

FOR DISCUSSION ONLY

January 15, 1992

CITY AND COUNTY OF SAN FRANCISCO/
SAN FRANCISCO AIDS FOUNDATION
PROPOSED NEEDLE EXCHANGE LEGISLATION

SECTION 1. The Legislature hereby finds and declares all of the following:

(a) The rapidly spreading AIDS epidemic poses an unprecedented public health crisis in California, and threatens, in one way or another, the life and health of every Californian.

(b) Injection drug users are the second largest group at risk for HIV/AIDS, and they are the primary source of heterosexual, female and perinatal transmission in California, the United States and Europe.

(c) According to the State Office of AIDS, injection drug use has recently emerged as one of the most prevalent risk factors for new AIDS cases in California.

(d) Studies indicate that the lack of sterile needles available on the streets and the existence of laws restricting needle availability, promote needle sharing and consequently the spread of HIV among injection drug users. The sharing of contaminated needles is the primary means of HIV transmission within the injection drug user population.

(e) As of September 1991, 32 percent of the 195,718 reported cases of AIDS in the United States were associated with injection drug use. Of the 10,989 cases of AIDS presumed to be transmitted through heterosexual sex, 53 percent of the cases occurred among the sexual partners of injection drug users. Of the 3,312 pediatric AIDS cases related to a mother with or at

risk for HIV infection, 70 percent were related to injection drug use. The number of reported AIDS cases reflects only a fraction of the total number of persons infected with HIV.

(f) An estimated 11.7, 6.2 and 5.5 percent of injection drug users entering methadone treatment programs between 1989 and 1991 in Contra Costa, San Mateo and Alameda counties, respectively, were infected with HIV. Public health officials generally consider the seroprevalence rates of those entering treatment to be significantly lower than the true rate of HIV infection among the injection drug user population as a whole. For example, in San Francisco where data were collected over the same period, the seroprevalence rate of those entering treatment was 8.3% compared to 15% among the estimated 16,000 injection drug user population.

(g) Most injection drug users use a variety of drugs - - mainly heroin and cocaine. Recently federal drug abuse surveys indicate that cocaine has replaced heroin as the injection drug user's drug of choice. Because cocaine-injecting drug users inject more frequently than heroin users, their risk for HIV infection is higher.

(h) Studies of injection drug users in New York City; San Francisco; Tacoma, Washington; Boulder, Colorado; Portland, Oregon; and other U.S. cities indicate that injection drug users are concerned about AIDS and do change their behavior when offered, in a nonjudgmental setting, reasonable strategies to protect themselves. A San Francisco study of injection drug

79,908

users found that the percentage of drug users who reported using bleach to sterilize their equipment increased from 3 percent to 61 percent after a street outreach program was in operation for six months and to 86 percent after two years.

(i) A study by Yale University of a needle exchange program authorized by the Connecticut Legislature in New Haven in 1990 estimates that in the first eight months of operation, the program reduced new HIV infections by 33 percent.

(j) California is one of eleven states that criminalizes the furnishing, possession or use of hypodermic needles or syringes without a prescription. Of these eleven states, four have either passed legislation or waived the prohibition through administrative action over the last several years to permit the development of needle exchange programs. California has the highest seroprevalence rate of HIV infection of any state which has not waived the prohibition or adopted a statute to permit needle exchange programs.

SECTION 2. THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS: Section 4146 of the Business and Professions Code is amended to read:

4146. (a) Notwithstanding any other provision of law, a pharmacist or physician may, without a prescription or a permit, furnish hypodermic needles and syringes for human use in the administration of insulin or adrenaline; a pharmacist or veterinarian may, without a prescription or permit, furnish hypodermic needles and syringes for use on poultry or animals;

and a person may, without a prescription or permit, obtain hypodermic needles and syringes from a pharmacist or physician for human use in the administration of insulin or adrenaline, or from a pharmacist, veterinarian, or permit holder, for use on poultry or animals; if all the following requirements are met:

(1) No needle or syringe shall be furnished to a person who is unknown to the furnisher and unable to properly establish his or her identity.

(2) The furnisher, at the time furnishing occurs, makes a record of the furnishing in the manner required by Section 4147.

(b) Notwithstanding any other provision of law, a pharmacist, physician, surgeon or other person designated under the operating procedures developed pursuant to paragraph (1) of subdivision (b) of Section 199.84 of the Health and Safety Code may furnish hypodermic needles and syringes without a prescription or permit when operating under the pilot project established pursuant to Chapter 1.18 of Part 1 of Division 1 of the Health and Safety Code.

SECTION 3. Chapter 1.18 (commencing with Section 199.83) is added to Part 1 of Division 1 of the Health and Safety Code, to read:

CHAPTER 1.18. CLEAN NEEDLE AND SYRINGE EXCHANGE PILOT PROJECT

199.83. The Legislature finds and declares the following:

(a) Scientific data from needle exchange programs in the United States and in Europe have shown that the exchange of used hypodermic needles and syringes for clean hypodermic needles and syringes does not increase drug use in the population, can serve as an important bridge to treatment and recovery from drug abuse and can curtail the spread of HIV infection among the intravenous drug user population.

(b) In order to attempt to reduce the spread of HIV infection among the intravenous drug user population within California, it is the intent of the Legislature that the Department of Health Services authorize a clean needle and syringe exchange pilot project pursuant to this Chapter in the City and County of San Francisco upon the request of the Board of Supervisors, Mayor and local health officer.

(c) The Department of Health Services may authorize additional pilot project sites upon the request of a county Board of Supervisors and the local health officer or upon the request of a City Council and Mayor and the local health officer in a city with a health department.

199.84. (a) If the county local health officer and Board of Supervisors or the City Council, Mayor and local health officer of a city with a health department requests authorization, the Department of Health Services may authorize the local health officer to establish a clean needle and syringe exchange pilot project pursuant to this Chapter.

(b) A City and County or a county or a city with a

health department which receives the Department's authorization pursuant to this Chapter shall, in consultation with the Department of Health Services, the Department of Alcohol and Drug Programs, and the University of California, conduct a pilot project on the exchange of clean hypodermic needles and syringes as part of a network of comprehensive services, including treatment services, to combat the spread of HIV infection among injection drug users. The pilot project shall include, but not be limited to, all of the following:

(1) The development of a set of operating procedures by the local health officer for the furnishing and exchange of hypodermic needles and syringes for injection drug users and the approval of the operating procedures by the Department of Health Services.

(2) The development of a data base and collection of data relating to the furnishing and exchanging of clean hypodermic needles and syringes to injection drug users by persons designated in the operating procedures developed pursuant to paragraph (1).

(3) The provision of community outreach and preventive education that is culturally sensitive and linguistically appropriate to reduce project participants' exposure to HIV infection.

(4) An effort to secure treatment for drug addiction for participants upon their request.

(5) The involvement of the community in the

development of the program and assessment design.

(6) The involvement of local public safety officials in the development of the program and assessment design.

(7) Accessibility of the project to the target population while being sensitive to community concerns.

(8) Appropriate levels of staff expertise in working with injection drug users and adequate staff training in providing community referrals, needle hygiene and safety precautions.

(9) Enhanced treatment capacity, insofar as possible, for injection drug users.

(10) Preferential acceptance, insofar as possible, of HIV-infected drug users into drug treatment programs.

(c) The pilot project authorized pursuant to this chapter shall be part of a network of voluntary and confidential HIV services, where available, including but not limited to: anonymous HIV antibody testing, counseling, voluntary, anonymous or confidential partner notification, early intervention and on-going primary medical care follow-up for infected persons and their partners, and social services to support families of HIV-infected drug users.

(d) Components of the pilot project authorized pursuant to this chapter shall be assessed by the participating counties or cities. Participants may individually or as a group contract with the University of California to assess the pilot project. Assessment may include measures of exchange rates,

behavioral changes such as change in level of drug use, level of needle sharing, use of condoms and bleach, program participation rates and the number of participants entering treatment and the status of their treatment and recovery.

(e) All components of the pilot project authorized pursuant to this Chapter shall be voluntary. Where persons are provided services as a part of the pilot project other than the furnishing or exchange of needles, such as antibody testing, counseling, medical or social services, those provisions of law governing the confidentiality and anonymity of such information shall apply. All information obtained in the course of implementing the pilot project that personally identifies any person to whom needle furnishing and exchange services are provided shall remain confidential and shall not be released to any person or agency not participating in the pilot project without the person's written consent.

(f) If the local health officer determines that the pilot project has a detrimental effect in terms of increased drug use and the increased spread of HIV, the project shall be terminated.

(g) No provision of this section shall apply to the University of California unless the Regents of the University of California by resolution enacted by January 1993, make that provision so applicable.

(h) This chapter shall remain in effect only until January 1, 1996, and as of that date is repealed, unless a later

statute, which is enacted on or before January 1, 1996, deletes or extends that date.

(i) A City and County, County or City with a health department entering into the pilot project, shall submit a written report one year from the project's inception, taking into account the factors stated in Sec. 199.84(d). The report shall be submitted to the Director of the Department of Health Services, the Governor, and the Chairs of Health Committees of the Legislature.

IF

AT

FIRST

YOU

DON'T

SUCCEED

ooo

MEETING ANNOUNCEMENT

BAY AREA NEEDLE EXCHANGE WORKING GROUP

WEDNESDAY, DECEMBER 9TH

11:00 AM TO 1:00 PM

SF AIDS FOUNDATION

25 VAN NESS, 3RD FLOOR CONF. ROOM

Please make a special effort to attend this meeting of the Needle Exchange Working Group. The agenda will include a discussion of plans to reintroduce state legislation, an update on local needle exchange efforts, and a discussion of the future role of the Working Group.

With questions, please call Regina Aragón at (415) 864-5855, x 2599.

INJECTION DRUG USE IN THE UNITED STATES

(references listed on back)

- * There are estimated to be as many as 1.5 million injection drug users (IDUs) in the United States.¹
- * Most IDUs use a variety of drugs -- mainly heroin and cocaine. Recent federal drug abuse surveys indicate that cocaine has replaced heroin as the IDU drug of choice.²
- * Because IDU cocaine addicts inject more frequently than heroin users, their risk for HIV infection is higher.³
- * Among IDUs, the major HIV transmission route is shared injection drug equipment.⁴
- * Prior to the HIV epidemic the sharing of drug-injection equipment was common, ranging from 70% to 100% in different regions of the country.⁵
- * The major reasons given by IDUs for sharing is the scarcity of sterile injection equipment and the laws that require a prescription to obtain syringes and make possession of syringes a crime.^{6 7}
- * Shooting galleries, where injection equipment is rented/sold or shared, are most common in the Northeast. The widespread presence of these shooting galleries is thought to be one of the principal reasons for a higher prevalence of HIV infection among Northeastern IDUs (as compared to IDUs in other regions of the country).⁸
- * An estimated 90% of all IDUs live in urban areas. Of these urban IDUs, approximately 15% are in drug treatment programs.⁹
- * The National Institute on Drug Abuse (NIDA) recently estimated that approximately 107,000 persons are currently on waiting lists for drug treatment.¹⁰

1. National Commission on AIDS: The Twin Epidemics of Substance Use and HIV, July 1991.
2. Hahn, R.A. and Onorato, I.M., et.al.: "Prevalence of HIV Infection Among Intravenous Drug Users in the United States." Journal of American Medical Association: May 12, 1989: 2677-2685.
3. Chaisson, R. E., Moss, A.R., Onishi, R., Osmond, D., Carlson, J.R. "Human Immunodeficiency Virus Infection Among Heterosexual Intravenous Drug Users in San Francisco." American Journal of Public Health. 1987; 77: 169-72.
4. Havekos, H.W., 1988. "Overview: HIV Infection Among Injection Drug Abusers in the United States and Europe." National Institute of Drug Abuse Research Monograph Series: 1988 Monograph 80: p.7-17.
5. Hahn, p.2680.
6. Feldman, H. W. and Biernacki, P. "The Ethnography of Needle Sharing Among Intravenous Drug Users and Implications for Public Policies and Intervention Strategies". National Institute of Drug Abuse Research Monograph Series; 1988 Mono 80, 28-39.
7. Murphy, S. "Intravenous Drug Use and AIDS: Notes on the Social Ecology of Needle Sharing." Contemporary Drug Problems vol.3, 1988, 373-396.
8. Hahn, p.2680.
9. ibid.
10. National Commission on AIDS, p.1.

INJECTION DRUG USE IN SAN FRANCISCO

(references listed on back)

- * The total number of injection drug users (IDUs) in San Francisco is estimated to be 16,000. Of these, 13,000 are heterosexual IDUs and 3,000 are homosexual/bisexual IDUs.¹
- * In 1989, a survey of gay/bisexual men showed that 9% engaged in injection drug use during the past year.²
- * Other similar surveys of gay/bisexual ethnic communities showed that 18.6% of African-Americans, 2% of Native Americans, 9% Filipinos, and 10% of Latinos had injected non-prescription drugs at least once in their lives.³
- * A survey of African-Americans in San Francisco in 1987 and in 1989 showed virtually identical rates of (7.4%) of previous year injection drug use. About 40% of those reporting injection drug use within the past year had also shared needles.⁴
- * In 1986, 43% of methadone detox admissions self-reported needle sharing within the last month prior to admission. In 1990, only 17% of detox admits self-reported needle sharing.⁵
- * During fiscal year 1990-1991, 6,000 IDUs sought treatment in San Francisco Department of Public Health clinics. Approximately 10,000 IDUs remain untreated. In any given year, there are approximately two IDUs out of treatment for every IDU in treatment.⁶

INJECTION DRUG USE IN SAN FRANCISCO

(references listed on back)

- * The total number of injection drug users (IDUs) in San Francisco is estimated to be 16,000. Of these, 13,000 are heterosexual IDUs and 3,000 are homosexual/bisexual IDUs.¹
- * In 1989, a survey of gay/bisexual men showed that 9% engaged in injection drug use during the past year.²
- * Other similar surveys of gay/bisexual ethnic communities showed that 18.6% of African-Americans, 2% of Native Americans, 9% Filipinos, and 10% of Latinos had injected non-prescription drugs at least once in their lives.³
- * A survey of African-Americans in San Francisco in 1987 and in 1989 showed virtually identical rates of (7.4%) of previous year injection drug use. About 40% of those reporting injection drug use within the past year had also shared needles.⁴
- * In 1986, 43% of methadone detox admissions self-reported needle sharing within the last month prior to admission. In 1990, only 17% of detox admits self-reported needle sharing.⁵
- * During fiscal year 1990-1991, 6,000 IDUs sought treatment in San Francisco Department of Public Health clinics. Approximately 10,000 IDUs remain untreated. In any given year, there are approximately two IDUs out of treatment for every IDU in treatment.⁶

1. San Francisco Department of Public Health, Comprehensive Plan to Reduce the Spread of HIV Infection Among Injection Drug Users (IDUs) in the City and County of San Francisco. January 21, 1992.

2. *ibid.* p.5.

3. *ibid.* p.5.

4. *ibid.* p.5.

5. *ibid.* p.8.

6. *ibid.* p.6.

**AIDS AND HIV SEROPREVALENCE AMONG INJECTION DRUG USERS IN
THE UNITED STATES**

(references listed on back)

AIDS

- * Injection drug users (IDUs) are the second largest group at risk of becoming infected with HIV and developing AIDS, and are the primary source for heterosexual, female, and perinatal transmission in, the United States and Europe.
- * As of September of 1991, 53% of the total number of AIDS cases presumed to be transmitted through heterosexual sex (10,989) occurred among the sexual partners of IDUs.¹
- * Of the 3,312 perinatal AIDS cases reported in the U.S. as of September 1991, 70% of the mothers were IDUs or the sexual partners of injection drug users.²
- * As of September 1991, 32% of the 195,718 reported cases of AIDS in the U.S. were associated with injection drug use.³
- * 71% of all female AIDS cases are linked directly to injection drug use.⁴
- * 19% of AIDS cases among men are directly linked to injection drug use, and an additional 7% of AIDS cases among men are linked to both homosexual/bisexual contact and injection drug use.⁵
- * While African-Americans make up 28% of all diagnosed AIDS cases and Hispanics make up 16%; of cases attributed to injection drug use, African-Americans account for 45%, and Hispanics for 26%.⁶

HIV SEROPREVALENCE

- * It is estimated that as many as 30% of this country's 1.5 million injection drug users may be infected with HIV.⁷
- * The highest HIV infection rates among injection drug users have been reported in New York City, San Juan (Puerto Rico), and other metropolitan areas of the Northeast.⁸
- * It is estimated that between 50% and 65% of New York's 200,000 injection drug users are infected with HIV. In addition, it is estimated that 45% of San Juan's, 29% of Baltimore's, and 28% of New Jersey's injection drug users are infected with HIV.⁹
- * African-Americans and Latinos have higher rates of HIV infection compared to whites. In some studies, the HIV infection rates are over three times higher for African-American and Latino IDUs than for white IDUs.¹⁰

1. U.S. Centers for Disease Control: HIV/AIDS Surveillance, October 1991: 8-10.
2. *ibid.*
3. *ibid.*
4. National Commission On AIDS: The Twin Epidemics of Substance Use and HIV, July 1991.
5. *ibid.*
6. *ibid.*
7. Hahn, R.A.; Onorato, I.M., et. al. : "Prevalence of HIV Infection Among Intravenous Drug Users in the United States." Journal of the American Medical Association: May 12, 1989: Vol 261, No. 18, 2677-2685.
8. *ibid.*
9. *ibid.*
10. *ibid.*

AIDS AND HIV SEROPREVALENCE AMONG SAN FRANCISCO IDUs

(references listed on back)

AIDS

- * As of September, 1991, there were a total of 349 reported AIDS cases among heterosexual injection users (IDUs) in San Francisco and 1,022 cases among homosexual/bisexual IDUs.¹
- * As of Sept. 30, 1991, injection drug use was associated with at least 12.2% of San Francisco's 11,218 total AIDS cases.²
- * Of the total AIDS cases among heterosexual IDUs, 47% are African-American, 38% are White, 14% are Latino, 1% are Asian/Pacific Islander, and 0.3% are Native American.³
- * Among the homosexual/bisexual IDU AIDS cases, 79% are White, 12% are African-American, 8% are Latino, 0.8% are Asian/Pacific Islander and 0.5% Native American.⁴
- * Among the total 177 female AIDS cases, 42% (75) of the cases are associated with injection drug use.⁵
- * About one-third of a surveyed group of African-Americans who reported intravenous drug use said that they had shared needles with gay IDUs or with people who later developed AIDS or who tested positive for HIV.⁶

HIV SEROPREVALENCE

- * According to the University of California's Urban Health Study, it is estimated that approximately 15% (2,080 IDUs) of San Francisco's 16,000 IDUs are infected with HIV.⁷
- * The same study suggests that HIV infection in the Tenderloin was 24%, in the Western Addition 20%, and at the Haight Ashbury Free Clinic Detoxification unit 7%.⁸
- * Among IDUs entering methadone treatment programs from 1989 to 1991, the overall HIV seroprevalence is 8.6%. Among African-Americans included in this survey, the rate of is 21.5%. For homosexuals and bisexuals it is 31.9%, and among lesbian/bisexual women it is 12.1%.⁹
- * The HIV infection rate for the population of untreated IDUs (approximately 10,000) is estimated to be 16%.¹⁰
- * In 1991, the HIV seroprevalence of heterosexual IDUs in San Francisco was 11%.¹¹
- * In 1990, 673 persons who tested anonymously for HIV infection had injected non-prescription drugs. This represents 5.5% of the entire population of 12,209 who were tested.¹²
- * In 1990, at confidential sites, 141 reported injecting non-prescription drugs. These represent 3.8% of the total 3,647 tested confidentially.¹³

1. San Francisco Department of Public Health, Comprehensive Plan to Reduce the Spread of HIV Infection Among Injection Drug Users (IDUs) in the City and County of San Francisco. January 21, 1992: p. 5.
2. *ibid.*
3. San Francisco Department of Public Health, Comprehensive Plan to Reduce HIV Transmission Among Injection Drug Users in the City and County of San Francisco, December 5, 1992, Community Review Draft: p. 2.
4. *ibid.* page 2.
5. SFDPH, January 21, 1992, p.5.
6. *ibid.*, p.5.
7. Watters J.K., "Meaning and Context: The Social Facts of Intravenous Drug Use and AIDS in the Inner-city," Journal of Psychoactive Drugs. 1988;20:173-177.
8. *ibid.*
9. SFDPH, January 21, 1992, p. 5.
10. *ibid.*, p. 7.
11. *ibid.*, Appendix 4.
12. *ibid.*, p.16.
13. *ibid.*, p.16.

IMPACT OF HIV PREVENTION PROGRAMS ON
INJECTION DRUG BEHAVIOR

(references listed on back)

- * Needle sharing among injection drug users (IDUs) is the primary means of HIV transmission within this population.¹
- * Studies of injection drug users in New York City, San Francisco, and other cities indicate that injection drug users are concerned about AIDS and do change their behavior when offered reasonable strategies to protect themselves in a non-judgmental setting.
 - Early studies among injection drug users before education and prevention programs were started show that a high percentage of IDUs already had considerable knowledge about HIV transmission and also reported some level of behavior change to avoid infection².
 - In San Francisco program evaluation studies published in 1990, injection drug users report using safe needle hygiene behavior (not sharing needles or sterilizing equipment with bleach or through other methods) 80% of the time - up from 13% in previous studies.³
 - Studies among San Francisco injection drug users have found that the percentage of drug users who reported using bleach to sterilize their equipment increased from 3% to 68% after a street outreach program was operating for six months.⁴
 - In a study of injection drug users in San Francisco, easy access to the means to stay safe -- condoms, bleach, and syringes -- was the key factor in the IDU's shift to safer behaviors.⁵

1. Havekos, H.W., 1988. "Overview: HIV Infection Among Injection Drug Abusers in the United States and Europe." National Institute of Drug Abuse Research Monograph Series: 1988 Monograph 80: p.7-17.
2. Selwyn, P.A.; Feiner, C.; Cox, C.P.; Lipschultz, C.; and Cohen, R.L. : "Knowledge About AIDS and High Risk Behavior Among Intravenous Drug Users in New York City." AIDS 1987, 1:247-254.
3. Watters, J.K., Cheng, Y.T., Segal, M., Lorvick, J., Case, P., Taylor, F., Carlson, J. "Epidemiology and Prevention of HIV in Heterosexual IV Drug Users in San Francisco, 1986 through 1989." Oral Presentation at the VI International Conference on AIDS, San Francisco, CA, 1990.
4. Watters, J.K. "Preventing Human Immunodeficiency Virus Contagion Among Intravenous Drug Users: The Impact of Street-based Education on Risk-Behavior." Paper read before the III International Conference on AIDS, Washington, D.C. June 2, 1987.
5. Huang, K.H.C., Watters, J.K., Case, P.; "Compliance with AIDS Prevention Measures Among Intravenous Drug Users: Health Belief or Social/Environmental Factors." Oral Presentation; Fifth International Conference on AIDS, Montreal, Canada. June 4-9, 1989, 3:571-576.

