringe exchange.

Undersized and underfunded syringe-exchange programs continue to save lives across America while this rump group of irrational fanatics continues to attempt to mislead Americans with ineptly constructed disinformation.

Syringe exchange is supported by more than a dozen highly respected organizations. In opposition to those groups we have tobacco supporter Sen. Jesse Helms, R-N.C., plus Gary Bauer and his Family Research Council. I leave it to the wisdom of your readers to decide in which hands the American people should place the future of our nation's health.

Joey Tranchina, executive director
AIDS Prevention ACTION Network Inc.
Redwood City, Calif.

Exchange first step to cure

Barry McCaffrey speaks of a wrong message to kids. Give me a break. A far worse message is sent when we allow addicts to contract and spread the AIDS virus through unclean needles. More than 190,000 Americans have been infected with HIV from infected needles. All of the government's own studies show that needle exchanges dramatically reduce the transmission of the AIDS virus without encouraging drug abuse. In fact, needle exchanges often refer addicts to drug-treatment programs.

Let's be clear: People don't experiment with drugs, or stay on them, because somebody gave them a clean needle.

Michael Shellenberger, co-director
Communication Works
San Francisco, Calif.

Better message for kids

As a mother, I strongly disagree with Barry McCaffrey's statement that needle-exchange programs send "the wrong message" to people who are addicted and trying to avoid HIV infection. These programs send the *right* message, which is that we encourage you to protect yourself and your loved ones from HIV so you can live, avoid HIV and get off drugs.

McCaffrey's stance also ignores the fact that seven federally funded scientific studies have concluded that needle-exchange programs work in preventing HIV without increasing drug use.

American needle exchanges are structured to be operated as public health programs so that used needles are actually traded in for clean syringes.

Needle-exchange programs that have been instituted in the United States bear no resemblance to those cited by the Family Research Council. Many U.S. programs offer vouchers for quick access to drug-treatment programs. As such, they provide a cost-effective way to deliver critically needed health care and education to a hard-to-reach population.

We must provide these health messages to all of our children, including those who are addicted.

Ann Kurth, executive director
Mothers' Voices
New York, N.Y.

SAN FRANCISCO AIDS FOUNDATION P.O. BOX 426182, SAN FRANCISCO, CALIFORNIA 94142-6182

August 26, 1997

Ms. Ricia McMahon
Senior Advisor on Demand Reduction Issues
Office of National Drug Control Policy
750 17th Street, NW
Washington, D.C. 20503

SENT VIA FAX

Dear Ricia:

On behalf of Joanna Rinaldi of AIDS Health Project, Roslyn Allen of the San Francisco AIDS Foundation HIV Prevention Project and myself, I want to thank you and John Gregrich for meeting with us on August 6th to discuss the issue of needle exchange. We appreciated the opportunity to explain how San Francisco's needle exchange program operates, and to present information about how this program has literally saved lives. We also appreciated the opportunity to discuss the scientific evidence in support of this intervention, and will forward additional data from San Francisco in the coming weeks.

As I indicated in my voicemail message to you yesterday, I was surprised and very concerned to read the Office of National Drug Control Policy's (ONDCP) August 20th public statement issued in response to the release of a survey by the Family Research Council (FRC). In the statement, ONDCP seems to play into the Family Research Council's suggestion that support for needle exchange and drug treatment services are mutually exclusive positions. This is, quite frankly, a misleading assumption that permeates the FRC survey, leading many of us to call into question the survey's validity. As Joanna, Roslyn and I discussed with you in our meeting, we do not in any way see the two as mutually exclusive. In fact, our experience demonstrates that needle exchange programs can and do facilitate access to drug treatment and other medical and support services for this very disenfranchised and isolated population.

While we strongly support the need for expanded drug treatment, the sad truth is that in our community and others, sufficient drug treatment services are not available. As John Gregrich stated in our meeting, the fact is that existing treatment services only serve approximately 15% of those in need. Moreover, even if sufficient treatment services were available, the reality is that there would continue to be individuals unwilling or unable to enter drug treatment. We believe strongly that these individuals both need and deserve access to HIV prevention efforts and other ancillary medical and support services, to which needle exchange acts as a bridge.