IMPACT OF NEEDLE EXCHANGE PROGRAMS
ON HIV-RELATED INJECTION DRUG BEHAVIOR

(references listed on back)

- * In the United States, needle exchange and/or distribution programs have been operating in New York City, N.Y.; Tacoma and Seattle, Washington; Boston, Massachusetts; Portland, Oregon; Philadelphia, Pennsylvania; Boulder, Colorado; and San Francisco, Santa Cruz, Redwood City, and Berkeley, California. Programs abroad include England, Scotland, the Netherlands, Australia, Switzerland and Sweden.
- * Studies in Europe report that needle exchange programs reduce needle sharing behavior among participating injection drug users (IDUs) and thus the risk of HIV infection.
 - For example, 74% of participants in a needle exchange program in Amsterdam reported that they used needles and syringes only once and then disposed of them. In comparison, only 26% of IDUs who did not participate in the program reported one time needle use.¹
 - In addition, the Amsterdam program reported that only 10% of the participants indicated that they have been involved in needle-sharing in the last month compared to 23% for non-participants.²
 - In London, needle exchange research showed that 55% of participating IDUs had shared needles the year prior to the program, but approximately four months into the program, 89% had not shared needles in the four weeks before the interview.³
 - An evaluation of needle exchange projects in Australia reports that in one program 72% of the participants increased the length of time since they had shared a needle and syringe and, in effect, had not shared since they registered in the exchange program.⁴
 - In England and Scotland, studies show that 79% of the program participants either sustained low risk behavior (nonsharing of needles), adopted low risk behavior, or reduced their level of high risk behavior.⁵

1. Hartgers, C.; Buning, E.C.; van Santen, G.W.; Verster, A.D. and Coutinho, R.A.: "The Impact of the Needle and Syringe-Exchange Programme in Amsterdam on Injecting Risk Behavior." AIDS 1989 3:571-576.
2. *ibid.*
3. Hart, G.; Carvell, A.; Woodward, N.; and et. al.: "Needle-Exchange in Central London: One Year Follow-up" Poster (T.A.O.9) presented at the Fifth International Conference on AIDS, Montreal, Canada, June 1989.
4. Vumbacca G., Milechem B., Wodack A. in Stimson G.V.: "Editorial Review Syringe-Exchange Programmes for Injecting Drug Users." AIDS 1989 3:253-260.
5. Donoghoe, M.C.; Stimson, G.V.; Dolan, K. and Alldritt, L.: "Changes in Risk Behavior in Clients of Syringe-Exchange Schemes in England and Scotland." AIDS 1989;3:261-265.
6. Buning E.C., van Brussel G.H.A., and van Santein G. "Amsterdam's Drug Policy and Its Implications for Controlling Needle Sharing," 1988 National Institute on Drug Abuse Research Monograph Series 80.
7. Donoghoe, M.C. et. al, above.
8. San Francisco Department of Public Health, Comprehensive Plan to Reduce the Spread of HIV Infection Among Injection Drug Users (IDUs) in the City and County of San Francisco. January 21, 1992: p. 20.
9. O'Keefe, E., Kaplan, E., and Khoshnood, K. Preliminary Report: City of New Haven Needle Exchange Program. July 31, 1991.
10. SFDPH, Appendix 1.
11. Stimson G.V., Aldritt L.J., Dolan K.A., Donoghoe M.C., Lart R.A.: "Injecting Equipment Exchange Schemes: Final Report," Monitoring Research Group, Goldsmiths' College, London, England. 1988.
12. New York City Department of Health: "The Pilot Needle Exchange Study in New York City: A Bridge to Treatment. A Report on the First Ten Months of Operation." December 1989.
13. Hagan, H.: "Studies Support Syringe Exchange," Focus: Guide to AIDS Research and Counseling. University of California AIDS Health Project; 3:11:4-6.
14. Personal Communication. Holly Hagan, MPH, Tacoma-Pierce County Health Department, March 2, 1992.
15. Clark, G., Personal Correspondence; Project Coordinator, Prevention Point Research, January 1992.

- * Needle exchange programs have found that the distribution of needles does not increase drug use among participants or within the general population.
 - ~~ In participant follow up studies in Amsterdam, no evidence of increased drug use was found. The estimated number of drug users has remained stable.⁶
 - ~~ In the England and Scotland exchange programs, use of heroin declined from 70% to 57%, as did the mean number of injections per month -- from 53 to 45 injections.⁷
- * Needle exchange programs have emerged in several U.S. cities as effective strategies to combat the spread of HIV in the IDU population.⁸
 - ~~ In August 1991, Yale University released the evaluation of the New Haven needle exchange program showing that the program had effectively reduced HIV transmission by 33%.⁹
 - ~~ As of June 1991, a Tacoma, WA program noticed a substantial decline in HIV infections and in injections with used syringes since August 1988.¹⁰
- * Needle exchange and distribution programs reach injection drug users who have had no contact with existing treatment services and provide an opportunity to refer IDUs to drug treatment services.
 - ~~ In needle exchange programs in England and Scotland, evaluation studies report that 74% of the participants were not currently receiving help or treatment for their drug problems.¹¹
 - ~~ In New York and Washington, needle exchange programs have led drug users to seek treatment.^{12 13}
 - ~~ In Tacoma, Washington, the local needle exchange program is now the largest source of referrals to methadone treatment services.¹⁴

16. Keffelew, A.; Clark, G.; Bacchetti, P.; Osmond, D. and Moss, A.R.: "Use of Needle Exchange Programs By San Francisco Drug Users in Methadone Treatment." Oral Presentation (F.C.107), Sixth International Conference on Needle Exchange, San Francisco, CA, June 1990.
17. Harris, E.; Fullilove, R.; Gross, S.; Fullilove, M.; and Dasher, T.: "Feasibility of Needle Exchange Program In San Francisco: A Survey of Street-based Addicts." Poster Presented (S.C.744) at the Sixth International Conference on AIDS, San Francisco, CA, June 1990.
18. Watters, J.K.; Cheng, Y.T.; Clark, G.L. and Lorvick, J.: "Syringe Exchange in San Francisco: Preliminary Findings" Oral Presentation (Session TH.C.99), Seventh International Conference on AIDS, Florence, Italy, June 20 1991.
19. Drucker, E.: "Through the Eye of the Needle III: In a Dark Season, One Million Points of Light," International Journal of Drug Policy. 2(8).
20. Guydish, J.; Clark, G.; Garcia, D.; Downing, M.; Case, P. and Sorenson, J.L.: "Evaluating Needle Exchange: Do Distributed Needles Come Back?" American Journal of Public Health. 81:5 p1-3.
21. Watters, J.K.; et. al above.
22. Clark, G.; Garcia, D.; Guydish, J. and Case, P: "Street-Based Survey of Needle Exchange Clients." Poster presented Seventh International Conference on AIDS, Florence, Italy, June 1991.
23. ibid.
24. ibid.
25. Watters, J.K.; et. al above.
26. Bucardo, J.; Guydish, J.; Young, M.; Grinstead, O.; Woods, W. and Clark, W.: "Evaluating Negative Effects of Needle Exchange Using Drug Treatment Data." Paper presented at the California AIDS/HIV Conference, San Francisco, CA, October 1991.

- * Prevention Point Needle Exchange has operated in San Francisco since November, 1988. The program now exchanges approximately 12,000 syringes each week with 750 IDUs in five neighborhoods; the Tenderloin, the Mission, the Lower Haight, Polk Gulch and Mission and Sixth St.. Each site is open two hours a week.¹⁵ Studies of Prevention Point report:
 - 76% of a sample of IDUs attending methadone treatment in San Francisco in 1989 reported injecting within the last month implying the continued need for drug treatment as well as needle exchange programs.¹⁶
 - 90% of IDUs surveyed indicated that they would be willing to participate in a needle exchange program.¹⁷
 - By late 1990, 43% of the injection drug users in a San Francisco study stated they usually obtained their clean syringes from Prevention Point.¹⁸
 - The current program is estimated to reach as much as 15% of San Francisco's estimated 16,000 IDUs.¹⁹
 - As many as 50% of the injection drug users that come to the exchange will return within two weeks.²⁰
 - Regular attenders of the exchange are 1/3 less likely to share syringes than those who do not attend.²¹
 - 80% of a sample of needle exchange users had no risk for HIV through injection practices (64% never shared, 26% always bleached if sharing).²²
 - 70% of the needle exchange users are not in treatment.²³
 - 56% of the exchange users were also exchanging for other injection drug users.²⁴
- * One study addressed the possible negative impacts of exchange. Conclusions were as follows:
 - As a daily average, the number of injections declined from 2.2 to 0.7 over the five year period.
 - The average age of the drug users rose from 34 years in 1986 to 40 years in 1990. (Although new users did adopt injection practices during this period, there was no increase in the rate that new young users began injection drug use).²⁵
 - Similar findings were found by examining data drawn from injection drug users admitted to treatment.²⁶



MEMORANDUM

Date: October 2, 1992

To: Needle Exchange Working Group, Other Interested Individuals

From: Regina Aragón, State Policy Coordinator

Re: GOVERNOR WILSON'S VETO OF NEEDLE EXCHANGE LEGISLATION (AB 2525/SB 1418)

Governor Wilson's veto message, enclosed for your review, speaks for itself. Though we are all a bit stunned by the callous disregard with which the Governor has vetoed AB 2525 and SB 1418, perhaps it would have been easier had Governor Wilson not chosen to hide behind the ridiculous and completely unsubstantiated fears of the Office of National Drug Control Policy and the shallow argument that there is insufficient evidence to demonstrate the efficacy of needle exchange. By relying on such weak reasoning, Governor Wilson has shut his eyes to the reality of thousands of men, women and children who continue to be at risk for HIV infection through injection drug use.

Governor Wilson talks the talk in his veto message, but the reality of a terribly underfunded system of HIV prevention, care and treatment services and the lack of drug treatment on demand speaks louder than words.

If you're angry about Governor Wilson's veto of AB 2525 and SB 1418, please come to Sacramento on Thursday, October 8th for a 12:00 noon rally/demonstration on the north steps of the State Capitol.

Join thousands of other activists -- and many who until recently have not considered themselves as such -- in a massive protest against Governor Wilson's veto of this and other bills, his drastic cuts in health and welfare programs, and his vision for California.

Bus transportation from San Francisco to Sacramento may be available provided we get a head count by Tuesday, October 6th at 12:00 noon. If you need bus transportation, please call me ASAP at 864-5855, ext. 2599.

On behalf of the San Francisco AIDS Foundation, I want to thank you for all the time and energy you have committed to this project over the past year. Though we are not yet sure of the next step, the AIDS Foundation looks forward to continuing our work with you toward the ultimate goal of a fully sanctioned needle exchange program in California.

LEGISLATIVE FACT SHEET

BILL NO: ASSEMBLY BILL 2525 - AS AMENDED JUNE 22, 1992

AUTHOR: ASSEMBLY SPEAKER WILLIE L. BROWN, JR.

COAUTHORS: WATSON (PRINCIPAL), ARCHIE-HUDSON, BANE, BATES, BURTON, CHACON, FARR, FILANTE, HUGHES, LEE, MOORE, MURRAY, ROYBAL-ALLARD, SPEIER, VASCONCELLOS, MARKS, PETRIS, TORRES

PURPOSE:

The purpose of this bill is to slow the spread of human immunodeficiency virus (HIV) disease and AIDS by permitting the development of needle exchange programs, thus reducing the use of intravenous injection equipment contaminated with HIV.

WHAT THE BILL DOES:

This bill establishes a three-year Clean Needle and Syringe Exchange Pilot Project. Specifically, the bill:

- 1) Requires the Department of Health Services (DHS) to authorize a clean needle and syringe exchange pilot project in the City and County of San Francisco, upon request of the board of supervisors, the Mayor and the local health officer.
- 2) Permits DHS to authorize additional counties and cities with a public health department to develop a pilot project upon the request of specified local officials.
- 3) Requires the local health department to consult with DHS, the Department of Alcohol and Drug Programs, and the University of California.
- 4) Requires each pilot project to include, at a minimum:
 - a) A set of operating procedures for the exchange of hypodermic needles and syringes, to be developed by the local health officer and approved by DHS.
 - b) A data base and collection of data.
 - c) Community outreach and preventive education that is culturally sensitive and linguistically appropriate.
 - d) An effort to secure drug treatment for participants in the project who request such treatment.
 - e) Involvement of the local community, including law enforcement officials, in the development and assessment of the project.

- f) Accessibility of the project to the target population while being sensitive to community concerns.
 - g) Staff expertise in working with injection drug users and training in providing community referrals, needle hygiene and safety precautions.
 - h) Enhanced treatment capacity for injection drug users.
 - i) Preferential acceptance of HIV-infected drug users into drug treatment programs.
- 5) Requires the pilot project to be part of a network of voluntary and confidential HIV services, where available, including, but not limited to:
- a) Anonymous HIV antibody testing
 - b) Counseling
 - c) Voluntary, anonymous or confidential partner notification
 - d) Early intervention and ongoing primary medical care follow-up for infected persons and their partners
 - e) Social services to support families of HIV-infected drug users.
- 6) Provides that all components of the pilot project be voluntary. Services other than the exchange of needles would be confidential and anonymous, as provided in existing law. All information that personally identifies any person served by the project must remain confidential and could not be released to any person or agency not participating in the pilot project without the person's written consent.
- 7) Requires the pilot project to be terminated if the local health officer determines that it is increasing drug use and the spread of HIV.
- 8) Allows a pharmacist, physician, surgeon or other person designated to distribute hypodermic needles as part of an authorized pilot project to furnish hypodermic needles and syringes without a prescription or permit.
- 9) Requires a written progress report to DHS, the Governor, and the Legislature one year after the pilot project begins and a final report by April 15, 1995. The report must include an assessment of the components of the pilot project by the participating counties or cities. This could be accomplished through an individual or group contract with UC. The evaluation would include at least four of the following measures:
- a) Incidence of HIV
 - b) Needle exchange rates
 - c) Change in level of drug use

- d) Change in level of needle sharing
- e) Change in use of condoms
- f) Change in use of bleach
- g) Program participation rates
- h) Number of participants entering substance abuse treatment
- i) Status of treatment and recovery of those entering treatment.

10) Sunsets January 1, 1996.

BACKGROUND:

This bill is the result of the combined efforts of the City and County of San Francisco and the San Francisco AIDS Foundation. The Foundation and the city brought together experts in drug abuse and HIV infection, members of the medical community, pharmacists, local health officers, representatives from local communities and from communities of color, politicians, law enforcement representatives, activists and university researchers to draft this measure.

Clean needle exchange programs, and let us emphasize exchange, i.e., a clean needle is not provided unless a needle is returned, have been shown to be an effective tool in lessening the risk of HIV infection among injection drug users and a successful bridge to drug treatment, HIV services and other primary health care services.

As of September 1992, 32% of the 195,718 reported cases of AIDS in the United States were associated with injection drug use. Of the 10,989 cases of AIDS presumed to have been transmitted through heterosexual sex, 53% were among the sexual partners of injection drug users. Of the 3,312 cases of pediatric AIDS cases related to a mother with or at risk for HIV infection, 70% were related to injection drug use.

Successful and sustained risk reduction among injection drug users is vital to slowing the spread of HIV infection.

The National Commission on AIDS, in its report, Americans Living with AIDS, recognizes the efficacy of needle and syringe exchange programs as a means of encouraging injection drug users to join treatment programs.

According to the Commission:

"Drug users know a great deal about how HIV is transmitted and are willing to make the changes necessary to reduce risk of transmission when encouraged to do so. There is evidence that HIV prevention strategies targeting injection drug users can result in decreased needle sharing, increased needle cleaning, increased demand for sterile needles on the street, and stable or declining seroprevalence rates among drug users."

The Commission also reports that, "Fears that needle and syringe exchange and distribution programs might encourage drug use and create a new class of drug injectors have not materialized."

Finally, the Commission recommends that laws and regulations that block implementation and study of needle and syringe distribution programs be repealed.

In the United States, needle exchange and/or distribution programs have been established in New York City, Tacoma, Seattle, Boston, Portland, Oregon, Philadelphia, Pennsylvania, Boulder, San Francisco, Santa Cruz, Redwood City, and Berkeley. Programs abroad include England, the Netherlands, Australia, Switzerland and Sweden.

A recent study by the Yale University Medical School reports that in New Haven, Connecticut, the HIV infection rate fell by one-third in just eight months after sterile hypodermic syringes were distributed to drug users. Needle exchange reduced the time that dirty needles were in circulation. Preliminary findings showed that the average time of circulation dropped from 2-1/2 weeks to six days. The percentage of needles found to be contaminated also fell, from 67.5% to 40%. Moreover, the needle exchange program increased the number of persons entering and seeking drug abuse treatment. Researchers estimate that the ultimate results in New Haven would be a 33% reduction in new AIDS cases.

A public health survey in Tacoma, Washington, indicates that nine out of 10 addicts no longer share needles. In Liverpool, England, data on the first three years of their needles exchange program show that not a single one of more than a thousand addicts receiving clean needles got infected with HIV.

A study of injection drug users in San Francisco found that the percentage of drug users who reported using bleach to sterilize their equipment increased from three percent to 61% after a street outreach program was in operation for only six months, and to 86% after two years.

Currently, only 11 states criminalize the furnishing, possession or use of hypodermic needles or syringes without a prescription. Four of these have enacted legislation or waived the prohibition administratively to permit the development of needle exchange programs. Of the remaining states, California has the highest seroprevalence rate of HIV infection. For example, according to the San Francisco Department of Public Health, one in 25 San Franciscans -- 28,000 people -- are infected with HIV, including one in eight drug users. An additional 1,000 residents will become infected this year.

SUPPORT LIST:

City and County of San Francisco (sponsor)
San Francisco AIDS Foundation (sponsor)
ACT-UP Golden Gate
ACT-UP San Francisco
AIDS Foundation San Diego
AIDS Project Advocacy Services, Los Angeles
AIDS Project Los Angeles

AIDS Service Providers Association of the Bay Area
Alameda County Board of Supervisors
American Civil Liberties Union
American College of Obstetricians and Gynecologists
American Foundation fo AIDS Research
American Indian AIDS Coalition
Asian/Pacific AIDS Coalition
Asian Pacific Lesbians & Gays, Inc.
Association of Bay Area Health Officers
Bay Area Physicians for Human Rights
Bay Area Reporter
California Academy of Physician Assistants
California AIDS Intervention Training Center
California AIDS Leadership Committee
California Association of AIDS Agencies
California Association of County Drug and Alcohol Program Administrators
California Conference of Local Health Officers
California Medical Association
California Nurses Association
California Pharmacists Association
California State Association of Counties
Children's Hospital of Los Angeles
City of Angels Hospice
City of Berkeley
City of West Hollywood
Community Consortium
Community Housing Services, Pasadena
County Health Executives Association of California
County of Santa Cruz
Didi Hirsch Community Mental Health Center
Homeless Health Care, Los Angeles
Kaiser Permanente, Oakland
Lambda Letters Project
Latino Caolition on AIDS/SIDA
LIFE AIDS Lobby
Los Angeles Times
Marin County Board of Supervisors
Marin County Pharmaceutical Association, AIDS Task Force
Minority A.I.D.S. Project, Los Angeles
Mobilization Against AIDS
Modesto Bee
Monterey County AIDS Project
Monterey County Board of Supervisors
National AIDS Brigade
National Council on Alcoholism and Drug Dependence
National Commission on AIDS
Oakland Tribune
Pacific Avenue Substance Abuse Clinic, Glendale
Pharmacists Planning Service Inc.
Planned Parenthood Affiliates of California
Sacramento Bee
Salinas Californian
San Francisco Black Coalition on AIDS

San Francisco Examiner
San Francisco Medical Society
San Francisco Sentinel
San Mateo County Board of Supervisors
Santa Cruz AIDS Project
Santa Cruz County Board of Supervisors
Santa Cruz County Public Health Commission
Santa Cruz Sentinel
Stockton Record
Tarzana Treatment Center
Union of Physicians and Dentists
18th Street Services, San Francisco
234 letters from individual citizens

6/22/92:PSK

AMENDED IN ASSEMBLY MARCH 9, 1992

CALIFORNIA LEGISLATURE—1991-92 REGULAR SESSION

ASSEMBLY BILL

No. 2525

Introduced by Assembly Member Brown

(Principal coauthor: Senator Watson)

(Coauthors: Assembly Members *Archie-Hudson, Bane, Bates, Burton, Chacon, Farr, Filante, Hughes, Lee, Moore, Murray, Roybal-Allard, Speier, and Vasconcellos*)

(Coauthors: Senators *Deddeh, Marks and Petris, Petris, and Torres*)

February 6, 1992

An act to amend Section 4146 of the Business and Professions Code, and to add and repeal Chapter 1.18 (commencing with Section 199.83) of Part 1 of Division 1 of the Health and Safety Code, relating to AIDS.

LEGISLATIVE COUNSEL'S DIGEST

AB 2525, as amended, Brown. AIDS: Clean Needle and Syringe Exchange Pilot Project.

Existing law authorizes pharmacists and physicians to furnish hypodermic needles and syringes without a prescription or permit for human use in the administration of insulin or adrenaline.

This bill would establish the Clean Needle and Syringe Exchange Pilot Project, and would authorize pharmacists, physicians, and certain persons authorized under the pilot project to furnish hypodermic needles and syringes without a prescription or permit as prescribed through the pilot project.

This bill would state the findings and declarations of the Legislature regarding infection with the human immunodeficiency virus (HIV), and development of

acquired immune deficiency syndrome (AIDS) among injection drug users.

This bill would require the State Department of Health Services to authorize a pilot project in the City and County of San Francisco upon the request of the San Francisco County Board of Supervisors, the Mayor of San Francisco, and the local health officer. This bill would permit the department to authorize additional counties, cities, or cities and counties to develop a pilot project upon the prescribed request of that county, city, or city and county and local health officer.

This bill would enumerate the components of the pilot project, and would require that the pilot project be part of a network of voluntary and confidential services where available. This bill would require that the county, city, or city and county participating in the pilot project assess the project using certain criteria, and submit a *progress report and a final report including that take into consideration* data from the assessment to the State Director of Health Services, the Governor, and the chairpersons of both health committees of the Legislature.

This bill would provide that if the local health officer determines the pilot project has a detrimental effect on drug use and the increased spread of HIV, the project is to be terminated.

This bill would repeal the pilot project on January 1, 1996.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. The Legislature hereby finds and
2 declares all of the following:

3 (a) The rapidly spreading acquired immune
4 deficiency syndrome (AIDS) epidemic poses an
5 unprecedented public health crisis in California, and
6 threatens, in one way or another, the life and health of
7 every Californian.

8 (b) Injection drug users are the second largest group
9 at risk of becoming infected with the human ~~immune~~
10 ~~deficiency~~ immunodeficiency virus (HIV) and

1 developing AIDS, and they are the primary source of
2 heterosexual, female, and perinatal transmission in
3 California, the United States, and Europe.

4 (c) According to the State Office of ~~Aids~~ AIDS,
5 injection drug use has recently emerged as one of the
6 most prevalent risk factors for new AIDS cases in
7 California.

8 (d) Studies indicate that the lack of sterile needles
9 available on the streets, and the existence of laws
10 restricting needle availability promote needle sharing,
11 and consequently the spread of HIV among injection
12 drug users. The sharing of contaminated needles is the
13 primary means of HIV transmission within the injection
14 drug user population.

15 (e) As of September 1991, 32 percent of the 195,718
16 reported cases of AIDS in the United States were
17 associated with injection drug use. Of the 10,989 cases of
18 AIDS presumed to be transmitted through heterosexual
19 sex, 53 percent of the cases occurred among the sexual
20 partners of injection drug users. Of the 3,312 pediatric
21 AIDS cases related to a mother with or at risk for HIV
22 infection, 70 percent were related to injection drug use.
23 The number of reported AIDS cases reflects only a
24 fraction of the total number of persons infected with HIV.

25 (f) An estimated 11.7 percent, 6.2 percent, and 5.5
26 percent of injection drug users entering methadone
27 treatment programs between 1989 and 1991 in Contra
28 Costa, San Mateo, and Alameda Counties, respectively,
29 were infected with HIV. Public health officials generally
30 consider the seroprevalence rates of those entering
31 treatment to be significantly lower than the true rate of
32 HIV infection among the injection drug user population
33 as a whole. For example, in San Francisco where data was
34 collected over the same period, the seroprevalence rate
35 of those entering treatment was 8.3 percent compared to
36 15 percent among the estimated 16,000 injection drug
37 user population.

38 (g) Most injection drug users use a variety of drugs.
39 ~~including~~ : mainly heroin and cocaine. Recent federal
40 drug abuse surveys indicate that cocaine has replaced

1 heroin as the injection drug user's drug of choice.
 2 Because cocaine-injecting drug users inject more
 3 frequently than heroin users, their risk for HIV infection
 4 is higher.

5 (h) Studies of injection drug users in New York, New
 6 York; San Francisco, California; Tacoma, Washington;
 7 Boulder, Colorado; Portland, Oregon; and other cities in
 8 the United States indicate that injection drug users are
 9 concerned about AIDS and do change their behavior
 10 when offered, in a nonjudgmental setting, reasonable
 11 strategies to protect themselves. A San Francisco study of
 12 injection drug users found that the percentage of drug
 13 users who reported using bleach to sterilize their
 14 equipment increased from 3 percent to 61 percent after
 15 a street outreach program was in operation for six months
 16 and to 86 percent after two years.

17 (i) A study by Yale University of a needle exchange
 18 program in New Haven, authorized by the Connecticut
 19 Legislature in 1990, estimates that in the first eight
 20 months of operation, the program reduced new HIV
 21 infections by 33 percent.

22 (j) California is one of 11 states that criminalizes the
 23 furnishing, possession, or use of hypodermic needles or
 24 syringes without a prescription. Of these 11 states, four
 25 have either passed legislation or waived the prohibition
 26 through administrative action over the last several years
 27 to permit the development of needle exchange
 28 programs. California has the highest seroprevalence rate
 29 of HIV infection of any state that has not waived the
 30 prohibition or adopted a statute to permit needle
 31 exchange programs.

32 SEC. 2. Section 4146 of the Business and Professions
 33 Code is amended to read:

34 4146. (a) Notwithstanding any other provision of
 35 law, a pharmacist or physician may, without a
 36 prescription or a permit, furnish hypodermic needles and
 37 syringes for human use in the administration of insulin or
 38 adrenaline; a pharmacist or veterinarian may, without a
 39 prescription or permit, furnish hypodermic needles and
 40 syringes for use on poultry or animals; and a person may,

1 without a prescription or permit, obtain hypodermic
 2 needles and syringes from a pharmacist or physician for
 3 human use in the administration of insulin or adrenaline,
 4 or from a pharmacist, veterinarian, or permit holder, for
 5 use on poultry or animals; if all of the following
 6 requirements are met:

7 (1) No needle or syringe shall be furnished to a person
 8 who is unknown to the furnisher and unable to properly
 9 establish his or her identity.

10 (2) The furnisher, at the time furnishing occurs, makes
 11 a record of the furnishing in the manner required by
 12 Section 4147.

13 (b) Notwithstanding any other provision of law, a
 14 pharmacist, physician, or other person designated under
 15 the operating procedures developed pursuant to
 16 paragraph (1) of subdivision (b) of Section 199.84 of the
 17 Health and Safety Code may furnish hypodermic needles
 18 and syringes without a prescription or permit when
 19 operating under the pilot project established pursuant to
 20 Chapter 1.18 (commencing with Section 199.83) of Part
 21 1 of Division 1 of the Health and Safety Code.

22 SEC. 3. Chapter 1.18 (commencing with Section
 23 199.83) is added to Part 1 of Division 1 of the Health and
 24 Safety Code, to read:

25 26 CHAPTER 1.18. CLEAN NEEDLE AND SYRINGE 27 EXCHANGE PILOT PROJECT 28

29 199.83. (a) The Legislature finds and declares that
 30 scientific data from needle exchange programs in the
 31 United States and in Europe have shown that the
 32 exchange of used hypodermic needles and syringes for
 33 clean hypodermic needles and syringes does not increase
 34 drug use in the population, can serve as an important
 35 bridge to treatment and recovery from drug abuse and
 36 can curtail the spread of human immunodeficiency virus
 37 (HIV) infection among the intravenous drug user
 38 population.

39 (b) In order to attempt to reduce the spread of HIV
 40 infection among the intravenous drug user population

1 within California, the state department shall authorize a
 2 clean needle and syringe exchange pilot project pursuant
 3 to this chapter in the City and County of San Francisco
 4 upon the request of the San Francisco County Board of
 5 Supervisors, the Mayor of San Francisco, and the local
 6 health officer.

7 (c) The state department may authorize additional
 8 *clean needle and syringe exchange* pilot project sites
 9 upon the request of a county board of supervisors and the
 10 local health officer of that county, or upon the request of
 11 the city council, the mayor, and the local health officer of
 12 a city with a health department.

13 ~~199.84. (a) If the local health officer of a county and~~
 14 ~~the board of supervisors, or the city council, the mayor,~~
 15 ~~and the local health officer of a city with a health~~
 16 ~~department requests authorization, the state department~~
 17 ~~may authorize the local health officer to establish a clean~~
 18 ~~needle and syringe exchange pilot project pursuant to~~
 19 ~~this chapter.~~

20 ~~(b)~~

21 (d) Authorization by the state department shall be
 22 based upon a proposed project as described in Section
 23 199.84.

24 199.84. (a) A city and county, or a county, or a city
 25 with a health department that receives the department's
 26 authorization pursuant to this chapter shall, in
 27 consultation with the state department, the State
 28 Department of Alcohol and Drug Programs, the local
 29 alcohol and drug administrator, and the University of
 30 California, conduct a pilot project on the exchange of
 31 clean hypodermic needles and syringes as part of a
 32 network of comprehensive services, including treatment
 33 services, to combat the spread of HIV infection among
 34 injection drug users. The pilot project shall include, but
 35 not be limited to, all of the following:

36 (1) The development of a set of operating procedures
 37 by the local health officer for the furnishing and
 38 exchange of hypodermic needles and syringes for
 39 injection drug users and the approval of the operating
 40 procedures by the state department.

1 (2) The development of a data base and collection of
 2 data relating to the furnishing and exchanging of clean
 3 hypodermic needles and syringes to injection drug users
 4 by persons designated in the operating procedures
 5 developed pursuant to paragraph (1).

6 (3) The provision of community outreach and
 7 preventive education that is culturally sensitive and
 8 linguistically appropriate to reduce project participants'
 9 exposure to HIV infection.

10 (4) ~~An~~ A demonstrated effort to secure treatment for
 11 drug addiction for participants upon their request.

12 (5) The involvement of the community in the
 13 development of the program and assessment design.

14 (6) The involvement of local public safety officials in
 15 the development of the program and assessment design.

16 (7) Accessibility of the project to the target population
 17 while being sensitive to community concerns.

18 (8) Appropriate levels of staff expertise in working
 19 with injection drug users and adequate staff training in
 20 providing community referrals, needle hygiene, and
 21 safety precautions.

22 (9) Enhanced treatment capacity, insofar as possible,
 23 for injection drug users.

24 (10) Preferential acceptance, insofar as possible, of
 25 HIV-infected drug users into drug treatment programs.

26 ~~(e)~~

27 (b) The pilot project authorized pursuant to this
 28 chapter shall be part of a network of voluntary and
 29 confidential HIV services, where available, including, but
 30 not limited to, all of the following:

31 (1) Anonymous HIV antibody testing :

32 ~~(2) Counseling.~~

33 ~~(3) Voluntary and counseling.~~

34 (2) Notwithstanding Section 199.25, voluntary,
 35 anonymous, or confidential partner notification.

36 ~~(4)~~

37 (3) Early intervention and ongoing primary medical
 38 care followup for infected persons and their partners.

39 ~~(5)~~

40 (4) Social services to support families of HIV-infected

1 drug users.

2 ~~(d)~~

3 (c) Components of the pilot project authorized
4 pursuant to this chapter shall be assessed *as to their*
5 *effectiveness* by the participating ~~counties or cities~~ *city*
6 *and county, county, or city*. Participants may individually
7 or as a group contract with the University of California to
8 assess the pilot project. Assessment ~~may include~~
9 ~~measures of exchange rates, behavioral changes such as~~
0 ~~change in level of drug use, level of needle sharing, use~~
1 ~~of condoms and bleach, program participation rates and~~
2 ~~the number of participants entering treatment and the~~
3 ~~status of their treatment and recovery.~~

4 ~~(e)~~ shall include, but not be limited to, at least four of
5 the following measures:

- 6 (1) Needle exchange rates.
- 7 (2) Change in level of drug use.
- 8 (3) Change in level of needle sharing.
- 9 (4) Change in use of condoms.
- 0 (5) Change in use of bleach.
- 1 (6) Program participation rates.
- 2 (7) The number of participants entering treatment.
- 3 (8) The status of treatment and recovery of those
4 entering substance abuse treatment programs.

5 (d) All components of the pilot project authorized
6 pursuant to this chapter shall be voluntary. Where
7 persons are provided services as a part of the pilot project
8 other than the furnishing or exchange of needles,
9 including, but not limited to, antibody testing,
0 counseling, or medical or social services, those provisions
1 of law governing the confidentiality and anonymity of
2 that information shall apply. All information obtained in
3 the course of implementing the pilot project that
4 personally identifies any person to whom needle
5 furnishing and exchange services are provided shall
6 remain confidential and shall not be released to any
7 person or agency not participating in the pilot project
8 without the person's written consent.

9 ~~(f)~~

0 (e) If the local health officer determines that the pilot

1 project has a detrimental effect in terms of increased
2 drug use and the increased spread of HIV, the project
3 shall be terminated.

4 ~~(g)~~

5 (f) No provision of this section shall apply to the
6 University of California unless the Regents of the
7 University of California by resolution enacted by January
8 31, 1993, make that provision so applicable.

9 ~~(h)~~

10 (g) A city and county, county, or city with a health
11 department entering into the pilot project, shall submit
12 a ~~written~~ progress report one year from the project's
13 inception, ~~including and a final report on or before April~~
14 ~~15, 1995. The reports shall take into consideration~~
15 ~~available data on factors listed in subdivision (d) of~~
16 ~~Section 199.84 (c).~~ The report shall be submitted to the
17 State Director of Health Services, the Governor, and the
18 chairs of both health committees of the Legislature.

19 199.85. This chapter shall remain in effect only until
20 January 1, 1996, and as of that date is repealed, unless a
21 later statute, which is enacted on or before January 1,
22 1996, deletes or extends that date.

O

**The Harvey Milk Progressive Democratic Club,
the San Francisco AIDS Foundation,
18th Street Services, and
AIDS Legal Referral Panel**

invite you to attend an

HIV/AIDS Forum for Board of Supervisors Candidates

DATE: Wednesday, October 21, 1992

TIME: 8:00 - 10:00 PM

**PLACE: The Women's Building
3543 18th Street
(between Valencia and Guerrero)**

The format for the evening will include an opening statement by each candidate, a round of questions from the panelists, and questions from the audience.

Panel members include:

**Pat Dunn, San Francisco AIDS Foundation
Ken Jones, STOP AIDS Project
Steve Lew, GAPA
Mike Shriver, 18th St. Services
Laura Thomas, ACT-UP San Francisco**

The purpose of this forum is to provide an opportunity for the community to hear and question the people who wish to represent them on the Board of Supervisors. With AIDS funding and services being seriously threatened, it is vital for the community to be well informed regarding these issues. We hope you will be able to attend.

DAVE -- PLEASE USE THE "ALT M" FUNCTION TO CREATE THIS MEMO
AND USE COLORED PAPER -- MUCH THANKS, REGINA.
MEMORANDUM

TO: Needle Exchange Working Group, Other Interested
Individuals

FR: Regina Aragon, State Policy Coordinator

DATE: October 1, 1992

RE: (BOLD) GOVERNOR WILSON'S VETO OF NEEDLE EXCHANGE
LEGISLATION (AB 2525/ SB 1418)

Governor Wilson's veto message, enclosed for your review, speaks for itself. Though we are all a bit stunned by the callous disregard with which the Governor has vetoed AB 2525 and SB 1418, perhaps it would have been easier had Governor Wilson not chosen to hide behind the ridiculous and completely unsubstantiated fears of the Office of National Drug Control Policy and the shallow argument that there is insufficient evidence to demonstrate the efficacy of needle exchange. By relying on such weak reasoning, Governor Wilson has shut his eyes to the reality of thousands of men, women and children who continue to be at risk for HIV infection through injection drug use.

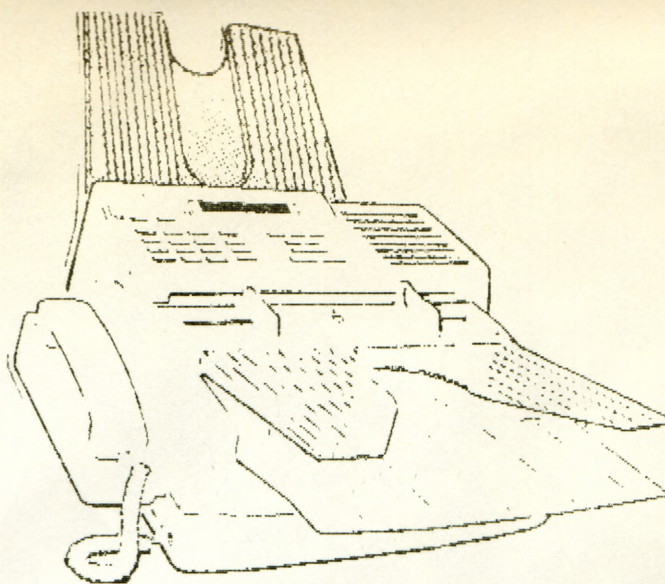
Governor Wilson talks the talk in his veto message, but the reality of a terribly underfunded system of HIV prevention, care and treatment services and the lack of drug treatment on demand speaks louder than words.

(BOLD) If you're angry about Governor Wilson's veto of AB 2525 and SB 1418, please come to Sacramento on Thursday, October 8th for a 12:00 noon rally/demonstration on the north steps of the State Capitol.

Join thousands of other activists -- and many who until recently have not considered themselves as such -- in a massive protest against Governor Wilson's veto of this and other bills, his drastic cuts in health and welfare programs, and his vision for California.

(BOLD) Bus transportation from San Francisco to Sacramento may be available provided we get a head count by Tuesday, October 6th at 12:00 noon. If you need bus transportation, please call me ASAP at 8684-5855, x2599.

(NOT BOLD) On behalf of the San Francisco AIDS Foundation, I want to thank you for all the time and energy you have committed to this project over the past year. Though we are not yet sure of the next step, the AIDS Foundation looks forward to continuing our work with you towards the ultimate goal of fully sanctioned needle exchange program in California.

TO: 1 Dave Robb , SF AIDS FoundationLOCATION: TELEPHONE: (415) 864-5855, X 2544FAX #: (415) 552-9762DATE: 10/1/92TIME: 1:00 pm (West Coast)Number of Pages: 2

(Including cover sheet)

FROM: Rogina AragonTELEPHONE:

FAX #: 483 0578

COMMENTS: Dave - If this can go out today to
needle lists + SF list + Roundtable with
"Urgent" stamped across the top (stamp
on my desk) That would be super.
If not, Friday's a must.

Thanks you

FIGHTING FEAR WITH FACTS

THE RELATIONSHIP BETWEEN DRUG USE, HIV AND NEEDLE EXCHANGE

AB 2525, introduced by Assembly Speaker Willie Brown and co-sponsored by the San Francisco AIDS Foundation and the City and County of San Francisco, proposes a three year clean needle and syringe exchange pilot program to reduce HIV transmission among injection drug users (IDUs), their sexual partners and children.

As members of the Legislature consider AB 2525, the co-sponsors of the bill ask you to fight fear with the facts. The life-saving nature of this public health intervention requires you to do no less.

Myth #1: Needle exchange may increase drug use by increasing the number of injection drug users.

There is no disputing that drug use takes a major toll on the health and safety of individuals, families and entire communities. The fear of increased drug use resulting from needle exchange is therefore a legitimate question for policy makers to ask. Fortunately, policy makers have available to them a number of studies that show no increase in drug use among current users and no increase in the number of new users as a result of exchange.

Since 1986, two years prior to the establishment of San Francisco's exchange, Prevention Point, the Urban Health Study at UC San Francisco has studied drug use patterns among out of treatment injection drug users. In 1991, the Urban Health Study concluded that as a daily average, the number of injections by users, in fact, declined from 2.2 to 0.7 over a five year period. In addition, the average age of drug users rose from 34 years in 1986 to 40 years in 1990. If needle exchange leads to the recruitment of new and younger users, one would expect the average age of the drug using population to decline or level off. In fact, the rate at which new users began injecting did not change despite the availability of clean needles through Prevention Point. Similar findings were found by examining data drawn from injection drug users admitted to drug treatment programs.

Myth #2: AB 2525 would result in the furnishing, rather than the one-to-one exchange of needles and syringes, thereby leading to an increase in the number of needles and syringes in circulation.

The language in AB 2525 mirrors existing law which prohibits the "furnishing" of hypodermic needles and syringes without a prescription or permit except under limited circumstances (Sec. 4146 of the Business and Professions Code). The intent of the legislation, as described in the author's legislative fact sheet and discussed in Committee, is to allow for the **one-to-one exchange** of used needles and syringes for clean ones within the context of a well-structured pilot program. Prevention

Point and other needle exchange programs now in existence operate on a **one-to-one exchange** basis, resulting in no increase in the number of needles and syringes in circulation. In fact, by placing a premium on used syringes, needle exchange can lead to fewer discarded needles and syringes in public areas such as parks and streets.

Myth #3: Needle exchange will lead to the downgrading of law enforcement efforts in California.

While decriminalizing the exchange of needles and syringes within the context of a pilot program, AB 2525 does not decriminalize possession of drugs or syringes by drug users. Law enforcement officials would retain their legal authority to arrest and prosecute drug users for these offenses. In order to ensure the cooperation of local public safety officials, AB 2525 specifically requires that they be involved in the design and assessment of the pilot program. Former Police Chief and Mayor of San Francisco Frank Jordan strongly endorses AB 2525 and refutes claims by opponents that needle exchange compromises law enforcement efforts.

Myth #4: Needle exchange sends the wrong message to drug users -- the acceptance of drug use in society.

The health and safety problems associated with drug use are well documented. Needle exchange, while not condoning drug use, recognizes that it exists and attempts to minimize the harm to the individual and society that is associated with such use. The primary educational message of the program is that there is a deadly connection between shooting drugs and acquiring HIV/AIDS. By requiring programs to make a demonstrated effort to secure voluntary drug treatment services for clients, AB 2525 recognizes that needle exchange is just one part of a comprehensive approach to the problem of HIV among injection drug users. AB 2525 also recognizes needle exchange as an important bridge to substance abuse treatment services. In Tacoma, Washington, for example, the government sponsored needle exchange program is now the largest source of referrals to the local drug treatment program.

AB 2525 has been endorsed by a number of professional groups that are intimately involved in the fight against drug use and addiction including but not limited to: the California Association of County Drug Program Administrators, the National Council on Alcoholism and Drug Dependence of California, the California Medical Association and the California Nurses Association.

Myth #5: Needle exchange will lead to increased criminal activity associated with illegal drug use.

The link between illegal drug use, violence and criminal activity is undisputed. Rather than exacerbating this problem, by serving as a bridge to voluntary drug treatment services, needle exchange could, in fact, contribute to a reduction in the incidence of crime associated

with drug use. At worst, needle exchange would have a neutral effect on crime, while at the same time it would result in reduced HIV transmission infection among injection drug users, their partners and children. In the end, needle exchange must be viewed as a public health, and not a public safety issue.

Myth #6: Educational programs targeting injection drug users have been successful in teaching IDUs to use bleach to sterilize needles, thereby eliminating the need for needle exchange.

So called "bleach and teach" programs encourage drug users to avoid injecting drugs and sharing needles, but teaches them how to clean their works with bleach should they continue to practice this high risk behavior. Despite the success of these programs, there remains a group of hard to reach drug users who do not use bleach consistently, thereby requiring the use of a variety of interventions, including exchange. In addition, according to one study, the use of bleach actually shortens the useful life of the syringe, resulting in clogged and dull syringes that will more likely be discarded in public areas such as streets and parks. Considering that the syringes used by drug injectors are designed to be single use disposable syringes, simply providing bleach is not enough to ensure consistently safe needle hygiene and disposal. Moreover, given the fact that exchange participants are largely out of treatment drug users, regular contact with needle exchange program staff often represents the only link this population has with the larger public health system.

Myth #7: There have been no studies showing the effect of needle exchange on drug use patterns.

Since 1986, the Urban Health Study at the University of California, San Francisco has surveyed injection drug users to document drug use patterns in San Francisco. In a 1991 report, Dr. John Watters of the Urban Health Study reports no increased drug use over time and no change in the number of new drug users since the creation of San Francisco's Prevention Point. A second study by Jesus Bucardo, et al entitled, "Evaluating Negative Effects of Needle Exchange Using Drug Treatment Data" for the University of California and the San Francisco Department of Public Health's Community Substance Abuse Services Division also concludes that after two years of needle exchange, there was no indication of increased injection drug use, no encouragement of drug use at an earlier age, and no increase in needle sharing behavior.

Furthermore, there are no studies showing that laws restricting the availability of injection equipment result in reduced drug use. The eleven states and the District of Columbia that have laws requiring a prescription are, in fact, states with some of the largest injection drug using populations and some of highest rates of HIV infection among injection drug users.

Myth #8: AB 2525 makes it easy for any county or city in the state to be a part of the three-year pilot program.

In order to participate in the pilot, a community must demonstrate local support for the program by having its Board of Supervisors and health officer in the case of a county, or in the case of a city with a health department, the health officer, City Council and Mayor request authorization from the State Department of Health Services. Aside from San Francisco, only three other cities have their own health officer and health department.

Myth #9: Experience from Needle Park in Zurich, Switzerland shows that needle exchange doesn't work.

Needle park in Zurich, Switzerland was an open drug using location that attempted to control drug use by bringing it out of hiding and into a place where the users could access health services, including syringe exchange. Although exchange was one of the services offered within the boundaries of this park, it was not the central organizing feature. Needle park was recently shut down due to the violence associated with drug-related gang warfare. The pilot program authorized under AB 2525 does not at all resemble the program in Zurich and in no way alters current laws against possession and use of illegal drugs in public or private areas. Early in the HIV epidemic the Swiss removed all barriers to obtaining sterile injection equipment. Some syringe exchange schemes are still successfully operating in Switzerland, as well as in England, the Netherlands and Australia.

Myth #10: The voluntary and confidential nature of the program makes it unlikely that the pilot program will produce any useful data on AIDS and drug abuse.

The availability of identifying information on needle exchange clients is irrelevant to the task of evaluating the effectiveness of the pilot program. Through the use of anonymous surveys and the collection of program data, this three year project will provide policy makers with the information they need to evaluate once and for all the effectiveness of needle exchange in California.

Conclusion:

Injection drug users are the second largest group at risk for HIV/AIDS and they are the primary source for heterosexual, female and perinatal transmission in California. According to the State Office of AIDS, an estimated 1 in every 200 Californians is now infected with HIV.

Without a cure or vaccine, the HIV/AIDS epidemic requires an aggressive emphasis on prevention programs that have proven themselves effective. Needle exchange deserves the support of the California State Legislature. Please support AB 2525 (Brown).

SENATE COMMITTEE ON
HEALTH AND HUMAN SERVICES

Appropriations
Tate

S
B

HEARING DATE: APRIL 8, 1992

1
4
1
8

STAFF ANALYSIS OF SENATE BILL 1418 (WATSON)
AS AMENDED IN SENATE APRIL 2, 1992

SUBJECT

AIDS: Pilot Needle Exchange Program

INTENT

This measure seeks to establish the Clean Needle and Syringe Exchange Program.