The ONDCP statement also implies that those who support using federal funds for needle exchange wish to divert drug treatment funds for this purpose. This is not an idea that AIDS advocates are pushing for, and makes me wonder if this is not, once again, an FRC effort to create a false dichotomy between needle exchange and drug treatment services. For the record, I would strongly oppose this idea, and believe that my colleagues on the President's Advisory Council on HIV/AIDS and others working on this issue would also oppose such a proposal. In addition, as you may know, the Cummins-Pelosi needle exchange bill now pending in the House, while requiring the Secretary of Health and Human Services to create a federally funded program, expressly prohibits the use of SAMHSA funding for needle exchange.

The ONDCP statement also suggests that drug treatment is the only proven intervention to address the twin epidemics of substance abuse and HIV. As you know from our discussion during our meeting, we disagree with this position. Many prominent, national health groups, including the American Medical Association and the American Public Health Association -- organizations that are equally concerned about the issues of drug addiction/treatment and HIV -- feel that there is sufficient scientific evidence to demonstrate the effectiveness of needle exchange.

It is our continued hope that the Clinton Administration as a whole will follow the science on this issue. In his remarks before the Commonwealth Club in San Francisco earlier this year, General McCaffrey himself indicated his commitment to do just that. My fear is that ONDCP's August 20th statement, by aligning the office with the Family Research Council and it's questionable survey, represents a setback in this regard.

On behalf of Joanna, Roslyn and myself, thank you, again, for meeting with us earlier this month. I hope that I will have an opportunity to speak with you directly about ONDCP's statement, and that, in general, we can continue our dialog on this extremely important issue. I can be reached at (415) 487-3099.

Sincerely,

Regina Aragón

Regina Aragón
Deputy Director for Public Policy

cc: Roslyn Allen, SF AIDS Foundation HIV Prevention Project
Joanna Rinaldi, AIDS Health Project
Kristin O'Connell, The Sheridan Group

FAX COVER SHEET

San Francisco AIDS Foundation
Public Policy Department

Date: 8/26/97

To: Todd Summers

FAX: 202/632-1096

From: Regina Aragón

Phone: (415) 487-3099

Return FAX: (415) 487-3089

Pages (incl. cover): 3

Message and/or special instructions:

BCC of
My letter to DNDCP folks - FYI
Please don't circulate. Tnl
we speak. Thanks

10 United Nations Plaza, Suite 630, San Francisco, CA 94102
Mailing address: PO Box 426182, San Francisco, CA 94142-6182

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

March 20, 1998

1545

Sandy

Dear Ms. Thurman:

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

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

Sincerely,

James R. McDonough
Director, Strategic Planning

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

Sandy,
Thanks for your help and patience.
Note the analysis I have attached. Think we

FOR IMMEDIATE RELEASE
_____, March ___, 1998

CONTACT: _____
(202) _____

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

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

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

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

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

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

March 20, 1998

MEMORANDUM FOR Jim McDonough

From Pancho Kinney

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

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

1. I reviewed the report and concluded that we should not use this article to support this statement. The study by Dr. Scott Holmberg does not make any comparison between numbers of new HIV infections in different periods. Consequently, we cannot draw conclusions from it about changes in rates of HIV infection among any population or sub population.

2. I also found that some of the author's (Dr. Scott Holmberg) assertions are not substantiated by a later CDC study (Summary of HIV/AIDS Surveillance Report (CDC: Edition Vol. 9, No. 1) which covers U.S. HIV and AIDS cases reported through June 1997. For example:

   a. Holmberg claims that "roughly ½ of new infections may be occurring among IDUs." The 1997 CDC study estimates the figure to be 15 percent (by my calculations).

   b. Holmberg estimates "that roughly 40,000 new infections occurring each year in the U.S." The 1997 CDC study estimates the number to be 13,111 between July 1996 and June 1997 (again, by my calculations).

   c. Holmberg states that "an estimated 19,000 injection drug users are infected each year." The 1997 CDC study estimates the number to be 2,203 between July 1996 and June 1997 (again, my calculations).