ABSTRACT

Existing law authorizes pharmacists and physicians to furnish hypodermic needles and syringes without a prescription or permit for human use in the administration of insulin or adrenalin.

1. This bill establishes the Clean Needle and Syringe Exchange Pilot Project.
2. Authorizes pharmacists, physicians, and certain persons who are part of the pilot project to furnish hypodermic needles and syringes without a prescription or permit as prescribed through the pilot project.
3. Requires the State Department of Health Services (DHS) to authorize a pilot project in the City and County of San Francisco upon the request of the San Francisco County Board of Supervisors, the Mayor of San Francisco, and the local health officer.
4. Permits DHS to authorize additional counties, cities, or cities and counties to develop a pilot project upon the prescribed request of specified officials of that local jurisdiction.
5. Enumerates the components of the pilot project, to require among other things:
 - a) The pilot project be part of a network of available voluntary and confidential services.
 - b) The pilot project includes the development of operating procedures, a specified data base, culturally sensitive community outreach and prevention education, demonstrated effort to provide drug treatment upon request, adequate

CONTINUED---

and appropriate staffing and community involvement in project development which includes local public safety officials.

6. Requires that a county, city, or city and county that participate in the pilot project assess the project using certain criteria, and submit a progress report and final report that take into consideration data from the assessment to the State Director of DHS, the Governor, and the chairpersons of both health committees of the legislature.
7. Provides, that if the local health officer determines that the pilot project has a detrimental effect on drug use and the increased spread of HIV, the project is to be terminated.
8. Repeals the pilot project on January 1, 1996.

FISCAL IMPACT

Unknown.

BACKGROUND

This measure is sponsored by the City and County of San Francisco and the San Francisco AIDS Foundation. This measure is intended to decrease the spread of human immunodeficiency (HIV) by permitting the development of needle exchange programs, thus reducing the use of contaminated intravenous injection needles and other "works".

San Francisco has reported that there approximately 16,000 injection drug users, of which 13,000 are heterosexuals and 3,000 are homosexual/bisexual. Injection drug users are the primary source of heterosexual and perinatal transmission of AIDS or HIV in the United States and Europe. Approximately 32 percent of the 195,718 reported AIDS cases in the US have been associated with injection drug use. Furthermore, the National Commission on AIDS in its report, Americans Living with AIDS, has identified needle and syringe exchange and distribution programs as a means of encouraging injection drug users to join treatment programs. Moreover, the California AIDS Leadership Committee in its report, California's Continuing Response to HIV Disease: A Strategic Plan, points towards similar conclusions. This report recommended that "legislation should be enacted to allocate resources and modify current statutes to allow the California State Department of Health Services and the State Department of Alcohol and Drug Programs to collaboratively establish pilot paraphernalia exchange programs in California...."

ARGUMENTS IN SUPPORT

Needle exchange programs are currently operating in Hawaii, Seattle and Tacoma, Washington, Portland, Oregon and New Haven, Connecticut. A 1991 Yale University study of a state-sponsored

CONTINUED---

needle exchange pilot program reported a 33 percent reduction in new HIV infections just eight months after the program's inception. Preliminary findings showed that the average length of time that dirty needles were in circulation dropped from 2-1/2 weeks to 6 days. The percentage of contaminated needles also dropped from 68 percent to 40 percent.

There are only 11 states in the nation that criminalize the furnishing, possession or use of hypodermic needles or syringes without a prescription. Four of these states have enacted legislation or waived the prohibition administratively to permit the development of needle exchange programs. Of the remaining seven states, California has the highest seroprevalence rate of HIV infection.

ARGUMENTS IN OPPOSITION

Opponents of this measure report that the war of drugs is being won and that since 1975 drug use within high school students has decreased. They report that this measure would take a giant leap backwards by giving free needles to the most serious illegal drug users in the state. This measure they report is in total opposition to the "just say no" campaign. It sends a message that drug addiction isn't that bad and AIDS is the only real threat. Since drug addiction is against the law, this groups appears to promulgate jail as a compassionate and safer means to eradicate this problem within our state.

POSITIONS

SUPPORT: City and County of San Francisco (COSPONSOR)
San Francisco AIDS Foundation (COSPONSOR)
AIDS Project Advocacy Services
AIDS Project Los Angeles
Bay Area Physicians for Human Rights
California Association of AIDS Agencies
Community Consortium (San Francisco)
LIFE AIDS Lobby
California Pharmacists Association
American College of Obstetricians and Gynecologists,
District IX
Minority AIDS Project
Pharmacists Planning Service, Inc.
City of Angels Hospice
California Nurses Association
Contra Costa County Health Services Department
Santa Cruz County Board of Supervisors
Shanti Project, San Francisco
185 individuals

OPPOSE: Committee on Moral Concerns
Sacramento County Sheriff's Department

#

Date of Hearing: March 10, 1992

ASSEMBLY COMMITTEE ON HEALTH
Bruce Bronzan, Chair

AB 2525 (Brown) - As Amended: March 9, 1992

SUBJECT: AIDS: pilot needle exchange program.

DIGEST

Existing law authorizes pharmacists and physicians to furnish hypodermic needles and syringes without a prescription or permit for human use in the administration of insulin or adrenaline.

This bill:

- 1) States legislative findings and declarations regarding infection with the human immunodeficiency virus (HIV), and development of acquired immune deficiency syndrome (AIDS) among injection drug users.
- 2) Establishes the Clean Needle and Syringe Exchange Pilot Project. Specifically, the project:
 - a) Authorizes pharmacists, physicians, and certain persons who are part of the pilot project to furnish hypodermic needles and syringes without a prescription or permit as prescribed through the pilot project.
 - b) Requires the state Department of Health Services (DHS) to authorize a pilot project in the City and County of San Francisco upon the request of the San Francisco County Board of Supervisors, the Mayor of San Francisco, and the local health officer. Also permits DHS to authorize additional counties and cities to develop a pilot project upon the prescribed request of specified officials of that local jurisdiction.
 - c) Specifies the components of the pilot project, requiring that, among other things:
 - 1) The pilot project be part of a network of available voluntary and confidential services.
 - 2) The pilot project includes the development of operating procedures, a specified data base, culturally sensitive community outreach and prevention education, demonstrated effort to provide drug treatment upon request, adequate and appropriate staffing, and community involvement in project development which includes local public safety officials.
 - 3) The local jurisdiction participating in the pilot project assess the project using specified criteria, and submit specified reports

- continued -

to DHS, the Governor, and the chairpersons of both health committees of the Legislature summarizing available data from the assessment.

- d) Provides that, if the local health officer determines the pilot project has a detrimental effect on drug use and the increased spread of HIV, the project is to be terminated.

- 3) Repeals the pilot project on January 1, 1996.

FISCAL EFFECT

Unknown, but likely minor, State General Fund costs associated with reviewing county proposals.

COMMENTS

This bill is sponsored by the City and County of San Francisco and the San Francisco AIDS Foundation. The sponsors state that the purpose of this bill is to slow the spread of HIV (human immunovirus) by permitting the development of needle exchange programs, thus reducing the use of contaminated intravenous injection equipment.

San Francisco reports an estimated 16,000 injection drug users, of which 13,000 are heterosexuals and 3,000 are homosexual/bisexuals. A survey of African-Americans in San Francisco in 1987 and in 1989 showed nearly identical rates of injection drug use (7.4%), of which 40% shared needles. A survey of methadone detox clients showed a significant drop in needle sharing, from 43% in 1986 to 17% in 1990.

Injection drug users are the primary source of heterosexual and perinatal transmission in the United States and Europe. As of September, 1991, 32% of the 195,718 reported AIDS cases in the United States were associated with injection drug use. Of the 10,989 cases presumed to have been transmitted through heterosexual sex, 53% were among sexual partners of injection drug users. Seventy-one percent of all female AIDS cases are linked directly to injection drug use. Seventy percent of the 3,312 perinatally-exposed pediatric AIDS cases were related to injection drug use.

African-Americans and Hispanics have higher rates of HIV infection compared with whites. In some studies, the HIV infection rates are four times higher for African-Americans and Latinos than for whites. Forty-five percent of the HIV-infected African-Americans and 26% of the HIV-infected Hispanics are attributable to injection drug use.

The National Commission on AIDS, in its report, Americans Living with AIDS, identifies needle and syringe exchange and distribution programs as a means of encouraging injection drug users to join treatment programs. According to the Commission:

- continued -

"Drug users know a great deal about how HIV is transmitted and are willing to make the changes necessary to reduce risk of transmission when encouraged to do so. There is evidence that HIV prevention strategies targeting injection drug users can result in decreased needle sharing, increased needle cleaning, increased demand for sterile needles on the street, and stable or declining seroprevalence rates among drug users."

The Commission also reports that, "Fears that needle and syringe exchange and distribution programs might encourage drug use and create a new class of drug injectors have not materialized." The Commission recommends that statutes and regulations which impede implementation and study of needle and syringe exchange and distribution programs should be repealed.

The California AIDS Leadership Committee (CALC), in its report, California's Continuing Response to HIV Disease: A Strategic Plan, draws the same conclusion. "Opponents of PE (paraphernalia exchange) programs have argued that PE programs condone and promote drug use; however, there is no evidence from Europe to indicate that drug use has risen as a result of PE programs. In proposing examination of PE programs in California, it must be emphasized that such programs are not an end to themselves." CALC recommends:

"Legislation should be enacted to allocate resources and modify current statutes to allow CDHS (California Department of Health Services) and CDADP (California Department of Alcohol and Drug Programs) to collaboratively establish pilot PE programs in California. These projects should be initiated following examination of existing PE programs in the United States and Europe for effectiveness and acceptance, and they should be answerable to an oversight committee of knowledgeable experts."

Needle exchange programs are currently operating in Hawaii, Seattle and Tacoma, Washington, Portland, Oregon, and New Haven, Connecticut. Recent data from the New Haven project reports a 33% reduction in HIV infection rates within the first 8 months of operation. Preliminary findings showed that the average length of time that dirty needles were in circulation dropped from 2-1/2 weeks to 6 days. The percentage of contaminated needles also fell, from 68% to 40%.

Currently, only 11 states criminalize the furnishing, possession or use of hypodermic needles or syringes without a prescription. Four of these have enacted legislation or waived the prohibition administratively to permit the development of needle exchange programs. Of the remaining states, California has the highest seroprevalence rate of HIV infection.

- continued -

POSITIONS

SUPPORT

City and County of San Francisco (CO-SPONSOR)
San Francisco AIDS Foundation (CO-SPONSOR)
AIDS Project Advocacy Services
AIDS Project Los Angeles
Bay Area Physicians for Human Rights
California Association of AIDS Agencies
Community Consortium (San Francisco)
LIFE AIDS Lobby

OPPOSE

Committee on Moral Concerns

LATE POSITIONS
ASSEMBLY HEALTH COMMITTEE
MARCH 10, 1992

AB 2286 (ELDER)

SUPPORT

California Association of Hospitals and Health Systems

OPPOSE

American Red Cross, Los Angeles-Orange Counties Biomedical Services Region
Sacramento Medical Foundation

AB 2525 (BROWN)

SUPPORT

California AIDS Intervention Training Center
California Nurses Association
California Pharmacists Association
Douglas Properties
Frank Jordan, Mayor of San Francisco
Lou B III Designs
Loyola Marymount University, Office of the Chancellor
Marin County Pharmaceutical Association
Pharmacists Planning Service, Inc.
Western Pacific Med./Corp.
27 Individuals

SB 166 (WATSON)

SUPPORT

Children's Advocacy Institute
California State Association of Counties
Planned Parenthood Affiliates of California
Respect Life Commission

SB 1247 (MADDY)

SUPPORT

Health Initiative--Santa Barbara County Special Health Care Authority

OPPOSE

March of Dimes

Assn BAAH Officers
- SF Med Society
- Marin Co Bd of S
- Nat'l Baptist?
- City of Bkly.
- Third Way, etc.
- Act 40
SF +
Gold. Co.
Cal Ale + D
Admin
ASSN.
Phys
Union of
& Dentists

CALIFORNIA ASSEMBLY
REGULAR SESSION
1991-92
VOTE TABULATION

SEQ. NO. 12.7
AYES 44
NOES 33
NV 3

FILE 39
AB 2525 - MR. SPEAKER
CONCURRENCE

DATE: 08/28/92
TIME: 8:26 PM

AYES - 44

/ ALPERT	/ CONNELLY	/ HAUSER	2 MURRAY
2 ARCHIE-HUDSON	/ CORTESE	/ HAYDEN	/ PEACE
/ AREIAS	/ COSTA	2 HUGHES	/ POLANCO
2 BANE	/ EASTIN	3 HUNTER	2 ROYBAL-ALLARD
2+BATES	/ ELDER	3 ISENBERG	/ SHER
/ BECERRA	2 FARR	/ KATZ	2 SPEIER
2 BURTON	/ FLOYD	/ KLEHS	3+STATHAM
/ CAMPBELL	/ FRIEDMAN,B	2 LEE	/ TANNER
/ CANNELLA	3 FRIEDMAN,T	/ LEMPert	1 TUCKER
2 CHACON	/ GOTCH	2 MARGOLIN	2 VASCONCELLOS
/ CLUTE	/ HANNIGAN	2 MOORE	MR. SPEAKER

NOES - 33

ALLEN	EAVES	+HORCHER	NOLAN
ANDAL	EPPLE	JONES	O'CONNELL
BAKER	+FELANDO	KELLEY	QUACKENBUSH
BENTLEY	FERGUSON	KNOWLES	SEASTRAND
BOLAND	FRAZEE	+LANCASTER	+UMBERG
BRULTE	FRIZZELLE	MAYS	WOODRUFF
CHANDLER	+HANSEN	+MCCLINTOCK	+WRIGHT
+COLLINS	HARVEY	MOUNTJOY	WYMAN
CONROY			

NOT VOTING - 3

3 BRONZAN 2 @FILANTE JOHNSON

VOTE ADDED UPON LIFTING OF CALL AT MEMBER'S DESK.
* VOTE CHANGED FROM FLOOR, ADDED AT MINUTE CLERK'S CONSOLE.
+ VOTE ADDED BY SIGNUP SHEET.
@ MEMBER ABSENT OR EXCUSED.

SEQ. NO. 12.7

Total
38: 1 - Thank you (26)
18: 2 - Thank you, sponsor, letter to Gov. (14)
12: 3 - Thank you, letter to Gov. (5) } get Fact sheet

Display 1991-1992 Votes - ROLL CALL

MEASURE: SB 1418
 AUTHOR: Watson
 TOPIC: AIDS: Clean Needle and Syringe Exchange Pilot Project.
 DATE: 08/31/92
 LOCATION: SEN. FLOOR
 MOTION: UNFINISHED BUSINESS SB 1418 WATSON
 (AYES 22. NOES 14.) (PASS)

AYES

/ Alquist	/ Calderon	2 Deddeh	/ Dills
3 Cecil Green	3 Bill Greene	/ Leroy Greene	/ Hart
/ Johnston	/ Keene	3 Killea	/ Lockyer
2 Marks	/ McCorquodale	3 Morgan	2 Petris
3 Roberti	/ Rosenthal	/ Thompson	2 Torres
/ Vuich	Watson		

NOES

Ayala	Bergeson	Beverly	Boatwright
Craven	Davis	Kopp	Leonard
Leslie	Lewis	Presley	Rogers
Royce	Russell		

ABSENT, ABSTAINING, OR NOT VOTING

Hill

3 Maddy

3 Mello

Vacancy

1 - Thank you (12)

2 - Thank you, sponsor, letter to Gov (4)

3. Thank you, letter to Gov (7)

get fact
sheet

**NATIONAL COMMISSION
ON
ACQUIRED IMMUNE DEFICIENCY SYNDROME**

Report

**The Twin Epidemics of
Substance Use and HIV**

July 1991

**1730 K Street, Northwest
Suite 815
Washington, D.C. 20006
(202) 254-5125**

Table of Contents

EXECUTIVE SUMMARY.....	1
THE TWIN EPIDEMICS OF SUBSTANCE USE AND HIV.....	4
Introduction.....	4
Overview.....	5
National Drug Control Policy	6
NOTES.....	16
APPENDICES.....	19

Executive Summary

The failure of the federal government to recognize and confront the twin epidemics of substance use and HIV infection has become glaringly apparent to the Commission throughout its nearly two years of hearings and site visits. The federal government's strategy of interdiction and increased prison sentences has done nothing to change the stark statistics:

- Approximately 32 percent of all adult/adolescent AIDS cases are related to IV drug use.
- Of the pediatric AIDS cases related to a mother with/at risk for HIV infection, 70 percent are directly related to maternal exposure to HIV through IV drug use or sex with an IV drug user.
- 71 percent of all female AIDS cases are linked directly or indirectly to IV drug use.
- 19 percent of AIDS cases among men are directly linked to IV drug use, and an additional 7 percent of AIDS cases among men are linked to both homosexual/bi-sexual contact and IV drug use.
- African-American and Hispanic communities are being extremely hard hit by the twin epidemics. While African-Americans make up 28 percent of all diagnosed AIDS cases and Hispanics make up 16 percent; of the cases attributed to IV drug use, African-Americans account for 45 percent of cases and Hispanics for 26 percent.
- The city of New York has an estimated 200,000 IV drug users (who are 50 percent HIV positive) with only 38,000 publicly funded treatment slots.
- The National Institute on Drug Abuse (NIDA) recently estimated (based on provisional data) that approximately 107,000 persons are currently on waiting lists for drug treatment.

These twin epidemics transcend all economic, geographic and racial boundaries; everyone is affected. Substance use enhances the spread of HIV infection through the sharing of needles and the practice of unsafe sex related to crack (the smokeable form of cocaine), alcohol, and other substances. Despite this insidious and indisputable link between substance use and HIV infection, the Office of National Drug Control Policy continues to virtually ignore it, and neglect the real public health and treatment measures which could and must be taken to halt the spread.

Repeatedly, medical and treatment experts have come before the Commission and stressed the absolute importance of treatment on demand. Increasing treatment slots is a stated goal of the federal drug control policy, yet, as Dr. Robert Newman told the Commission, "...there seems to be nothing...to indicate that any government agency either at the federal or at any of the 50 state levels is indeed pursuing the objective of expansion

on a massive scale to make treatment for addicts who want it readily available." Providing quality treatment and treatment on demand may be an expensive proposition, but so is the unchecked spread of HIV infection. For a successful short and long-term solution we must shift our focus from expensive prison beds which represent society's failure, to less expensive treatment slots which represent our only hope, and provide easily accessible drug treatment to all those who need and request it. (See Appendix A) As the Commission Working Group on Social/Human Issues stated in its April, 1991 report, "...it is fundamentally unjust, as well as unwise, to tell those who seek treatment for drug addiction that there is no room; but then tell them that the taxpayers are willing to spend thousands of dollars a year to keep them in jail."

We must also take immediate steps to curb the current spread of HIV infection among those who cannot get treatment or who cannot stop taking drugs. Outreach programs which operate needle exchanges and distribute bleach not only help to control the spread of HIV, but also refer many individuals to treatment programs. Legal sanctions on injection equipment do not reduce illicit drug use, but they do increase the sharing of injection equipment and hence the spread of HIV infection.

If HIV transmission related to substance use is going to stop, the federal government must take a leadership role in coordinating public health and drug treatment on all levels and in creating and implementing a cohesive national plan. Currently, the issue of HIV and substance use is falling through the cracks, and without clear policy directives to the medical, public health and drug treatment communities it will continue to do so.

The federal government must also ensure that the great strides made from research and demonstration projects are not lost through cut-backs or lack of funding. Successful demonstration projects should be identified and funding made available for their continuation as active federal projects. Funding for research on substance use and HIV should be expanded, not cut back or simply held constant. Research, both sociological and epidemiological, holds the key to discovering the answers to crucial questions around HIV and substance use. Clinical trials, a key component to research, should be open to individuals with a history of, or current, substance use problems.

Finally, all levels of government and the private sector must work together to attack the deep-rooted social and economic problems which promote and sustain substance use. The poor of this nation, especially in communities of color, have been inordinately hard hit by the twin epidemics of HIV and substance use. In order to combat these epidemics which affect the entire nation, we must provide basic needs such as housing, medical care and food. HIV education and drug treatment often seem like luxuries to individuals who do not know where they will sleep at night or where their next meal will come from. To reach the point where our nation's drug epidemic is really a thing of the past, we must create communities and neighborhoods which promote health and hope, not addiction and despair.

RECOMMENDATIONS:

To help work toward these goals the Commission puts forward the following recommendations:

1. Expand drug abuse treatment so that all who apply for treatment can be accepted into treatment programs. Continually work to improve the quality and effectiveness of drug abuse treatment.
2. Remove legal barriers to the purchase and possession of injection equipment. Such legal barriers do not reduce illicit drug injection. They do, however, limit the availability of new/clean injection equipment and therefore encourage the sharing of injection equipment, and the increase in HIV transmission.
3. The federal government must take the lead in developing and maintaining programs to prevent HIV transmission related to licit and illicit drug use.
4. Research and epidemiologic studies on the relationships between licit and illicit drug use and HIV transmission should be greatly expanded and funding should be increased, not reduced or merely held constant.
5. All levels of government and the private sector need to mount a serious and sustained attack on the social problems that promote licit and illicit drug use in American society.

The Twin Epidemics of Substance Use and HIV

It is my firm belief that policies related to AIDS and policies related to drugs are so intertwined that commenting and really wrestling and getting to the solutions to one will impact the other, and that it is necessary to consider both national drug policy and national policies related to AIDS.¹

-Kurt Schmoke, December 18, 1990

-Testimony before the National Commission on AIDS

INTRODUCTION

In this the tenth year of the HIV epidemic the nation continues to face not one epidemic, but two: the twin epidemics of substance use and HIV infection. Since the early 1980s the close and deadly link between the sharing of injection drug equipment^{*} and HIV has been well recognized. More recently, the link between non-injectable substances, such as alcohol and crack, and unsafe sexual activity which can result in the spread of HIV infection has also become glaringly evident. Yet, instead of responding to these epidemics with public health and treatment measures to cope with both, the federal government's primary response has been imprisonment and increased jail sentences, often ignoring drug/HIV relationships. The dire results of this myopic criminal justice approach are shown in the following statistics:

- Within the estimated half to 1.5 million people who inject drugs in the United States, the rate of HIV infection has increased rapidly over the past decade.²
- Approximately 32 percent of all adult/adolescent AIDS cases are related to IV drug use. (IV drug use; Male homosexual/bisexual and IV drug use; and Heterosexual contact with an IV drug user).³
- Of the pediatric AIDS cases related to a mother with/at risk for HIV infection, 70 percent are directly related to maternal exposure to HIV through IV drug use or sex with an IV drug user.⁴
- 71 percent of all female AIDS cases are linked directly or indirectly (i.e. sexual transmission from an IV drug user) to IV drug use.⁵
- 19 percent of AIDS cases among men are directly linked to IV drug use, and an additional 7 percent of AIDS cases among men are linked to both homosexual/bisexual contact and IV drug use.⁶

* The Commission uses "injection drug equipment" to refer to those paraphernalia that carry the potential for contamination: the syringe, needle, "cooker," cotton and rinse water.

- African-American and Hispanic communities are being extremely hard hit by the twin epidemics. While African-Americans make up 28 percent of all diagnosed AIDS cases and Hispanics make up 16 percent; of the cases attributed to IV drug use, African-Americans account for 45 percent of cases and Hispanics for 26 percent.⁷
- The city of New York has an estimated 200,000 IV drug users (who are 50 percent HIV positive) with only 38,000 publicly funded treatment slots.⁸
- The National Institute on Drug Abuse (NIDA) recently estimated (based on provisional data) that approximately 107,000 persons are currently on waiting lists for drug treatment.⁹

Despite these dreadful growing numbers, (see Appendices B and C) our national drug control strategy does not reflect the immediacy of the problem, the need for significant expansion of drug treatment to permit treatment on demand, or the obvious and critically important relationship between HIV infection and substance use. To address this huge public health threat, the National Commission on AIDS convened a hearing on "Substance Use and HIV" in January 1991. Through the testimony of experts and individuals who are experiencing the problems of HIV and substance use firsthand, the Commission was better able to identify certain key issues and the urgent actions the nation must take to deal with these twin epidemics. Current programs are seriously wanting.

OVERVIEW

Through the Commission's hearings and site visits over the last year and a half, the wide range and diverse nature of substance use and the population of substance users has become very much apparent. Substance use problems cross all lines of age, geography, ethnicity and economics. Infants, adolescents and adults, rural and urban, poor and rich -- all are affected. Of special concern to the Commission is the importance of recognizing the behaviors that put an individual at risk for exposure to HIV whether or not that individual believes he or she fits into the category of "drug addict." Some high school and college athletes share needles to inject steroids.¹⁰ Individuals from cultures and countries with differing medical practices often share needles to inject vitamins.¹¹ Practicing these behaviors poses the danger of transmitting and acquiring HIV just as sharing a needle to inject heroin or cocaine does.

The Commission is also deeply concerned by the force with which these twin epidemics have struck communities of color, women, and adolescents. There are significantly elevated rates of HIV infection among blacks and Hispanics compared with whites.¹² The rates of HIV infection related to IV drug use are also growing among women, many of whom do not perceive that they are at risk.¹³

Adolescents are especially at risk. Adolescents, and others, who avoid intravenous drugs still expose themselves to the risk of HIV infection through unsafe sexual behavior

during the use of alcohol and other substances. It is important, when considering this issue, to be realistic about when young adults in the U.S. begin having sex. "In 1990, the researchers at the Alan Guttmacher Institute in New York and the Urban Institute in Washington analyzed federally funded surveys of boys and girls conducted in 1988. They reported [that] both boys and girls were more likely to be sexually experienced than those surveyed in the late '70s and early '80s. Half of girls had sex by age 17; half of boys by age 16." The survey also shows that, "...3 out of 4 unmarried 19-year old women and 5 out of 6 unmarried 19-year old men were sexually experienced."¹⁴

The linkage between sexual behavior and substance use is vividly reflected in the following example from Dr. Robert Johnson of Adolescent Medicine at the University of Medicine and Dentistry of New Jersey:

[O]ur last four adolescents who had heterosexual transmission of the disease all had sexual behavior that was associated with alcohol use, particularly a drug form of 'wine cooler' named Cisco, and these young people who had used condoms in other situations did not use condoms [here]...

Adolescents, and others, are also at risk through the growing practice of trading drugs, especially crack (the smokeable form of cocaine), for sex. Dr. Johnson gave the following example which dramatically illustrates this connection:

One particular crack dealer...in our adolescent clinic in Newark revealed that in the month of August he had sex with 30 different women in trade for crack. In addition, he carried on a sexual relationship with his girlfriend who did not use drugs. All of this activity occurred without the benefit of the protection of condoms. In that month, he and his girlfriend, and his girlfriend's new boyfriend, and his girl friend's new boyfriend's alternative sexual partner, all became infected with gonorrhea and chlamydia.¹⁵

While much of this, and other substance using activity, is concentrated in urban areas, there has been an increasing trend towards substance use, especially crack, in suburban and rural areas as well. The Commission previously highlighted this trend in its August 1990 report on HIV in rural America. Another disturbing trend, with serious implications for the HIV epidemic, is the resurgence of heroin use in the Northeast.¹⁶

It can be seen from even this small sample of issues that substance use plays a major role in the transmission of HIV disease — indeed, a much larger role than has been generally recognized. Clearly, our nation's drug control policies must recognize this inextricable linkage between drugs and HIV disease and be designed to address the two aggressively and simultaneously.

NATIONAL DRUG CONTROL POLICY

To date, the National Drug Control Policy has failed to address the coupling of the epidemics of HIV and substance use. Indeed, thus far, the Office of National Drug Control

Policy (ONDCP) and other federal agencies have barely recognized the linkages. In the 1991 report from ONDCP, (a 161 page report), there are only three paragraphs of text addressing this issue. The failure to acknowledge this -- the obvious -- is bewildering and tragic. The first step is for the ONDCP, and other federal drug agencies to fully recognize the problem. In order to do this, the federal government must recognize that HIV and substance use is one of the issues of paramount concern within the "war on drugs." Any program which does not deal with the duality of the HIV/drug epidemic is destined to fail.

The current national approach to the problems of substance use is to deal with those who are addicted primarily by means of the criminal justice system. Clearly, this approach is not working and a public health approach is desperately needed. Despite the fact that "we [a]re incarcerating people at a greater rate than any nation in the world, and incarcerate blacks at a higher rate than South Africa,"¹⁷ substance use continues, and transmission of HIV related to injection drug use has increased rapidly over the past decade.¹⁸ The criminal justice system is the least viable setting for providing treatment and addressing issues of HIV and substance use. Yet this has become the primary strategy in our "war on drugs." Those forums which should have a proactive role in dealing with substance use, namely the medical and public health communities, have been seriously neglected. We must develop a system which coordinates public health and health care with treatment and outreach, both of which have shown positive results.

RECOMMENDATION 1.

Expand drug abuse treatment so that all who apply for treatment can be accepted into treatment programs. Continually work to improve the quality and effectiveness of drug abuse treatment.

Repeatedly, medical and treatment experts have come before the National Commission on AIDS and stressed the absolute necessity of treatment on demand. It has been over three years since the Presidential Commission on HIV made their recommendations for developing "a plan for increasing the capacity of the drug treatment system so that the goal of treatment-on-demand can be met." Yet we still lack the commitment we need from the federal government to achieve this goal. While treatment expansion is a stated goal of the federal drug control policy, no real gains have been made on any level. As Dr. Robert Newman told the Commission, "...there seems to be nothing...to indicate that any government agency either at the federal or at any of the 50 state levels is indeed pursuing the objective of expansion on a massive scale to make treatment for addicts who want it readily available."¹⁹ We must also work to ensure that the quality of treatment is constantly improving. Immediately available, effective, high-quality treatment slots are the final goal. The Commission recognizes that improved quality of treatment and treatment on demand are expensive; but so is the unchecked spread of HIV infection. As the following statement illustrates, we are putting the available, much needed resources elsewhere:

Exactly a year ago the White House issued a strategy on drug abuse control in which it made reference to a request for \$1.5 billion for one fiscal year to expand by 24,000 the number of prison beds in the federal system in addition to even more massive expansion of prisons at the state and local level.

Contrast those very specific and massive goals with what was said in that strategy report with regard to treatment. It was proposed that \$100 million, be added for treatment expansion to allow 11,000 additional treatment slots to be created and to put that into perspective, the Institute of Medicine within the last six months referred to an estimate of 66,000 people in our country currently being identified as on waiting lists for various types of treatment programs.²⁰

The numbers are likely even higher. NIDA has made estimates based on provisional data which indicate that as many as 107,000 persons are currently on waiting lists for drug treatment.²¹ And, as early as 1988, "more than half of New York City's estimated 200,000 IV drug users were infected with HIV. At any given time, about 33,000 publicly funded drug treatment slots were available to assist these people." As of September 1990, there were a little over 38,000 publicly funded treatment slots.²²

The reality of these numbers was made clear to the Commission through the following eloquent testimony of a woman who lives every day with the epidemics of HIV and substance use:

I still work the streets to support a \$150 a day habit of heroin and crack. I am forced to have sex with approximately ten men per day to support my habit, which is putting me at risk of further HIV infection, sexually transmitted diseases, and rape or death. What I want to tell you is that if I ha[d] been accepted into a drug treatment program three years ago, I would not be sitting here in front of you today telling you that I am HIV infected.²³

Federal response to treatment on demand

Federal officials have questioned the wisdom of treatment on demand on three major grounds: first, there are already enough open slots in treatment programs, but poor coordination results in waiting lists; second, the efficacy of treatment methods is still unknown; and third, treatment on demand may create a "revolving door" effect with substance users moving in and out of treatment programs without ever taking treatment seriously.²⁴

The government has argued that with a computerized system and increased coordination we could fill all the available slots, thus rendering new slots redundant. Further coordination between treatment centers and a computerized program to help expand access are excellent ideas, but coordination can only do so much. Treatment programs need to be easily accessible to people in need -- being shunted to another part of the city to an open

treatment slot may make treatment impossible for many substance users. Open slots in certain treatment programs may also reflect programs which are not thought to work by the substance users themselves. Whether the perception is justified or not, research should be done on what draws substance users to a particular program or type of treatment, and what drives them away.

While the Commission recognizes this need to coordinate treatment programs to make the system of providing care as efficient as possible, it also recognizes that many of the "open slots" may, in fact, exist only on paper. Budget cuts on both the state and federal levels have limited the operating capacity of many treatment programs, while leaving the original operating capabilities "on the books." Therefore, a treatment center listed as having 100 slots may in fact have only enough staff and equipment to serve 70 individuals -- leaving a "phantom" 30 spots "unfilled."

Questions about the efficacy of treatment have been raised by many medical problems. The Commission recognizes the frustration faced by those who try to treat substance use, and believes that further research into treatments for specific "new" and "multiple" substance use behaviors must be developed; at the same time we must continue to treat individuals with the methods which we have on hand. As the Commission's vice chairman Dr. David Rogers said in response to this argument, "We don't use the excuse of, 'We don't know quite how to treat you.....' to people with congestive heart failure...[or]...cancer."²⁵

Finally, the Commission does not agree that treatment on demand will create a lax attitude among those who seek treatment, as officials of ONDCP have argued. Instead, the Commission recognizes the medical nature of substance use problems and the need to provide treatment for those problems. As Dr. Rogers said, "I know of no other fatal disease in which we say, 'Go away; we'll treat you later.' [Or, in which we] use the excuses of, '...[Y]ou may not behave; you may not stay in treatment.'"²⁶ The Commission recognizes the role of relapse in the process of drug treatment and believes strongly that treatment on demand can offer the substance user the hope of further treatment rather than the despair of waiting with further risk of death and disease.

In order for treatment to be truly available we also need to remove those barriers placed in the path of the substance user which can make it virtually impossible to gain access to care and treatment. As one witness told the Commission:

The drug treatment system to many substance abusers is unworkable and unmanageable. Addicts must apply for treatment, and keep in mind that most are homeless and with no support services. They must have at least two pieces of identification, a permanent mailing address, be Medicaid eligible, give and pay for a urine test, have an initial first fee for screening for the screening day, go through a series of interviews and processes, and after all this they may be admitted and medicated. This is too much for an addicted person to face.²⁷

Given these requirements, it is no wonder that there may be some open slots in drug treatment centers. Treatment programs, secondary to law enforcement efforts, housed in dilapidated centers, and poorly staffed, now have been charged with not only treating substance use, but also solving the problem of HIV. It is little wonder that the problem continues to grow.

RECOMMENDATION 2.

Remove legal barriers to the purchase and possession of injection equipment. Such legal barriers do not reduce illicit drug injection. They do, however, limit the availability of new/clean injection equipment and therefore encourage the sharing of injection equipment, and the increase in HIV transmission.

National drug policy must recognize the success of outreach programs which link needle exchange and bleach distribution programs with drug treatment. The Commission has visited numerous programs throughout the country which distribute bleach and some that exchange clean needles. These programs have demonstrated the ability to get substance users to change injection practices. Most significantly, these programs, rather than encouraging substance use, lead substantial numbers of substance users to seek treatment.

For example, the Tacoma, Washington project conducts a syringe exchange and other AIDS prevention activities, as well as providing some basic services. Soon after its establishment it became the "largest referral source to treatment in [the] county."²⁸ Studies of demonstration projects like these have shown that they are an immediate and effective way of addressing the public health threat of HIV and of reducing demand. Yet, state to state, and even city to city, policy and practice on this issue differs to such a degree that outreach workers may have the full cooperation of the local police in one area, and be arrested in another. There must be increased coordination between law enforcement officers and outreach workers. The very real fear that clean syringes and bleach vials will be used as evidence for arrest and prosecution may be having a "chilling effect" on drug users' practice of safer injection behaviors. These legal sanctions on injection equipment thus serve to increase the sharing of injection equipment and, through this behavior, the transmission of HIV. It is imperative that we remove these legal barriers so that the transmission of HIV can be lessened for those who cannot stop injecting drugs.

* Twelve states currently require prescriptions to obtain needles.
Source: AIDS Policy Center, Intergovernmental Health Project, The George Washington University, June 1991.

Examples from some U.S. cities and the U.K., the Netherlands, and Australia show that cooperation of law enforcement and public officials can make a major difference in the success of outreach programs. In Tacoma, where the city and county jointly run the health department, all city and county representatives who sit on the health board have been educated about AIDS. The chief of police is also "AIDS educated" and was able to cooperate with the outreach programs in the city. This syringe exchange and basic needs outreach program in Tacoma has resulted in "approximately an 80 percent reduction in risk behavior in terms of injecting practices of the people that use the exchange as opposed to those who don't."²⁹ In the documentary "Taking Drugs Seriously," a film about the Merseyside Regional Health Authorities' harm reduction approach in the U.K., Allan Parry, Director of the Maryland House in Liverpool, believes that "the main reason we're keeping down the spread of the virus is because of the police support of [syringe exchange] activity." Detective Superintendent and Drug Squad Chief Derek O'Connell explains that while they do not support decriminalization..., "because of the AIDS problem which is now recognized by the government as a very, very serious problem, it would be remiss if we didn't give support wherever it was needed." In fact, since beginning their new "cautioning" program which steers individuals toward drug dependency programs instead of prosecuting, they have seen "an 85 % success rate; that is, people not re-offending."³⁰

RECOMMENDATION 3.

The federal government must take the lead in developing and maintaining programs to prevent HIV transmission related to licit and illicit drug use.

To date, no single agency or group has taken charge of this issue of overwhelming importance to the national health. In drug treatment programs, a level of awareness about AIDS which was never sufficient to control the epidemic now seems to be fading.³¹ One woman with HIV disease told the Commission that "[i]n North Carolina, in Narcotics Anonymous, they do not talk about AIDS. It is considered an outside issue."³² Some individuals with HIV disease are even denied access to treatment programs because of their HIV infection.³³

Public health and health care agencies have ignored the problem from the other side -- not confronting the substance use issues involved with individuals who have HIV infection or who may be at risk. Although in the rest of the developed world, medical and public health professionals have directed national drug policy to target prevention of the spread of HIV within the injecting drug user community, there has been no parallel in claiming such policy-setting responsibility here in the U.S.

The real responsibility for these shortfalls lies with the federal government. Because of the lack of coordination and planning on the federal level with regard to HIV in general, and substance use and HIV in particular, groups in both public health/health care and drug

treatment lack direction in the face of the epidemic. The Commission applauds such efforts as the November 1990 "National Conference on HIV and Substance Abuse: State/Federal Strategies" sponsored by ADAMHA, ASTHO, CDC, HRSA, NAPO and NASADAD,* which attempted to coordinate state and federal agencies and discover new directions for action.

The conference focused on a number of inter-related issues: the need for increased coordination of traditional public health departments and substance abuse treatment programs; improvement of joint program planning by state health and substance abuse treatment systems; and the need to increase state and federal collaboration in addressing the HIV/substance abuse issue.³⁴ The recommendations which came out of the conference in the areas of provision of services, evaluation of services, training, and research are insightful and relevant. Examples include many recommendations which reflect the concerns of the Commission:

Provide HIV prevention services in drug treatment settings and services for drug users in public health clinics; Provide outreach to drug users who are not in drug treatment and to the sex partners of drug users; Improve and expand the capacity of drug treatment; Provide drug treatment services in primary health care facilities; Provide primary health care in drug treatment centers; Provide training and cross-training of staff; and, Improve the evaluation of HIV/substance abuse programs.³⁵

The question now is, where do we go from here? Without a cohesive national strategy which assigns responsibility, provides leadership and vision, and follows through on coordination, these excellent recommendations and advances will be lost. In order for coordination to truly work, there need to be incentives for public health and drug treatment providers to join together in seeking grants and other federal monies. The present system discourages rather than encourages such cooperation. Demonstration projects need to be set up with a component for evaluation and further funding already in place so that valuable people, time and resources are not lost. Increased federal action in the areas of evaluation, technical assistance and development of training, guidelines, and models can help bring about the cooperation and coordination of health care and drug treatment which are essential to meeting the goal of providing primary care to substance users with HIV disease.³⁶

* The Conference was sponsored by the following organizations: Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA); Association of State and Territorial Health Officials (ASTHO); Centers for Disease Control (CDC); Health Resources and Services Administration (HRSA); National AIDS Program Office (NAPO); and the National Association of State Alcohol and Drug Abuse Directors (NASADAD).

RECOMMENDATION 4.

Research and epidemiologic studies on the relationships between licit and illicit drug use and HIV transmission should be greatly expanded and funding should be increased, not reduced or merely held constant.

While the definite link between HIV transmission and substance use is well-established, many questions about the relationship between substance use and HIV remain unanswered. What effect does continued substance use have on the progression of HIV disease? What behaviors place individuals at the greatest risk for transmission? Although further research is essential to help us answer and provide solutions for these and related questions, much has been learned thus far -- policy makers are not in a scientific vacuum. Since the beginning of the epidemic we have learned much more about injection drug use and substance use and sexual practices which are linked to HIV. Research into these topics should not be relegated to private sponsors because of a mistaken perception that substance use and HIV are not critical national problems. Such research falls squarely under the aegis of the federal government.

There are two issues of particular concern to the Commission within the larger context of research on HIV and substance use. First, the future of projects funded through demonstration grants and second, the potential cuts in the number of federally funded investigator-initiated grants. The Commission's concern for demonstration projects is reflected in the discussion above on outreach projects. The whole concept of "demonstration" projects needs to be better defined; the evaluation process should be designed so that successful projects can be identified at an early stage. Funding can then be made available for their continuation as on-going federal projects. A consistent policy must be developed to prevent the shut down of successful programs and the loss of trust, staff and progress.

The Commission is also concerned with proposed cuts in funding for investigator-initiated grants and the numbers of programs to be covered in the coming years. The Commission believes strongly that funding for research on HIV and substance use should be increased and is specifically concerned with the potential cuts in the numbers of grants available under ADAMHA. The Commission believes that the basic and applied research funded through this mechanism is often among the most productive and creative and holds great potential for progress in finding the answers to crucial questions around HIV and substance use. To cut these innovative programs, either in funding amount or numbers of grants, would delay once again the answers to questions which are crucial in curbing the spread of these epidemics.

Clinical trials are a key component of research and can offer both immediate and future benefits in treatment and care of HIV disease. The Commission believes strongly that those with a history of, or current, substance use problems should be actively enrolled in clinical trials. As with the provision of primary care, it may be appropriate to look to

increased cooperation with treatment centers for finding participants and conducting these clinical trials.

RECOMMENDATION 5.

All levels of government and the private sector need to mount a serious and sustained attack on the social problems that promote licit and illicit drug use in American society.

The combined epidemic of HIV and substance use has hit hardest the individuals in our society who are least equipped to deal with it — the poor. The poor of this nation, especially within communities of color, lack access to medical care, housing, food, and other basic needs. Substance use treatment and HIV education may often seem like luxuries to people who do not know where they will sleep at night or where their next meal will come from. As Sandra Vining-Bethea of the Bridgeport Women's Project told the Commission, "It's hard to educate a woman who is homeless and hungry."³⁷

Those who live in poverty are also subject to extremes of social neglect which can add to the likelihood of substance use and risk practices. As Dr. Robert Fullilove of the Psychiatric Institute in New York told the Commission:

The one thing we know about poverty in this country in the last 20 years is that it has really altered the structure of many of the neighborhoods in the United States. Blacks and Latins are increasingly concentrated in areas that are becoming poorer and poorer, and with that concentration has come a tremendous increase, not just in HIV infection, not just in the prevalence of drug abuse, but a whole host of other serious social problems ranging from crime to just about anything that you can possibly describe."³⁸

If the nation is to provide treatment and education which will move people away from substance use problems and the risk of HIV infection, it must recognize the role which poverty plays in this dilemma.

As Dr. Fullilove went on to tell the Commission:

...the most common feature of drug abuse is relapse. And we think relapse is related to environmental factors, the degree to which people live in neighborhoods where the neighborhood itself is a toxic agent that promotes addiction.Unless we are able to stabilize the communities in which drug abuse, (particularly non-white communities), unless we're able to stabilize these neighborhoods and provide them with some kind of economic base, the underground economy which pushes and promotes crack cocaine addiction is going to do far more to damage our efforts to reach individuals....³⁹

While attacking the problems of HIV and substance use in the short-term with the methods discussed above, the federal government must lead the way in simultaneously addressing the larger social issues of poverty, homelessness and lack of medical care. We must work cooperatively with both the public and private sectors to remove these barriers to prevention and treatment.