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

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

July 25, 1997

Dear Mr. Yates:

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

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

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

Best Wishes,

Hoover Adger

Hoover Adger, MD, MPH
Deputy Director

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

RECEIVED
JUL 28 1997
TYRONE K. YATES

City of Cincinnati

Tyrone K. Yates
Vice Mayor

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

COMMITTEES

Chairman
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Member
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Health, Social & Children's Services
Select Committee on Special Projects
City Planning Commission

August 19, 1997

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

Dear Mr. Adger:

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

You write:

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

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

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

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

Sincerely,

Tyrone K. Yates

Tyrone K. Yates
Vice Mayor

Enclosure: July 25, 1997 letter
cc: President Bill Clinton
Vice President Al Gore
Mr. Paul Helmke, President, U.S. Conference of Mayors
Mr. J. Thomas Cochran, Executive Director, U.S. Conference of Mayors
Dr. David Satcher, Director, Centers for Disease Control

Office of HIV/AIDS Policy

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

☐ Room 733-E
Fax. (202) 690-6584

☐ Room 730-E
Fax. (202) 690-7560

Deliver to: Sandy Thurman

Fax: _____

Tel: _____

From:

Date: 9/2 : _____

This fax contains 5 pages + cover

If transmission problems occur, please call _____

Comments: _____

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

August 21, 1997

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

DRAFT

Dear Secretary Shalala:

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

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

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

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

DRAFT

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

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

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

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

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

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

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

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

Respectfully,

Barry R. McCaffrey
Director

Attachment

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

DRAFT

August 21, 1997

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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August 21, 1997

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

August 21, 1997

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

DRAFT

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Respectfully,

Barry R. McCaffrey
Director

Attachment

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

DRAFT

SLT-
FYI-
Told

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503
July 25, 1997

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

Best Wishes,

Hoover Adger

Hoover Adger, MD, MPH
Deputy Director

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

RECEIVED
JUL 28 1997
TYRONE K. YATES

Subj: Re: Drug Czar's comments on needle-exchange
Date: 97-07-09 05:58:59 EDT
From: LTHOMAS@SFAF.MHS.CompuServe.COM (Thomas, Laura)
Sender: nep@drcnet.org
Reply-to: nep@drcnet.org
To: nep@drcnet.org (Multiple recipients of list)

Notes taken by Regina Aragon, Public Policy Department, San Francisco AIDS Foundation

Introduction:

General Barry McCaffrey, the Director of the Office of National Drug Control Policy, spoke at the Commonwealth Club in San Francisco July 2 about the nation's drug control strategy. During the question and answer period, he spoke briefly about the issue of needle exchange. He also made some relevant statements in his prepared remarks. Below is a summary, and in some cases, direct quotes from General McCaffrey's remarks. I thought that you might find this information interesting, if not helpful.

McCaffrey Remarks:

In his opening remarks, he stated that, "by the end of the century, we must replace ideology with science in discussions about drug addiction." He spoke to the need for factual information and for facts to inform our discussions.

He referred to the AIDS epidemic and its link to the abuse of illegal drugs. Per the materials handed out at the event, the goal of reducing the health and social costs associated with illegal drug use (with an emphasis on infectious diseases) is one of five major goals listed in the 1997 National Drug Control Strategy. He emphasized that overall, his strategy is to focus on prevention and intervention (including substance abuse treatment).

When asked about needle exchange, his response was that he realized that there can be a tension or trade-off between the desire to reduce harm associated with drug use and preventing drug use. He said that there were over 80 NEPs nation-wide, that studies are now being done, that "the Federal government recently reported to the Congress that in some cases, needle exchange will reduce the spread of HIV" and that he believed that this was a "tremendously desired good."

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He then stated that, "The problem I have with needle exchange is that I don't want health professionals to walk away from those addicted to drugs." He went on to say that it is clearly cheaper to "drive around in a van and pass out condoms and clean needles" than it is to provide outreach to link IDU's with treatment and to provide the treatment itself. He closed his comments on the topic by saying that he "did not want for needle exchange to be seen as a cheap cop out in this battle."

Parenthetically, during the Q & A he was asked by a number of audience members about medicinal use of marijuana. His first response was that, in his opinion, the question of which drugs doctors should make available to patients is a question for NIH/FDA and not for politicians; that there needs to be a scientific basis for determining whether or not marijuana should be prescribed for medical use, and that the Administration has asked the Institute of Medicine, National Academy of Sciences and Dr. Varmus to "entertain serious scientific scrutiny" of this question. I mention this only because I was somewhat heartened by his tendency to want to rely on scientific evidence to dictate federal policy on this controversial issue.