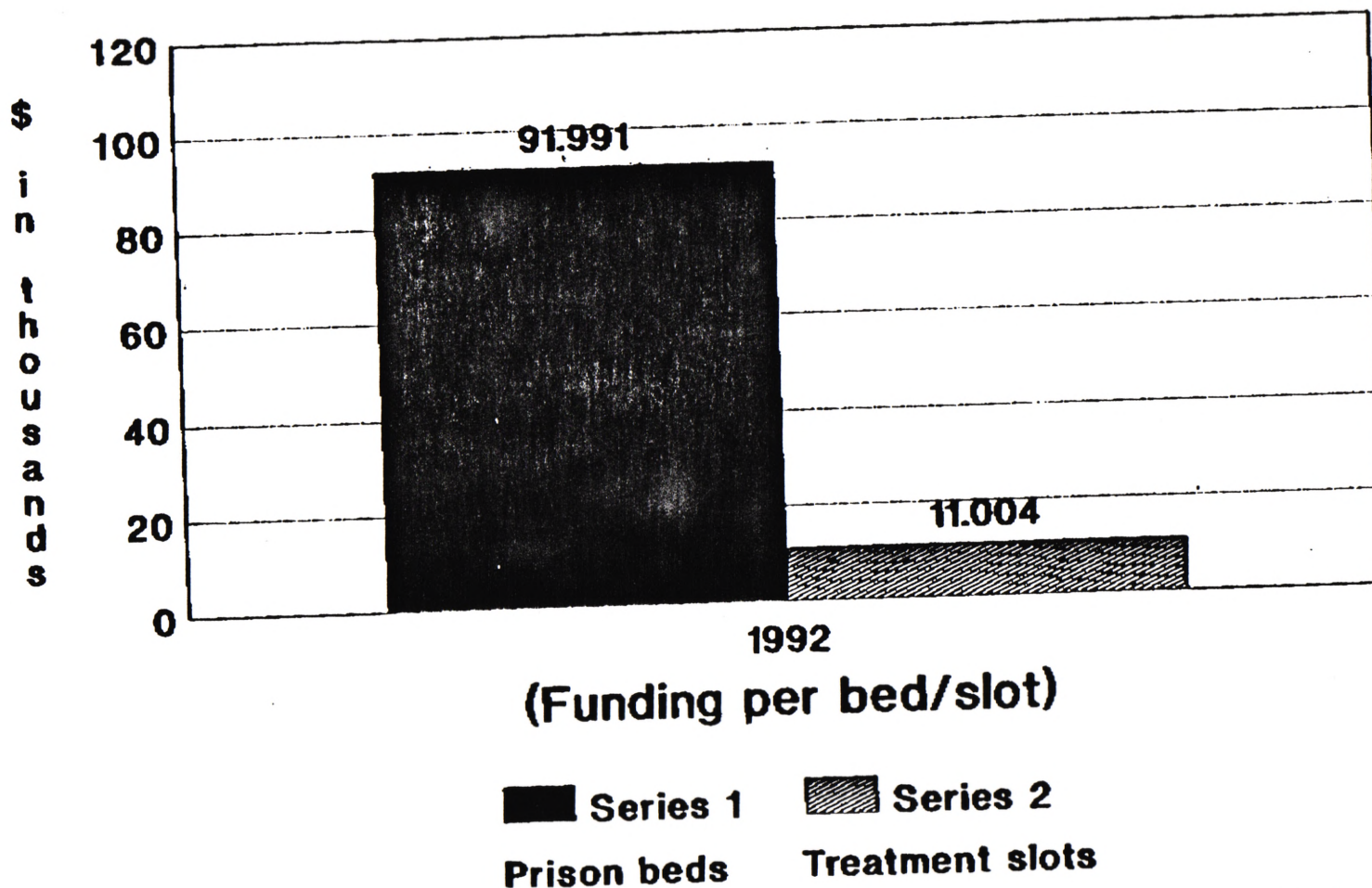
Notes

1. Schmoke, K. (1990) Testimony before the National Commission on AIDS. Baltimore, December 18. Transcript at pp. 141-2.
2. DesJarlais, D. Personal Communication, May 30, 1991.
3. Centers for Disease Control (1991) "AIDS/HIV Surveillance." (U.S. AIDS cases reported through May 1991) pp. 9 & 10.
4. Ibid.
5. Ibid.
6. Ibid.
7. Ibid.
8. The Citizens Commission on AIDS for New York City and Northern New Jersey. (1991) AIDS: Is There a Will to Meet the Challenge? p. 31.
9. National Institute on Drug Abuse (NIDA)/Division of Applied Research. (1991) "Drug Services Research Survey." Conducted by Brandeis University. (Estimates based on provisional data pending refined data in Fall, 1991).
10. Kamens, D. (1991) Testimony before the National Commission on AIDS. Chicago, March 13. Transcript p. 92.
11. Marin, B. (1990) AIDS prevention for non-Puerto Rican Hispanics. AIDS and Intravenous Drug Use: Future Directions for Community-Based Prevention Research, NIDA Research Monograph 93:39.
12. Hahn et.al. (1989) HIV Prevalence. Journal of the American Medical Association 261:2682.
13. Philadelphia Inquirer "Study: Women fail to see AIDS risk." Luran Neergaard p. A4 March 29, 1991.
14. USA Today, "Fewer kids save sex for adulthood," pp. 1D;1E March 5, 1991.
15. Johnson, R. (1991) Testimony before the National Commission on AIDS. Washington, January 17. Transcript at pp. 53-60.
16. DesJarlais, D. (1991) Personal Communication. July 2, 1991.
17. Mulligan, D. (1991) Testimony before the National Commission on AIDS. Washington, January 17. Transcript at p. 133.
18. DesJarlais, D. (1991) Personal Communication. May 30, 1991.
19. Newman, R. (1991) Testimony before the National Commission on AIDS. Washington, January 17. Transcript at p. 124.

20. Newman, R. (1991) Testimony before the National Commission on AIDS. Washington, January 17. Transcript at pp. 125-6.
21. National Institute on Drug Abuse (NIDA)/Division of Applied Research. (1991) "Drug Services Research Survey." Conducted by Brandeis University. (Estimates based on provisional data pending refined data in Fall, 1991).
22. The Citizens Commission on AIDS for New York City and Northern New Jersey. (1991) AIDS: Is There a Will to Meet the Challenge? p. 31.
23. Yvette (1991) Testimony before the National Commission on AIDS. Washington, January 17. Transcript at p. 110.
24. Primm, B. (1991) Testimony before the National Commission on AIDS. Washington, January 17.
- Kleber, H. (1990) Testimony before the National Commission on AIDS. Washington, March 15.
25. Rogers, D. (1990) Testimony before the National Commission on AIDS. Washington, March 15. Transcript at p. 74.
26. Rogers, D. (1990) Testimony before the National Commission on AIDS. Washington, March 15. Transcript at pp. 73-4.
27. Serrano, Y. (1991) Testimony before the National Commission on AIDS. Washington, January 17. Transcript at p. 108.
28. Purchase, D. (1991) Testimony before the National Commission on AIDS. Washington, January 17. Transcript at p. 102.
29. Purchase, D. (1991) Testimony before the National Commission on AIDS. Washington, January 17. Transcript at p. 103.
30. Parry, A. (1990) Taking Drugs Seriously (Video 30 minutes) An Open Space Video/BRC, Liverpool. (N. Platt, director; K. Hinchey, editor; M. MacCormack, producer.)
31. Sorenson, J. (1991) Testimony before the National Commission on AIDS. Washington, January 17. Transcript at p. 141.
32. Thompson, A. (1991) Testimony before the National Commission on AIDS. Washington, January 17. Transcript at p. 134.
33. Sorenson, J. (1991) Testimony before the National Commission on AIDS. Washington, January 17. Written testimony at p. 2.
34. Primm, B. (1991) Testimony before the National Commission on AIDS. Washington, January 17. Transcript at pp. 34-35.
35. Department of Health and Human Services. (1991) Draft Report of The National Conference on HIV and Substance Abuse: State/Federal Strategies. November 13-15, 1990. pp. ix-xii. (Please note: In the final version recommendations appear in the body of the report.)

36. Coye, M. (1991) Testimony before the National Commission on AIDS. Washington, January 17. Transcript at pp. 163-166
37. Vining-Bethea, S. (1991) Testimony before the National Commission on AIDS. Washington, January 17. Transcript at p.100.
38. Fullilove, R. (1991) Testimony before the National Commission on AIDS. Washington, January 17. Transcript at p. 62.
39. Fullilove, R. (1991) Testimony before the National Commission on AIDS. Washington, January 17. Transcript at p. 62.

Proposed Funding for New Prison Beds vs. New Treatment Slots in 1992

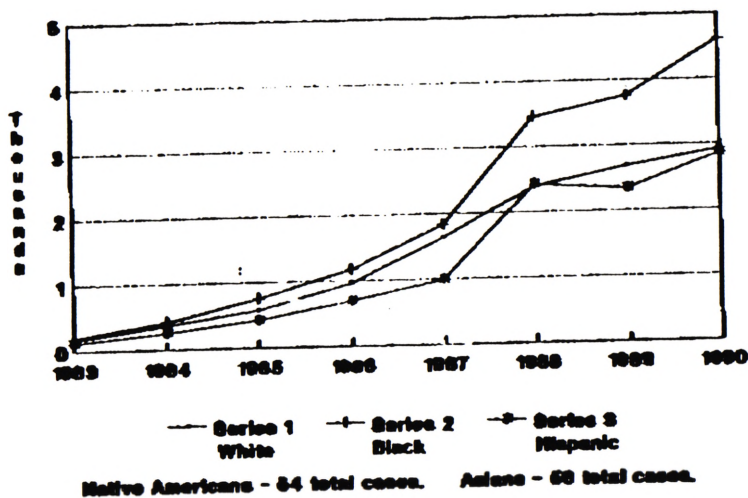


Data for proposed new prison bed funding for 1992 from, "FY 1992 Congressional Budget Estimates," p. 5, & "National Drug Control Strategy: Budget Summary, 1991," p. 58. The "New Construction figure" includes the new construction estimate of \$285,169,000 and an additional \$46,000,000 which is expected to be transferred from the Special Forfeiture Fund.

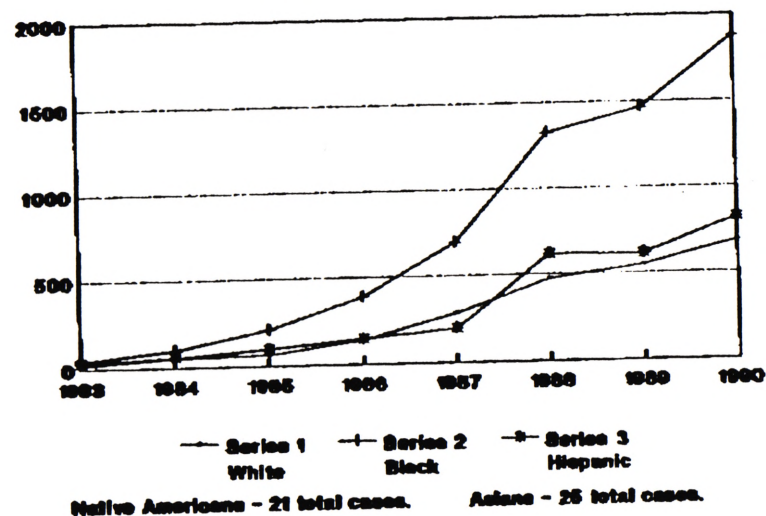
$\$331,169,000(\text{New Construction})/3,600(\text{Proposed beds})=\$91,991/\text{bed.}$

Data for proposed new treatment slot funding for 1992 from, "National Drug Control Strategy: Budget Summary, 1991," p. 157.
 $\$99,000,000(\text{CEP})/8,997(\text{proposed slots})=\$11,004/\text{slot.}$

Adult Male IVDU Associated AIDS Cases by Race and Year



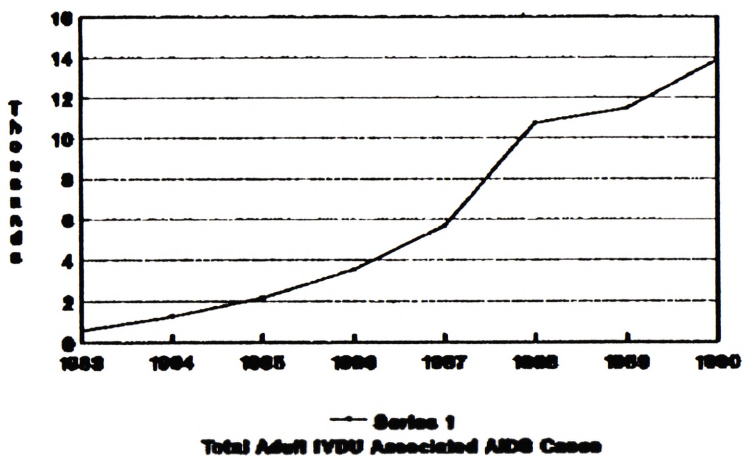
Adult Female IVDU Associated AIDS case by Race and Year



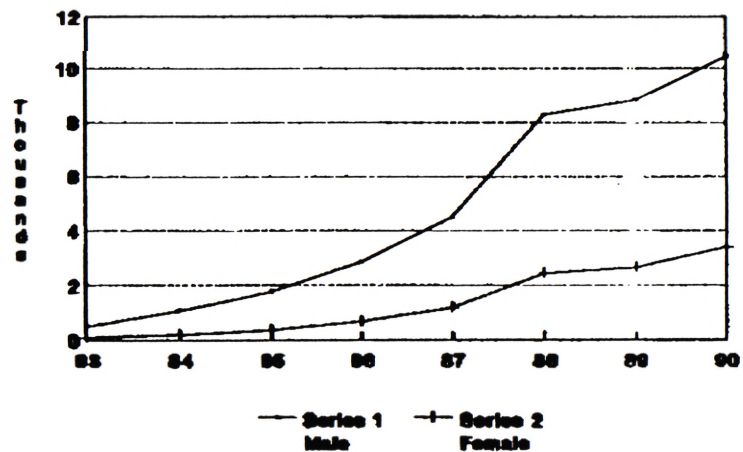
Intravenous drug use (IVDU) associated cases include: IV drug use/Heterosexual; Male Homosexual/Bisexual contact and IV drug use; and, Heterosexual Contact: Sex with an IV drug user.

Centers for Disease Control AIDS Data as of December 31, 1991.

**Total Adult IVDU Associated Cases
by Year**



**Adult IVDU Associated Cases by
Sex and Year**



Intravenous drug use (IVDU) associated cases include: IV drug use/Heterosexual; Male Homosexual/Bisexual contact and IV drug use; and, Heterosexual Contact: Sex with an IV drug user.

Centers for Disease Control AIDS Data as of December 31, 1991.

ACTION ALERT

URGE GOVERNOR WILSON TO SIGN NEEDLE EXCHANGE LEGISLATION

WHERE WE ARE NOW:

Due to the budget stalemate, the Legislature did not take its Summer recess and is continuing to work on other legislation. Both needle exchange bills, AB 2525 (Brown) and SB 1418 (Watson), are moving through the final steps of the process. **Though Aug. 31 is the deadline for either house to pass a bill, one of the bills could get to the Governor as early as the first week in August.**

On July 20, AB 2525 was reported out of Senate Appropriations Committee and is now awaiting a vote on the Senate floor. The floor vote will likely take place on Thurs., July 30. We expect a close vote, as was the case with SB 1418 (21-14) -- (21 is the minimum needed for passage). Because we fell one vote short of the 12 votes needed to get it out of the Assembly Ways and Means on July 22nd, SB 1418 must go before this same Committee for "reconsideration" on Aug. 5th. After Ways and Means, SB 1418 goes to the Assembly floor.

Because both bills were amended in the second house to clarify the one-for-one nature of exchange, they must return to their house of origin for a "concurrence vote" before going to the Governor. The Governor then has 12 days to sign or veto it. If he takes no action on the bill within 12 days of its receipt, it becomes law. He could also send the bill back to the Legislature with a request that it be amended. If, however, he receives the bill after August 20th, he has until Sept. 20 to take action. The Governor has not yet indicated his position on needle-exchange, but we have requested a meeting with his staff to discuss it. **Your help is needed now, more than ever.**

WHAT YOU CAN DO:

1. Using the sample letter on back, write the Governor and urge him to sign the needle exchange bill into law. To be most effective, mail your letter by August 21st.
2. If you live in a district that is represented by one of the following five Republican supporters, send a copy of your letter to him or her. This will assist our efforts to enlist their help with the Governor.

Assemblyman Bill Filante, M.D. (R-San Rafael), Room 5135
Assemblywoman Tricia Hunter (R-Bonita), Room 2002
Assemblyman Stan Statham (R-Redding), Room 4098
Senator Ken Maddy (R-Fresno), Room 305
Senator Rebecca Morgan (R-Los Altos Hills), Room 4090

Send to: Hon. _____,
State Capitol, Room _____,
Sacramento, CA 95814

THANK YOU FOR YOUR HELP. YOUR ACTION WILL SAVE LIVES!

SAMPLE LETTER

July 24, 1992

Hon. Pete Wilson
Governor, State of California
State Capitol
Sacramento, CA 95814

Dear Governor Wilson:

I am writing (on behalf of _____, if you're from an agency) to urge you to sign legislation (AB 2525/SB 1418) to establish a clean needle and syringe exchange pilot project when it comes to you in the next few weeks.

It is essential that local communities, at their discretion, are able to incorporate this public health intervention into their ongoing efforts to halt the spread of HIV. According to the State Office of AIDS, injection drug use has emerged as one of the most prevalent risk factors for new AIDS cases in California.

Numerous studies of needle exchange programs in the United States and abroad show that needle exchange is an effective HIV prevention intervention. Studies also show that needle exchange can serve as an important bridge to voluntary drug treatment and other primary medical and social services. At the same time, the claim that needle exchange programs lead to increased drug use and criminal activity are completely unfounded. Rather than basing your position on these unsubstantiated fears, we urge you to rely upon available research and the recommendations of public health experts.

In addition to bi-partisan support in the Legislature, this legislation has been endorsed by most of California's major public health and professional organizations, including: the California Medical and Nurses Associations, the California Conference of Local Health Officers, County Drug Program Administrators, and the National Council on Alcoholism and Drug Dependence of California.

I (name of your organization) urge(s) your support of this life-saving legislation. Thank you.

Sincerely,

Name

PLEASE PASS ALONG THIS ALERT!!

ACTION ALERT

URGE GOVERNOR WILSON TO SIGN NEEDLE EXCHANGE LEGISLATION

WHERE WE ARE NOW:

Due to the budget stalemate, the Legislature did not take its Summer recess and is continuing to work on other legislation. Both needle exchange bills, AB 2525 (Brown) and SB 1418 (Watson), are moving through the final steps of the process. **Though Aug. 31 is the deadline for either house to pass a bill, one of the bills could get to the Governor as early as the first week in August.**

On July 20, AB 2525 was reported out of Senate Appropriations Committee and is now awaiting a vote on the Senate floor. The floor vote will likely take place on Thurs., July 30. We expect a close vote, as was the case with SB 1418 (21-14) -- (21 is the minimum needed for passage). Because we fell one vote short of the 12 votes needed to get it out of the Assembly Ways and Means on July 22nd, SB 1418 must go before this same Committee for "reconsideration" on Aug. 5th. After Ways and Means, SB 1418 goes to the Assembly floor.

Because both bills were amended in the second house to clarify the one-for-one nature of exchange, they must return to their house of origin for a "concurrence vote" before going to the Governor. The Governor then has 12 days to sign or veto it. If he takes no action on the bill within 12 days of its receipt, it becomes law. He could also send the bill back to the Legislature with a request that it be amended. If, however, he receives the bill after August 20th, he has until Sept. 20 to take action. The Governor has not yet indicated his position on needle-exchange, but we have requested a meeting with his staff to discuss it. **Your help is needed now, more than ever.**

WHAT YOU CAN DO:

1. Using the sample letter on back, write the Governor and urge him to sign the needle exchange bill into law. To be most effective, mail your letter by August ~~7th~~ 21st.
2. If you live in a district that is represented by one of the following five Republican supporters, send a copy of your letter to him or her. This will assist our efforts to enlist their help with the Governor.

Assemblyman Bill Filante, M.D. (R-San Rafael), Room 5135
Assemblywoman Tricia Hunter (R-Bonita), Room 2002
Assemblyman Stan Statham (R-Redding), Room 4098
Senator Ken Maddy (R-Fresno), Room 305
Senator Rebecca Morgan (R-Los Altos Hills), Room 4090

Send to: Hon. _____,
State Capitol, Room _____,
Sacramento, CA 95814

THANK YOU FOR YOUR HELP. YOUR ACTION WILL SAVE LIVES!

SAMPLE LETTER

July 24, 1992

Hon. Pete Wilson
Governor, State of California
State Capitol
Sacramento, CA 95814

Dear Governor Wilson:

I am writing (on behalf of _____, if you're from an agency) to urge you to sign legislation (AB 2525/SB 1418) to establish a clean needle and syringe exchange pilot project when it comes to you in the next few weeks.

It is essential that local communities, at their discretion, are able to incorporate this public health intervention into their ongoing efforts to halt the spread of HIV. According to the State Office of AIDS, injection drug use has emerged as one of the most prevalent risk factors for new AIDS cases in California.

Numerous studies of needle exchange programs in the United States and abroad show that needle exchange is an effective HIV prevention intervention. Studies also show that needle exchange can serve as an important bridge to voluntary drug treatment and other primary medical and social services. At the same time, the claim that needle exchange programs lead to increased drug use and criminal activity are completely unfounded. Rather than basing your position on these unsubstantiated fears, we urge you to rely upon available research and the recommendations of public health experts.

In addition to bi-partisan support in the Legislature, this legislation has been endorsed by most of California's major public health and professional organizations, including: the California Medical and Nurses Associations, the California Conference of Local Health Officers, County Drug Program Administrators, and the National Council on Alcoholism and Drug Dependence of California.

I (name of your organization) urge(s) your support of this life-saving legislation. Thank you.

Sincerely,

Name

PLEASE PASS ALONG THIS ALERT!!

**THE ALIOTO LEGISLATIVE PROGRAM
"NEEDLE EXCHANGE FOR SAN FRANCISCO"**

1. Resolution Establishing Program

This measure memorializes the Mayor to request the Health Commission to adopt the report of the Department of Public Health's AIDS Office, *"Comprehensive Plan to Reduce the Spread of HIV Infection Among Injection Drug Users (IDUs) in the City and County of San Francisco,"* and, thereby, establish a formal needle exchange program.

The goals of the program are to:

- A. Reduce needle sharing among IDUs and, thereby reduce the rate of transmission of HIV infection among them, their sexual partners, and their offspring. The Department of Public Health estimates that 16-20 percent of the City's 16,000 injection drug users are infected with HIV.
- B. Enroll IDUs into substance abuse treatment and, ultimately, into ongoing recovery.
- C. Educate IDUs about safer sex practices and inform them of opportunities for HIV testing and other services.
- D. Refer IDUs to primary health care programs and early intervention programs to meet their primary medical needs.

2. Resolution Endorsing State Legislation

This measure endorses state legislation that will be introduced next week by Speaker Willie Brown in the Assembly and Senator Diane Watson in the State Senate to permit a needle exchange demonstration project in San Francisco and other qualifying counties. This measure further authorizes and directs the City's Legislative Lobbyist to make enactment of the Brown/Watson bills the chief legislative goal for the City in 1992.

3. Resolution Authorizing Private Grants Solicitations

This measure authorizes the Department of Public Health to solicit funding support for the needle exchange program from the private sector, including businesses and non-profit

foundations. Further, this measure specifically authorizes the Department of Public Health to make application for grant support from the American Foundation for AIDS Research (AmFAR).

4. Resolution Requesting Supplemental Appropriation

This measure memorializes the Mayor to ask the Health Commission to submit a request for supplemental appropriations in the amount of \$150,000 to pay for the cost of the comprehensive program for needle exchange and for drug treatment services.

5. Resolution Memorializing the City Attorney to Act

This measure memorializes the Mayor to request the City Attorney to represent, or contract out for representation, the legal interests of the Mayor, Board of Supervisors, Department of Public Health, Police Department, City, or City-contracted employees, in the event of any legal injunctions, prosecutions, challenges, or sanctions to implementing any provision of the above-referenced measures.

6. Resolution Honoring the Work of Prevention Point

This measure honors the work of Prevention Point, the nation's single largest distributor of clean needles to injection drug users. Further, the measure recognizes the work of Prevention Point as an essential public health service and life-saving program.

(1)

1 [Public Health -- Needle Exchange Program]

2 MEMORIALIZING HIS HONOR, THE MAYOR, TO REQUEST THAT THE
3 SAN FRANCISCO PUBLIC HEALTH COMMISSION FULLY IMPLEMENT THE
4 "COMPREHENSIVE PLAN TO REDUCE THE SPREAD OF HIV INFECTION
5 AMONG INJECTION DRUG USERS (IDUs) IN THE CITY AND COUNTY OF
6 SAN FRANCISCO," ENDORSING AND ESTABLISHING A CITY-SPONSORED
7 NEEDLE EXCHANGE AND TREATMENT PROGRAM FOR INJECTION DRUG
8 USERS, AND REQUESTING A REPORT ON ITS READINESS.

9 WHEREAS, The San Francisco Department of Public Health
10 estimates that 16-20 percent of the City's 16,000 injection drug
11 users are infected with the Human Immunodeficiency Virus (HIV) that
12 causes AIDS; and

13 WHEREAS, The Centers for Disease Control (CDC) and other
14 scientific experts have determined that HIV is spread through
15 unprotected sexual intercourse or sharing needles with persons
16 infected with the deadly virus; and

17 WHEREAS, The San Francisco Department of Public Health
18 documents 1,022 cases of AIDS among gay and bisexual injection drug
19 users, and 349 cases of AIDS among heterosexual injection drug users,
20 representing 9.2 percent and 3.2 percent, respectively, of the City's
21 11,218 total AIDS cases reported as of September, 30, 1991; and

22 WHEREAS, Gays, bisexuals, and people of color account for most
23 cases of HIV infection contracted from injection drug use, according
24 to statistics collected by the San Francisco Department of Public
25

SUPERVISOR ALIOTO

1 Health: Gay and bisexual injection drug users represent 9.1 percent
2 of the City's total AIDS cases. Of these, 79 percent are Caucasian,
3 12 percent African American, 8 percent Latino, 0.8 percent Asian/
4 Pacific Islander, and 0.5 percent Native Americans. Among
5 heterosexual injection drug users with AIDS, 47 percent are African
6 American, 38 percent Caucasian, 14 percent Latino, 1 percent
7 Asian/Pacific Islander, and 0.3 Native American; and

8 WHEREAS, Injection drug use was the route of HIV transmission
9 for 42 percent of the 177 women in San Francisco who have an AIDS
10 diagnosis; and

11 WHEREAS, The seroprevalance among heterosexual injection drug
12 users has climbed to a present level of 15 percent, and among gay and
13 bisexual male injection drug users to 70 percent in San Francisco;
14 and

15 WHEREAS, City public health officials declare a "second wave"
16 of the AIDS epidemic is occurring among injection drug users in San
17 Francisco, with an associated increase in the number of perinatal
18 AIDS cases; and

19 WHEREAS, Leading scientific and public health authorities
20 support needle exchange programs, including the National Commission
21 on AIDS, National Academy of Sciences, American Foundation for AIDS
22 Research, California Medical Association, California State Board of
23 Pharmacy, San Francisco Medical Society, and San Francisco AIDS
24 Foundation; and

25 **SUPERVISOR ALIOTO**

1 **WHEREAS**, A Yale University study completed in July, 1991,
2 for the City of New Haven showed 91 percent of shared needles are
3 contaminated with the AIDS virus. The study showed that the rate of
4 new HIV infection was reduced by one-third in New Haven within seven
5 months of implementing a needle exchange program; and

6 **WHEREAS**, Prevention Point volunteers in San Francisco risk
7 arrest and imprisonment as they conduct the nation's single largest
8 needle exchange program, with 12,000 clean needles distributed
9 weekly; and

10 **WHEREAS**, Evidence shows that needle exchange significantly
11 reduces the risk of HIV infection through injection drug use. In
12 1986, 43 percent of methadone detox admissions had self-reported
13 sharing needles. In 1990, just 17 percent of methadone detox
14 admissions had self-reported sharing needles. Public Health
15 officials credit this dramatic decline to (1) the initiation of
16 Prevention Point needle exchange program in November, 1988; and (2)
17 education of in-treatment injection drug users; and

18 **WHEREAS**, Community concerns have been expressed about the
19 possible ~~legal and~~ sociological consequences of a needle exchange
20 program on people of color, but these concerns are relieved if a
21 City-sponsored needle exchange program is comprehensive, and sets as
22 its goal drug treatment and care for injection drug users; and

23 ////

24 ////

25 ////

SUPERVISOR ALIOTO

amendment

1
2 **WHEREAS,** San Francisco voters have adopted a policy
3 supporting decriminalization of possession and use of syringes; and

4 **WHEREAS,** The San Francisco Health Commission recently adopted
5 the joint report of the Department's AIDS Office and community
6 substance abuse services, "*Comprehensive Plan to Reduce the Spread of*
7 *HIV Infection Among Injection Drug Users (IDUs) in the City and*
8 *County of San Francisco*," which would establish a comprehensive,
9 City-sponsored, needle exchange-drug treatment program; and

10 **WHEREAS,** The goals of the San Francisco Health Commission plan
11 are to: (1) Reduce needle sharing among injection drug users and,
12 thereby, reduce the rate of transmission of HIV infection among IDUs,
13 their sexual partners, and their offspring; (2) Enroll injection drug
14 users into substance-abuse treatment and, ultimately, into ongoing
15 recovery; (3) Educate injection drug users about safer sex practices
16 and inform them of opportunities for HIV testing and other services;
17 and (4) Refer injection drug users to primary health care programs
18 and early intervention services to meet their medical care needs; and

19 **WHEREAS,** The lack of a sanctioned and City-sponsored needle
20 exchange program threatens the lives and well-being of thousands of
21 San Franciscans, their sexual partners, and offspring; and,
22 furthermore, it puts at risk for arrest and imprisonment the
23 dedicated volunteers of Prevention Point as they go about their life-
24 saving work; now, therefore, be it

25 **SUPERVISOR ALIOTO**

1 RESOLVED, It shall be the policy of the City and County of San Francisco
2 to act swiftly to protect the lives of its residents by offering the necessary HIV
3 educational and prevention tools to all persons at risk for HIV infection, including
4 City distribution of condoms, needles, bleach, and any other devices determined by the
5 County Health Officer as necessary to control the spread of HIV; and, be it

6 FURTHER RESOLVED, That the Board of Supervisors memorializes his honor, the
7 Mayor , to ask the Health Commission to implement the "Comprehensive Plan to Reduce
8 the Spread of HIV Infection Among Injection Drug Users (IDUs) in the City and County
9 of San Francisco," and, thereby, formally establish a City-sponsored needle exchange
10 program to help prevent HIV transmission and to serve as a bridge for those seeking
11 drug treatment services; and, be it

12 FURTHER RESOLVED, That the Board of Supervisors memorializes his honor, the
13 Mayor, to ask the Health Commission to report on the readiness of a City-sponsored
14 needle exchange program.

15
16 SUPERVISOR ALIOTO
17
18
19
20
21
22
23
24
25

FILE NO. _____

RESOLUTION NO. _____

1 [State Legislation -- Needle Exchange Program]
2 MEMORIALIZING THE GOVERNOR AND CALIFORNIA LEGISLATURE TO
3 ENACT LEGISLATION AUTHORIZING THE CITY AND COUNTY OF SAN
4 FRANCISCO TO IMPLEMENT A NEEDLE EXCHANGE PROGRAM TO REDUCE
5 THE INCIDENCE OF HIV TRANSMISSION, MEMORIALIZING MEMBERS OF
6 THE SAN FRANCISCO DELEGATION IN THE STATE LEGISLATURE TO
7 SUPPORT THE LEGISLATION, AND DIRECTING THAT COPIES OF THIS
8 RESOLUTION BE FORWARDED TO HIS HONOR, THE MAYOR, FOR
9 TRANSMISSION TO THE APPROPRIATE STATE REPRESENTATIVES.

10
11 WHEREAS, The San Francisco Department of Public Health
12 estimates that 15 percent of the City's 16,000 injection drug users
13 are infected with the Human Immunodeficiency Virus (HIV) that
14 scientists believe causes AIDS; and

15 WHEREAS, The Centers for Disease Control (CDC) and other
16 scientific experts have determined that HIV is spread through
17 unprotected sexual intercourse or sharing needles with persons
18 infected with the virus; and

19 WHEREAS, The National Commission on Acquired Immune Deficiency
20 Syndrome has released a report recognizing the effectiveness of
21 needle exchange in preventing the spread of AIDS; and

22 WHEREAS, Leading public and scientific health authorities
23 support needle exchange as a proven strategy for controlling the
24 spread of HIV, including the National Commission on AIDS, National
25 SUPERVISOR ALIOTO

1 Academy of Sciences, American Foundation for AIDS Research,
2 California Medical Association, California State Board of Pharmacy,
3 San Francisco Medical Society, and the San Francisco AIDS Foundation;
4 and

5 **WHEREAS**, The voters of San Francisco have adopted a policy
6 supporting decriminalizing the possession of syringes; and

7 **WHEREAS**, State law may make it illegal to furnish needles for
8 unlawful drug use and, except in certain limited circumstances, to
9 furnish needles without a permit from the California State Board of
10 Pharmacy and the prescription of a physician; now, therefore, be it

11 **RESOLVED**, That the Board of Supervisors hereby memorializes
12 the Governor and Legislature to pass legislation, sponsored by
13 Assembly Speaker Willie Brown and State Senator Diane Watson,
14 authorizing the City and County of San Francisco to undertake as part
15 of a comprehensive plan to reduce the spread of HIV infection among
16 injection drug users in the City and County of San Francisco a pilot
17 project to control HIV transmission among substance abusers,
18 which project would include a needle exchange program; and, be it

19 **FURTHER RESOLVED**, That the Board of Supervisors hereby
20 memorializes the members of the San Francisco delegation in the State
21 Legislature to support such legislation; and, be it

22 **FURTHER RESOLVED**, That the Board hereby directs the Clerk of
23 the Board of Supervisors to furnish copies of this resolution to his
24

25 **SUPERVISOR ALIOTO**

1
2 Honor, the Mayor, for transmission to the State Legislative Advocate
3 for presentation to the appropriate State representatives.
4

5
6 **SUPERVISOR ALIOTO**
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

FILE NO. _____

RESOLUTION NO. _____

1 [Public Health -- Needle Exchange Program]

2 AUTHORIZING THE DEPARTMENT OF PUBLIC HEALTH TO SOLICIT
3 PRIVATE GRANTS TO SUPPORT THE OPERATION OF A CITY-SPONSORED
4 NEEDLE EXCHANGE PROGRAM.
5

6
7 WHEREAS, The Board of Supervisors has adopted a measure
8 memorializing his Honor, the Mayor, to request that the San Francisco
9 Public Health Commission to fully implement the "*Comprehensive Plan*
10 *to Reduce the Spread of HIV Infection Among Injection Drug Users*
11 *(IDUs) in the City and County of San Francisco*," and, thereby,
12 endorsing and establishing as part of this comprehensive program a
13 City-sponsored needle exchange and treatment program for injection
14 drug users; and

15 WHEREAS, The San Francisco Department of Public Health has
16 indicated that private grants may be available to the City and County
17 of San Francisco for the purpose of establishing and operating a
18 needle exchange program that serves as a bridge to drug treatment;
19 now, therefore, be it

20 RESOLVED, That the San Francisco Department of Public Health
21 is hereby authorized to solicit private grants for the purpose of
22 establishing and operating a City-sponsored needle exchange program.
23
24
25

SUPERVISOR ALIOTO

FILE NO. _____

RESOLUTION NO. _____

[Public Health -- Needle Exchange Program]
MEMORIALIZING HIS HONOR, THE MAYOR, TO SUBMIT A SUPPLEMENTAL
APPROPRIATIONS REQUEST TO FUND A COMPREHENSIVE NEEDLE
EXCHANGE PROGRAM AND TO PROVIDE FOR TREATMENT SERVICES TO
INJECTION DRUG USERS.

WHEREAS, The Board of Supervisors has adopted a measure
memorializing his Honor, the Mayor, to request the San Francisco
Public Health Commission to fully implement the *"Comprehensive Plan
to Reduce the Spread of HIV Infection Among Injection Drug Users
(IDUs) in the City and County of San Francisco,"* and, thereby,
endorsing and establishing as part of this comprehensive plan, a
City-sponsored needle exchange and treatment program for injection
drug users; and

WHEREAS, The San Francisco Department of Public Health
estimates that it will require \$150,000 in public funds to operate
the above-referenced needle exchange program; and

WHEREAS, The San Francisco Department of Public Health is in
the process of determining the cost of providing drug treatment to
persons who request substance abuse treatment services in the City-
sponsored needle exchange program, but believes forthcoming resources
will provide significant support to help meet the demand; and

WHEREAS, San Francisco is expected to receive \$25.9 million
in Medicaid disproportionate share money, as outlined in SB 855
(Robbins) in the next six weeks; now, therefore, be it

SUPERVISOR ALIOTO

1
2 **RESOLVED**, It is the will of the Board of Supervisors that
3 \$150,000 of the SB 855 money, or funds from any other source, be used
4 to establish and operate a City-sponsored needle exchange program;
5 and, be it further

6 **RESOLVED**, It is the will of the Board of Supervisors that the
7 Director of the Department of Public Health specify the exact amount
8 needed to provide treatment services to participants in the needle
9 exchange program and for his Honor, the Mayor, to include such an
10 amount from non-allocated SB 855 funds in a supplemental
11 appropriations request to the Board of Supervisors.

12
13 **SUPERVISOR ALIOTO**
14
15
16
17
18
19
20
21
22
23
24
25

*amended to
state specific amt.
\$2.5M
of
\$26.9M
of SB 855*

FILE NO. _____

RESOLUTION NO. _____

[City Attorney -- Needle Exchange]

MEMORIALIZING HIS HONOR, THE MAYOR, TO REQUEST THE CITY ATTORNEY TO REPRESENT, OR CONTRACT OUT FOR REPRESENTATION, THE LEGAL INTERESTS OF THE CITY AND COUNTY OF SAN FRANCISCO ON MATTERS RELATING TO NEEDLE EXCHANGE.

RESOLVED, The Board of Supervisors memorializes his Honor, the Mayor, to request the City Attorney to represent, or contract out for representation, the legal interests of the Mayor, Board of Supervisors, Department of Public Health, Police Department, City, or City-contracted employees, in the event of any legal injunctions, prosecutions, challenges, or sanctions to implementing any provision of Board of Supervisors Resolutions Nos. _____, _____, _____, and _____.

SUPERVISOR ALIOTO

1 [RECOGNITION -- PREVENTION POINT]

2 RECOGNIZING THE PUBLIC SERVICE CONTRIBUTIONS AND LIFE-SAVING
3 WORK OF PREVENTION POINT.
4

5 WHEREAS, The San Francisco Department of Public Health
6 estimates that 16-20 percent of the City's 16,000 injection drug
7 users are infected with the Human Immunodeficiency Virus (HIV) that
8 causes AIDS; and

9 WHEREAS, Prevention Point is a non-profit, community-based
10 organization, founded November 2, 1988, to combat the spread of HIV
11 among injection drug users by operating a needle exchange program;
12 and

13 WHEREAS, The Prevention Point program is non-judgmental, low
14 profile, and respected among injection drug users and public health
15 officials alike; and

16 WHEREAS, Prevention Point now distributes 12,000 clean needles
17 each week; and since its inception had made over 80,000 client
18 contacts and exchanged 800,000 syringes.

19 WHEREAS, Evidence shows that the work of Prevention Point
20 significantly reduces the risk of HIV infection through injection
21 drug use. In 1986, 43 percent of methadone detox admissions had
22 self-reported sharing needles. In 1990, just 17 percent of methadone
23 detox admissions had self-reported sharing needles. Public health
24 officials credit this dramatic decline to the initiation of

25 SUPERVISOR ALIOTO

1 the Prevention Point needle exchange program and education of in-
2 treatment injection drug users; and

3 **WHEREAS**, Prevention Point has an annual budget of \$114,000, and
4 is completely reliant on private donations to sustain its life-saving
5 work; and

6 **WHEREAS**, Because of confusion and uncertainty about State laws
7 governing the possession and use of syringes, the volunteers of
8 Prevention Point expose themselves to arrest, prosecution, and
9 imprisonment for their vital public health outreach with injection
10 drug users; and

11 **WHEREAS**, The real heroes in the war against AIDS are the
12 volunteers of Prevention Point and other activists and community-
13 based groups that put themselves at risk for arrest, serve jail time,
14 and public ridicule in order to draw public attention to the
15 pandemic, and those who devote long hours to care for people with HIV
16 or at risk for infection; now, therefore, be it

17 **RESOLVED**, That the Board of Supervisors hereby recognizes and
18 applauds the life-saving contributions of Prevention Point to the
19 people of San Francisco; and, be it further

20 **RESOLVED**, That the Board of Supervisors hereby declares the
21 work of Prevention Point is essential to the public health, and
22 encourages individuals, foundations, businesses, and community groups
23 to help sustain Prevention Point in its work with financial support
24 and in-kind contributions.

25 **SUPERVISOR ALIOTO**

DR



MEMORANDUM

Date: June 26, 1992

To: Needle Exchange Working Group Members, Other Interested Individuals and Organizations

From: Regina Aragón, State Policy Coordinator *RA*

Re: Meeting Notice; Legislative Update on AB 2525/SB 1418

WORKING GROUP MEETING NOTICE:

The next meeting of the Needle Exchange Working Group is scheduled for Thursday, July 17, from 11:00 AM to 1:00 PM in the 3rd floor conference room at the SF AIDS Foundation (25 Van Ness at Market). I hope you will be able to attend to discuss the final stages of the legislative campaign and to update the group on the status of local efforts around the Bay Area.

LEGISLATIVE UPDATE:

First a bit about the legislative schedule. After the Legislature completes the FY 92-93 budget, it will be in recess until August 3rd. All bills must sent to the Governor before the Legislature adjourns for the year on August 29th. Governor Wilson then has until Sept. 30th to sign or veto a bill. Governor Wilson has not yet taken a formal position on the bill.

AB 2525 (Brown)

On May 18 the Assembly approved AB 2525 by a vote of 43-33. It then crossed over to the Senate, where it was amended to include the words "one-for-one" (this was causing a bit of confusion and allowing certain critics to claim that the pilot would lead to an increase in the number of discarded needles) and was moved out of Senate Health and Human Services Committee on June 24th by a vote of 5-2 (see enclosed roll call). It now goes to the Senate Appropriations Committee. Because the bill involves negligible (if any) state costs, we don't expect any problem getting it out of Appropriations and sending it to the Senate floor for a vote.

SB 1418 (Watson)

The Senate approved SB 1418 by a vote of 21-14 on June 4th. Despite bipartisan support --Senate Maddy (R-Fresno) and Senator Morgan (R-Menlo Park) both voted in favor of the bill -- there were a couple of disappointments, including a no vote by Senator Quentin Kopp (D-SF/San Mateo) and an abstention by Senator David Roberti (D-West LA).

SB 1418's next hurdle is a hearing before the Assembly Health Committee on Tuesday, June 30th (1:30 pm, Room 4202 of the State Capitol). This same committee approved the Speaker's bill by a vote of 12-1 in March. SB 1418 will also be amended to include specific reference to "one-for-one" exchange. It is important that we have a strong presence at this final policy committee hearing, particularly in light of the opposition we are now encountering (see below). From Assembly Health, SB 1418 will go the Assembly Ways and Means Committee and then to the Assembly floor.

Opposition Becoming More Vocal

In May, the California District Attorneys Association added their voice to the Peace Officers, Police Chiefs and Sheriffs Associations and the Committee on Moral Concerns, who have all taken an "oppose" position on AB 2525. Though we expected the DAs to show up at the Senate Health and Human Services Committee hearing on AB 2525, they never did. (AB 2525 was originally scheduled to go before the Committee on June 17, when the Alameda and Santa Cruz DAs and someone from the Sacramento Sheriff's office were there to testify against the bill.)

We, on the other hand, had a number of strong witnesses at the hearing, including SF District Attorney Arlo Smith, who gave an extremely effective response to the Committee on Moral Concerns. Norma Hottlinger also presented very moving testimony to the Committee from the perspective of a former injection drug user. Thanks to all who came to the hearing and waited to testify in support of the bill.

SPEAKING OF THANK YOUS...

Hellan Roth Dowden, San Francisco's state lobbyist, who has worked tirelessly on the issue of needle exchange, has left her current position to be Chief of Staff for the Senate Democratic Caucus. We all owe Hellan a huge debt of gratitude. Thank you letters can be sent to Hellan c/o Senate Democratic Caucus, State Capitol, Sacramento, CA, 95814.

While you're at it, please take some time in the next week to thank legislators who voted in support of either SB 1418 or AB 2525 in the past few weeks. A short note is all that's needed. We will need each and every one of their votes in August when both bills go for a final floor vote (AB 2525 in the Senate, SB 1418 in the Assembly). A list of roll calls and members' addresses are enclosed for your use.

Needle Exchange Working Group
June 26, 1992
Page 3

NEED TO PROTECT LOCAL FUNDING FOR PARTICIPATION IN PILOT

With both state and local funding situations up in the air, don't forget to ensure that your county has set aside funds to pay for its participation in the clean needle and syringe exchange pilot project. Once signed into law, the bill will take effect in January 1993, which would require up to six months of funding in FY 92-93.

OTHER DEVELOPMENTS

- On June 25th the National Commission on AIDS blasted the Bush Administration for its failure to implement the Commission's numerous recommendations, including the need for needle exchange and treatment on demand.
- The National Institute on Drug Abuse (NIDA) has awarded its first ever federally-funded research on needle exchange to Dr. Ed Kaplan of the Yale School of Organization and Management.
- The CA Medical Assoc. and the National Council of Alcoholism and Drug Dependence of CA have added their names to the growing list of AB 2525/SB1418 endorsers.

SEE YOU ON JULY 17TH!!

Display 1991-1992 Votes - ROLL CALL

MEASURE: SB 1418
 AUTHOR: Watson
 TOPIC: AIDS: Clean Needle and Syringe Exchange Pilot Project.
 DATE: 06/04/92
 LOCATION: SEN. FLOOR
 MOTION: SENATE THIRD READING SB 1418 WATSON
 (AYES 21. NOES 14.) (PASS)

Mail to:
 The Honorable _____
 State Capitol, Room -
 Sacramento, CA 95834

AYES

Alquist
 Bill Greene
 Keene
 Marks
 Petris
 Watson

Calderon
 Leroy Greene
 Killea
 McCorquodale
 Rosenthal

Deddeh
 Hart
 Lockyer
 Mello
 Thompson

Dills
 Johnston
 Maddy
 Morgan
 Torres

NOES

Ayala
 Davis
 Leonard
 Royce

Bergeson
 Cecil Green
 Leslie
 Russell

Beverly
 Hill
 Presley

Boatwright
 Kopp
 Rogers

ABSENT, ABSTAINING, OR NOT VOTING

Craven
 Vacancy

Lewis

Roberti

Vuich

Senate Health and Human Services Committee Roll Call on AB 2525
 Weds., June 24th

(AYE 5. NO 2. ABSENT 2.)

AYES

Watson
 Mello
 Calderon
 Deddah
 Rosenthal
 Thompson

NO

Bergeson
 Royce

ABSENT

Maddy
 Mello

(over for addresses)

CALIFORNIA STATE SENATE

LEGISLATOR	CAPITOL ROOM NUMBER	PHONE (916/445-____)	
*ALQUIST, Alfred (D-San Jose)	5100	-9740	
AYALA, Ruben (D-Chino)	2082	-6868	
BERGESON, Marian (R-Newport Beach)	3063	-4961	
BEVERLY, Robert (R-Manhattan Beach)	5082	-6447	
*BOATWRIGHT, Daniel (D-Concord)	3086	-6083	
*CALDERON, Charles (D-Whittier)	2048	-8315	
CRAVEN, William (R-Oceanside)	3070	-3731	
DAVIS, Ed (R-Chatsworth)	5052	-8873	
DEDDEH, Wadie (D-Bonita)	3048	-6767	
DILLS, Ralph (D-Gardena)	5050	-5953	
GREEN, Cecil (D-Norwalk)	2054	-5581	
GREENE, Bill (D-Los Angeles)	4035	-2104	
GREENE, Leroy (D-Carmichael)	3082	-7807	
*HART, Gary (D-Santa Barbara)	4074	-5405	
*HILL, Frank (R-Whittier)	4082	-2848	
JOHNSTON, Patrick (D-Stockton)	2068	-2407	
KEENE, Barry (D-Benicia)	313	-3375	
KILLEA, Lucy (I-San Diego)	4062	-3962	
KOPP, Quentin (I-San Francisco)	3056	-0503	
LEONARD, Bill (R-Upland)	5087	-3688	
*LESLIE, Tim (R-Auburn)	4081	-5788	* Senate Budget & Fiscal Review Committee Member
LEWIS, John (R-Orange)	3074	-4264	
LOCKYER, Bill (D-San Leandro)	2032	-6671	
MADDY, Kenneth (R-Fresno)	305	-9600	
MARKS, Milton (D-San Francisco)	5035	-1412	
*McCORQUODALE, Dan (D-San Jose)	4032	-3104	
MELLO, Henry (D-Monterey)	5108	-5843	
*MORGAN, Rebecca (R-Los Altos Hills)	4090	-6747	
*PETRIS, Nicholas (D-Oakland)	5080	-6577	
PRESLEY, Robert (D-Riverside)	4048	-9781	
ROBERTI, David (D-Hollywood) President	205	-8390	
*ROGERS, Don (R-Bakersfield)	5064	-6637	
ROSENTHAL, Herschel (D-Los Angeles)	4070	-7928	
ROYCE, Ed (R-Anaheim)	4053	-5831	
RUSSELL, Newton (R-Glendale)	5061	-5976	
*THOMPSON, Mike (D-St. Helena)	3056	-3353	
TORRES, Art (D-Los Angeles)	2080	-3456	
VUICH, Rose Ann (D-Dinuba)	5066	-4641	
*WATSON, Diane (D-Los Angeles)	4040	-5215	

CALIFORNIA STATE ASSEMBLY

*ALLEN, Doris (R-Cypress)	4153	-6233	
ALPERT, Deirdre (D-DelMar)	3147	-2112	
ANDAL, Dean (R-Stockton)	4116	-7931	
ARCHIE-HUDSON, Marguerite (D-Los Angeles)	5119	-2363	
AREIAS, Rusty (D-Los Banos)	5136	-7380	
*BAKER, William (R-Danville)	3013	-8528	
BANE, Tom (D-Van Nuys)	3152	-3134	
BATES, Tom (D-Oakland)	446	-7554	
BECERRA, Xavier (D-Los Angeles)	2174	-0854	
BENTLEY, Carol (R-El Cajon)	4130	-6161	
BOLAND, Paula (R-Granada Hills)	4208	-8366	
BRONZAN, Bruce (D-Fresno)	448	-8514	
BROWN, Willie (D-San Francisco) Speaker	219	-8077	
BRULTE, James (R-Ontario)	4009	-8490	
*BURTON, John (D-San Francisco)	2179	-8253	
*CAMPBELL, Robert (D-Richmond)	2163	-7890	
CANNELLA, Sal (D-Modesto)	5144	-8570	
CHACON, Peter (D-San Diego)	5016	-7610	

* Assembly Ways &
Means Committee
Member

(over for roll call votes) —

**the Napa Valley
Register**

Opinion

Sunday, May 3, 1992

Needle bill offers local control

By REGINA ARAGON

For over 10 years, this nation's AIDS crisis has demanded extraordinary public health measures to prevent the spread of HIV infection and save lives — measures that frequently have tested and challenged our sense of humanity and conventional values.