Laura Thomas

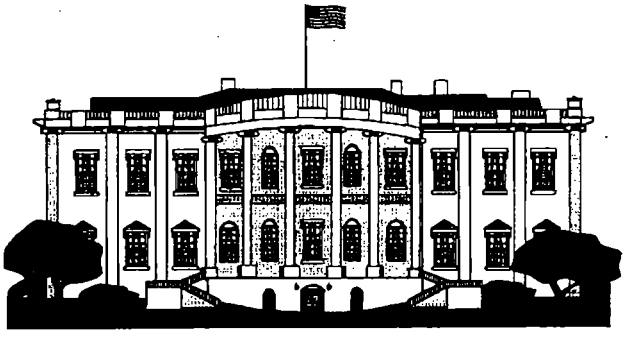
San Francisco AIDS Foundation

---------- Headers ----------
From nep@drcnet.org Tue Jul 8 18:48:17 1997
Return-Path: <nep@drcnet.org>
Received: from forcade.calyx.net (ns2.calyx.net [208.132.136.4])
by mrin69.mail.aol.com (8.8.6/8.8.5/AOL-4.0.0)
with SMTP id SAA26392 for <mdshriver@aol.com>;
Tue, 8 Jul 1997 18:48:16 -0400 (EDT)
Date: Tue, 8 Jul 1997 18:48:16 -0400 (EDT)
Received: (qmail 1905 invoked from network); 8 Jul 1997 22:48:10 -0000
Received: from localhost (HELO ns.calyx.com) (127.0.0.1)
by localhost with SMTP; 8 Jul 1997 22:48:10 -0000
Message-Id: <970708220248_555063.0_EHF59-2@CompuServe.COM>
Errors-To: mikempls@minn.net
Reply-To: nep@drcnet.org
Originator: nep@drcnet.org
Sender: nep@drcnet.org

From: "Thomas, Laura" <LTHOMAS@SFAF.MHS.CompuServe.COM>
To: Multiple recipients of list <nep@drcnet.org>
Subject: Re: Drug Czar's comments on needle exchange
X-Listprocessor-Version: 6.0 -- ListProcessor by Anastasios Kotsikonas
X-Comment: NEP is the Needle Exchange Program mailing list.

EXECUTIVE OFFICE OF THE PRESIDENT

Office of National Drug Control Policy
Washington, DC 20503



FACSIMILE MESSAGE

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

FROM: DIANE STUMPF, OFFICE OF PUBLIC AFFAIRS

PHONE: (202) 395-6618

FAX: (202) 395-6730

COMMENTS:

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

August 20, 1997

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

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

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

Contact Don Maple, (202) 395-6618

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

January 14, 1998

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

Dear Mr. Lew:

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

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

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

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

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

I hope you find this information helpful.

Sincerely,

Janet L. Crist
Chief of Staff

MEMORANDUM

To: NORA NXC Sub-Committee
Other Interested Parties

Date: July 3, 1997

cc: The Sheridan Group
Randy Miller

From: Regina Aragón

RE: Remarks of Drug Czar Barry McCaffrey in San Francisco, July 2, 1997

Introduction:

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Tuesday, July 8, 1997

Needle Programs Are Needed

Evidence is in: They can reduce AIDS without fostering drug use

PREV STORY
NEXT STORY

Understandably uneasy with government agencies giving drug addicts needles and other paraphernalia, Congress prohibited federally funded needle exchange programs in 1988. The ban could be lifted, Congress said, when there was proof that such programs reduced transmission of the AIDS virus without increasing illegal drug use. Now, that time has come.

Since 1993, several major studies have shown that the programs that give addicts clean needles in exchange for used ones decrease HIV infection in injected-drug users by 30%, increase the likelihood that addicts will enter drug treatment programs and do nothing to lead nonusers into drug habits. But, unlike in most developed nations, many U.S. state laws and federal law prohibit government from supplying clean needles. (California does not prohibit private programs, but Gov. Pete Wilson has thrice vetoed bills that would have explicitly legalized such programs.)

Prohibitions cost lives and money. According to the federal Centers for Disease Control, most of the 41,000 new HIV infections each year occur among injected-drug users and their sexual partners and children. The average cost of lifetime care for those infected with HIV or suffering from AIDS runs about $120,000, while each sterile needle costs 10 cents.

Citing "an urgent public health need," the American Medical Assn. and the U.S. Conference of Mayors have called for revocation of the 1988 law and of similar state laws prohibiting needle exchange programs. In a resolution sponsored by Los Angeles Mayor Richard Riordan and San Francisco Mayor Willie Brown, the Conference of Mayors went a step further, urging Health and Human Services Secretary Donna Shalala to use her authority to permit federal funding.

Reflecting the conventional wisdom in Washington, conservative public policy analyst Gary L. Bauer says the idea of lifting the ban on needle exchange is unthinkable because it "strikes the average voter in the gut as being against common sense." But recent polls suggest otherwise: A Kaiser Family

Foundation survey last year found that 66% of Americans support needle exchange programs.

Washington should listen to the civic leaders and public health experts who have seen close up how the programs can be an effective and inexpensive way of curbing the spread of a deadly disease.

PREV STORY

NEXT STORY

News GO Site Index GO

AMERICAN FOUNDATION FOR

AmFAR

AIDS RESEARCH

PUBLIC POLICY OFFICE
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Washington, D.C. 20036
(202) 331-8600
FAX: (202) 331-8606

FACSIMILE COVER SHEET

DATE: 6/17

TO: Sandy Thurman

FROM:
X Jane Silver
___ Scott Sanders
___ Jim Oleson

TOTAL # OF PAGES: (INCLUDES COVER) ___

MESSAGE: Here is FACT SHEET, MMWR coming Out This Week, and Resolutions Passed by organizations. Call me ANY TIME (H) 202 398-5271 (W) 202 331-8600

AND THANK YOU FOR HAVING THE PHONE CALL.

Facts About AIDS and Syringe Exchange in the United States

AIDS in the United States

- One in 250 people in the United States is infected with HIV
- One-third of AIDS cases in the US. are directly or indirectly associated with injecting drug use
- 50% of new HIV infections are occurring among injecting drug users
- HIV infection is almost always fatal

AIDS Prevention

- No preventive vaccine is likely to become available soon
- Syringe exchange programs (SEPs), which are a major component of HIV prevention strategies in most developed and many developing countries, have been shown to reduce the rate of transmission of HIV
- Early implementation of SEPs and legal status influences the spread of HIV. In the United Kingdom, where SEPs were implemented early in the epidemic and have always been legal, only 614 cumulative injection-related AIDS cases had been reported through March of 1995, compared with 48,450 cases in New York City alone or 146,359 in the United States.

The Controversy Surrounding Syringe Exchange

- Syringe exchange has been met with controversy in the United States, resulting in a ban on federal funding of syringe exchange programs
- Opponents argue that syringe exchange will increase the number of injecting drug users
- Scientific studies, including 7 government sponsored studies, show that SEPs do not lead to any detectable increase in the number of drug users on a community level
- An evaluation of SEPs in New York City showed a reduction in the frequency of HIV risk behaviors and the rate of new HIV infections among participants
  - frequency of risky injection among participants was reduced by 63%
  - frequency of injection among participants decreased by 7%
  - the rate of new HIV infections among participants decreased by two-thirds

Facts About AIDS and Syringe Exchange in the United States

"More than Just Clean Needles"

- SEPs are complex organizations which provide a multitude of services both on-site and through referral
- A survey of the approximately 100 SEPs operating in 71 cities in 29 states found that:
  - 97% make referrals to drug treatment
  - The 3% that do not offer drug treatment referrals are "underground" exchanges which operate in states with prescription or paraphernalia laws & have not received a formal vote of support or approval from local or elected officials
  - 97% offered sexual and/or drug risk reduction
  - More than 40% provided on-site HIV counseling and testing

SEPs are Cost Effective

- The median annual budget of SEPs in the United States is $169,000; Since the lifetime cost of treating one person with AIDS is approximately $120,000, each SEP more than pays for itself by preventing the transmission of HIV/AIDS to less than two people
- Syringe exchange programs could have prevented 9,700 HIV infection nationwide at a savings of $538 million

Public Opinion Supports SEPs

- A 1996 Kaiser Survey on Americans and AIDS/HIV found that 66% of respondents