Currently, the California State Legislature is considering Legislation (AB 2525, SB 1418) that, if approved, would allow communities to establish programs that would permit injection drug users to exchange dirty syringes for clean ones to prevent HIV transmission. It is an unconventional, extraordinary public health measure that is already saving lives and strongly merits the approval of the state Legislature and Gov. Wilson.

Through a relatively new concept for most lay people, over the last three years needle exchange, as an effective HIV prevention strategy, has gained widespread support from many of the most respected health policy groups in California and the nation, including the California Medical Association, the California Nurses Association, the State Board of Pharmacy, the National Commission on AIDS, the California Association of County Drug Program Administrators and the California Conference of Local Health Officers.

These groups have seen the data from needle exchange programs in this country and abroad — data which strongly indicates that such programs reduce the risk of HIV



REGINA ARAGON

infection among injection drug users and decrease the spread of HIV. For example, a recent evaluation of a state-approved pilot needle exchange program in New Haven, Conn., reported a 30 percent reduction in HIV transmission among injection drug users.

AB 2525, by Assembly Speaker Willie Brown, and its companion measure, SB 1418, by Senator Diane Watson, represent an extremely responsible approach to needle exchange that respects the unique needs and decision-making authority of local communities. Only those counties whose local health officers and boards of supervisors request authorization from the state would be eligible to participate in a pilot program. In

other words, if a community does not want to institute a needle exchange program, it can make that decision with full local control.

Each time the merits of needle exchange are debated, a number of concerns emerge and must be addressed responsibly. By far the greatest concern is that needle exchange programs condone and increase drug use. Needle exchange studies in the U.S. and abroad consistently report that drug use has not risen. In fact, in Tacoma, Wash., the local needle exchange program has actually increased utilization of drug treatment services by injection drug users. What's more, needle exchange programs appear to be reaching injection drug users who have largely ignored the traditional drug and HIV prevention services of local communities.

AB 2525 and SB 1418 take a highly responsible and realistic approach to HIV prevention among injection drug users. The measures require communities to implement a comprehensive HIV prevention program that relies not just on exchanging clean needles, but also builds in strong drug treatment services and HIV education strategies. When reviewed with objectivity and with a clear view of the facts, locally controlled needle exchange programs can play an effective and valuable role in reducing the spread of HIV and merit state legislative approval.

(Regina Aragón is State Policy Coordinator with the San Francisco AIDS Foundation).

NEEDLE EXCHANGE SAVES LIVES

SUPPORT AB 2525 (BROWN)/SB 1418 (WATSON)

BACKGROUND

Current law prohibits the dispensing of hypodermic needles and syringes without a prescription or permit. In an effort to curtail the spread of HIV among injection drug users, AB 2525 (Brown) and SB 1418 (Watson) would amend this law to allow for the one-to-one exchange of clean needles and syringes for used ones within the context of a three-year pilot needle exchange program. Both bills are co-sponsored by the San Francisco AIDS Foundation and the City and County of San Francisco.

Before the end of May, the full Assembly and Senate will vote on AB 2525 and SB 1418, respectively. **Encourage your legislators to vote for this life-saving public health intervention.**

NEEDLE EXCHANGE VIEWED AS PART OF A COMPREHENSIVE PREVENTION EFFORT

AB 2525 and SB 1418 support the belief that needle exchange must be seen as one part of a comprehensive prevention plan targeting injection drug users. Other program components outlined in the legislation include community-based HIV education outreach to injection drug users and their partners, linkage to drug treatment services and primary medical care.

COMMUNITIES DECIDE WHETHER OR NOT TO PARTICIPATE IN THE PILOT

The legislation specifically provides for the participation of the City and County of San Francisco. Other counties and cities with health departments could opt-in to the program through the request of their local health officers and Boards of Supervisors. **Though the majority of California's counties are not expected to request authorization to participate in the pilot program, it is vitally important that those communities that are ready and eager to participate be able to do so.**

The legislation states clearly that local communities, including public safety officials, must be involved in the design and assessment of the program. There must also be assurance that education and outreach programs are accessible to the client population, culturally sensitive and linguistically appropriate.

STUDIES FROM SAN FRANCISCO AND OTHER PROGRAMS SHOW EFFECTIVENESS

A 1991 Yale University study of a state-sponsored pilot needle exchange program in New Haven, Connecticut reports a 33% reduction in new HIV infections just eight months after the program's inception. In San Francisco, researchers at the University of

California have concluded that the program does not result in increased drug use by current users, nor does it lead to the recruitment of new drug users. In addition, public health officials in Tacoma, Washington report that the local needle exchange program is now the largest source of referrals to voluntary drug treatment services.

Despite the availability of these and other studies showing the effectiveness of this intervention, AB 2525 and SB 1418 require communities that participate in the pilot program to complete an assessment of the program's effectiveness and to submit this assessment to the Department of Health Services and the State Legislature. **At the conclusion of this three-year pilot program, state officials will be able to conclude for themselves that needle exchange saves lives.**

THE PUBLIC HEALTH COMMUNITY SUPPORTS NEEDLE EXCHANGE

Both bills represent a cautious and limited approach to a public health intervention that is supported by a wide range of community groups and professional organizations, including the California Medical Association, the California Nurses Association, the California Conference of Local Health Officers, the California Association of County Drug Program Administrators, the California AIDS Leadership Committee, the California Association of AIDS Agencies and the LIFE AIDS Lobby. The National Commission on AIDS also endorsed needle exchange in its recent report entitled "The Twin Epidemics of Substance Use and HIV."

SOME KEY FACTS ABOUT HIV, INJECTION DRUG USE, AND NEEDLE EXCHANGE

- ▶ Injection drug users are the second largest group at risk for HIV/AIDS, and they are the primary source of heterosexual, female and perinatal transmission in California and the United States.
- ▶ While African-Americans and Latinos make up 28% and 16% of all diagnosed AIDS cases in the United States, respectively, of the cases attributed to injection drug use, African-Americans account for 45% of the cases and Latinos for 26%.
- ▶ Studies show that needle sharing among injection drug users is the primary means of HIV transmission within this population.
- ▶ San Francisco's Prevention Point is now the largest program in the country, exchanging up to 15,000 needles on a one-to-one basis each week.

AB 2525 EDITORIAL CAMPAIGN STATUS REPORT
(As of 4/10/92)

Previous Editorials Supporting Needle Exchange:

Oakland Tribune - 12/24/91
Peninsula Times-Tribune - 5/91
San Francisco Examiner - 1/21/92
Santa Cruz Sentinel - 3/3/92
Stockton Record - 12/91
USA Today - 8/22/91

Editorials Achieved in Support of AB2525:

Bay Area Reporter - 4/9/92
Fresno Bee - 4/2/92
Modesto Bee - 3/14/92
Oakland Tribune - 3/31/92
Sacramento Bee - 3/17/92
San Francisco Examiner - 4/6/92
San Jose Mercury News - 4/8/92
San Francisco Sentinel - 3/26/92
Santa Cruz Sentinel - 4/7/92
Stockton Record - 4/8/92

Commitment to Print Supporting Editorial:

San Francisco Bay Times - unscheduled
San Francisco Bay Guardian - unscheduled
Santa Rosa Press-Democrat - Will schedule as soon as Assembly floor vote date is set

Probable (Pending):

San Francisco Chronicle (Ed Board meeting scheduled for 4/27 10am)

Definite "No"s:

Glendale News Press - Advised no possibility of pro-bill editorial
Orange County Register - No possibility
San Diego Union-Tribune - Opposing NX editorial - 2/21/92

Suggest Alternative of Guest Editorial:

Napa Register - Fears community backlash/doing 2 page spread of guest ed. on issue 4/26. Our piece (500 words) due 4/24
Salinas Californian - Don't do statewide issues/suggest guest editorial instead

AB 2525 EDITORIAL CAMPAIGN STATUS REPORT
(As of 4/2/92)

Previous Editorials Supporting Needle Exchange:

Oakland Tribune - 12/24/91
San Francisco Examiner - 1/21/92
Santa Cruz Sentinel - 3/3/92
Stockton Record - 12/91
USA Today - 8/22/91

Editorials Supporting AB2525:

Modesto Bee - 3/14/92
Sacramento Bee - 3/17/92
San Francisco Sentinel - 3/26/92

Commitment to Print Supporting Editorial:

Bay Area Reporter - 4/9/92
Fresno Bee - sometime before 4/8 vote
San Francisco Bay Times - 4/9/92
San Francisco Bay Guardian - future/cannot fit it in before 4/8 vote
Stockton Record - pushing to get it in before 4/8 vote

Probable (Pending):

San Francisco Examiner (Being considered and urged by staffers)
San Francisco Chronicle (Editorial Page editor out until 4/6)
Oakland Tribune
Santa Cruz Sentinel (going before ed. board to rush thru before 4/8 vote)

Definite "No"s

Glendale News Press - Advised no possibility of pro-bill editorial
Orange County Register - No possibility
Salinas Californian - Don't do statewide issues/suggest guest editorial
San Diego Union-Tribune - Opposing NX editorial - 2/21/92



San Francisco AIDS Foundation
Board of Directors Resolution on
Needle Exchange

The San Francisco AIDS Foundation supports needle exchange programs as a necessary component in a comprehensive strategy to stop the spread of HIV infection among injection drug users (IDUs). Such programs must be viewed as one small part of a larger constellation of outreach efforts, treatment programs, and prevention and education campaigns targetted at the IDU community.

Studies in the U.S. and abroad indicate that needle exchange programs do not increase the incidence of drug use and have actually increased referrals to drug treatment programs.

Needle exchange programs should not be seen as a replacement for treatment programs. "Treatment on demand" -- the availability of sufficient treatment slots to eliminate waiting lists for treatment -- must remain a goal in any comprehensive AIDS treatment strategy.

Similarly, needle exchange is no substitute for culturally sensitive, non-judgmental prevention and education programs which may keep individuals from ever using injection drugs, may prevent the sharing of needles, and will promote the use of bleach to clean needles. Education and information regarding safe sex practices, the availability of anonymous testing and counseling, and referrals to treatment sites must also be readily available to participants in needle exchange programs and the IDU community at large.

Needle exchange programs -- in conjunction with treatment on demand, adequate prevention and education efforts, and access to anonymous HIV antibody testing and counseling -- are likely to slow the spread of AIDS among the IDU population, will not increase drug use, and will increase referrals to drug treatment programs. Clearly, these programs must be implemented immediately and supported fully by public health officials, city, state and federal policy-makers, and individuals and organizations committed to hastening the end of the HIV epidemic.

4/25/89

Dawe



MEMORANDUM

Date: January 15, 1992

To: Needle Exchange Working Group Members

From: Regina Aragón, State Policy Coordinator, SFAF

Re: **Final Bill Language, Next Working Group Meeting,
Upcoming Hearings of Interest to SF Supporters**

Final Bill Language/Authors

Enclosed please find the final bill language, which was submitted to Leg Counsel this afternoon. In a last minute turn of events, we have not one, but two lead authors! The identical bill will be introduced by the Speaker in the Assembly and Senator Diane Watson, Chair of the Health and Human Services Committee in the Senate. To date, Senator Marks, Assemblywoman Speier and Assemblyman Burton have all agreed to be co-authors. Senator Kopp has declined our request to do the same. The City and County of San Francisco and the SF AIDS Foundation will co-sponsor the bill.

The final language includes a broad opt-in provision for any county or city with a health department that can meet the program, data collection and assessment requirements contained in the bill. Thanks to all on the Expanded Options Committee who contributed to the development of this opt-in language. I think this is a good bill with a solid chance of success, given its lead authors.

Next Needle Exchange Working Group Meeting

The next meeting of the Needle Exchange Working Group will be on **Wednesday, January 29th, from 11:00 am to 1:00 pm in the 3rd Floor Conference Room at the SF AIDS Foundation, 25 Van Ness (at Market)**. Agenda items will include an update on the status and schedule of the bill, legislative/grassroots strategy, and outreach to other areas of the state and potential supporters.

- over -

If you know of another person who should be on the Working Group (remembering, of course, that we agreed that this will, in fact, be a working group) please invite him or her to the next meeting. Given space limitations, however, the selection of one or two representatives from any given organization or group would be greatly appreciated.

If there are key individuals who are unable to attend working group meetings, but would like to be on the mailing list, they can contact me at (415) 864-5855, x2599.

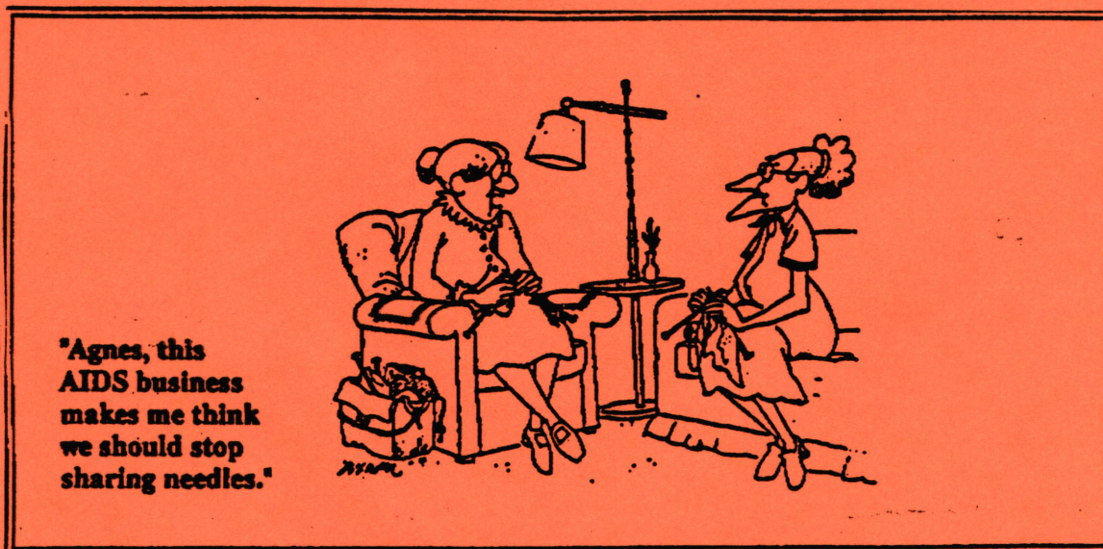
Upcoming Hearings of Interest to San Francisco Supporters

Needle exchange will be the topic of two upcoming hearings in San Francisco.

Tuesday, January 21, 3:00 pm, 101 Grove Street, Room 300
The Health Commission will hear testimony on a resolution to accept the City's Comprehensive Plan to Reduce HIV Infection Among Injection Drug Users. You can call the Health Commission at 554-2666 for further details.

Wednesday, January 22, 10:00 am, City Hall, Room 228
The City Services Committee has tentatively scheduled the the continuation of its discussion of needle exchange during its regularly scheduled committee hearing. You can call the office of the Committee Chair, Supervisor Alioto, to confirm the agenda at 554-7788.

And on A Less Serious Note...



**MINUTES OF THE
EPIDEMIOLOGY & DISEASE CONTROL COMMITTEE
OF THE CCLHO**

Subsequently passed at the Board of Directors meeting.

N/S/P that CCLHO recommends that needle and syringe exchange programs should be a standard part of a broad HIV Prevention Program to reduce the transmission of HIV infection among injection drug users with the following caveats. Since we are concerned that such a program might be incorrectly perceived to be a complete solution, which it is not, we believe that needle and syringe exchange programs are likely to be effective only when part of a comprehensive approach which includes:

1. priority on treatment programs for opiate and stimulant users;
2. outreach for hard to reach addicts to include: referral and training on safer injection and safer sex;
3. provision and evaluation of sterile injection equipment;
4. voluntary (Confidential and Anonymous) HIV testing, counseling and medical follow-up for infected persons and their sexual partners;
5. confidential counseling, testing and appropriate treatment programs in jail and prisons;
6. social service to support families of HIV infected drug users;
7. evaluation of all components; and
8. community involvement in decisions as to how the program will be carried out.

We discussed possible actions to follow this strategy and talked about either a San Francisco legislative or regional approach which can be expanded. We asked our AIDS Affiliate to discuss this strategy and give us some possible actions. The question of direct action by some Health Officers was raised under Section 3110, which may or may not be legal and we have contradictory opinions and the questions of the timing, community support, and Medical and Pharmacy Board's opinions were raised.

Provided to the Monterey County Health Department on 12/11/91 by Eileen M. Eastman of the California Conference of Local Health Officers, Office of Advisory Liaison.

CMA Policy on Clean Needle and Syringe Exchange

CMA supports needle and syringe exchange programs to reduce transmission of HIV infection among intravenous drug users (IVDUs) with the following caveats. Since we are concerned that such a program might incorrectly be perceived to be a complete solution, which it is not,* CMA believes needle and syringe exchange programs are likely to be effective only when part of a comprehensive approach which includes:

1. Priority on treatment programs for opiate and stimulant users;
2. Outreach for hard-to-reach addicts to include;
 - o Referral for treatment
 - o Training on safer injection, e.g. bleach
 - o Training on safer sex
3. Provision and evaluation of sterile injection equipment;
4. Voluntary (confidential and anonymous) HIV testing, counseling, and medical follow-up for infected persons and their sexual partners;
5. Confidential counseling, testing, and appropriate treatment programs in jails and prisons;
6. Social services to support families of HIV-infected drug users;
7. Evaluation of all components, and;
8. Community involvement in decisions as to how the program will be carried out.

* Several areas of the world have provided sterile injection equipment to drug addicted persons. The conclusions to date from the experience at these sites have been:

1. They do not increase drug use.
2. They increase referrals to drug treatment programs.
3. They may reduce the transmission of HIV and other blood-borne infections.
4. That HIV risk behaviors decrease for some participants of needle and syringe exchange programs.

July 1989

AIDS

Advisory

California Medical Association, Department of Physician Education

Volume 2, Number 4

July 1989

An overview of U.S. needle exchange programs

During the March 1989 Annual Session and Western Scientific Assembly, the CMA House of Delegates adopted Resolution 712-89, "Programs for Intravenous Drugs Users," which called for the CMA to encourage evaluation of the use of needle exchange programs, among other things. The following is a report on the needle exchange programs in California and other states.

California

Currently, it is a misdemeanor to possess syringes without a prescription in California. However, in November 1988, a group of 20 people in San Francisco calling themselves Prevention Point began illegally distributing needles to the public. This prompted the city's public health authorities



to announce that they will go to the State and seek permission to institute a needle exchange program for drug addicts this fall. East Bay public health authorities are also discussing the possibility of instituting needle exchanges. In the Los Angeles area there is a move afoot to provide ready access to condoms and bleach to intravenous drug users (IVDUs) but talks about needle exchange have not been serious to date.

Tacoma, WA

One of the first in the nation, Tacoma's program was begun in 1988. A former drug outreach counselor, Dave Purchase, set up shop on the street in downtown Tacoma without official government sanction, although the program had support from the city's mayor, health officials and police who have suspended the enforcement of the misde-

Needle exchange in Tacoma: initial results

In September and October 1988, a pilot survey of 66 needle exchange participants was conducted by the Tacoma-Pierce County Health Department AIDS Prevention Program. Of the 66, 57 percent were male; the mean age was 32.4; 51 percent were non-white. The majority (66 percent) had been injecting drugs for more than five years, and 16 percent had begun injecting drugs within the last year. About 60 percent had been to the needle exchange five times or less.

With regard to injection practices, 71 percent reported sharing needles before the exchange began, this compares with 37 percent that continued to share after the program began. Bleach was used to disinfect needles among 50 percent of those who shared before the exchange began, while 75 percent of those who report sharing after the program began, used bleach. Needle hygiene was defined as either not sharing, or sharing but using either bleach or boiling to disinfect needles. Ninety percent of the IVDUs reported practicing needle hygiene after the program began, as opposed to 66 percent prior to the exchange program.

Behavior changes were

(Continued on page four)

Inside...

HTLV-I in California Page 3

NIAID Clinical Trials Information Page 4

IVDU Table Page 4

Editor—Elizabeth Zima
P.O. Box 7690
San Francisco, CA 94120-7690
(415) 882-5186

(Continued on page two)

New York City

Three quarters of the IV drug-related AIDS cases come from the New York City metropolitan area, where the seroprevalence is estimated to be between 50 and 60 percent among the 200,000 IVDUs.

New York City health officials announced in August 1988 that a pilot program to distribute clean needles to IVDUs would begin that November. New York prohibits the sale or purchase of hypodermic needles and syringes without a prescription from a medical practitioner. Criminal penalties are imposed for the sale, purchase or possession of unprescribed needles and syringes. State Health commissioner Dr. David Axelrod issued a special regulation that judged the pilot program as an experiment and, therefore, an exception to the laws regarding hypodermic needles.

The study was designed to involve 400 IVDUs who are waiting for entry into a drug treatment program. Two hundred users will receive needles and counseling, and the other 200 will receive counseling but no needles.

While the needle exchange began in November, it was slow getting off the ground. Originally there were to have been four sites in sections of Manhattan and Brooklyn where drug use is heavy. Only one of the four has opened—at the Health Department in lower Manhattan, far from the areas that are heavily populated by IVDUs. The exchange is also open only on a limited basis. To date, enrollment has been low. The emphasis of the program has changed to focus on getting drug users into drug rehabilitation, and the test group aspect of the study has been abandoned.

HTLV-I antibody in California IVDUs

The information for this article was drawn from California Morbidity (June 24, 1988) published by the California Department of Health Services.

History

Human T-Cell Lymphomic Virus-I (HTLV-I), a type C retrovirus, was first isolated in 1978 from a patient in the United States with cutaneous T-cell lymphoma and subsequently has been associated with adult T-cell leukemia in Japan. Since 1985, HTLV-I has been serologically and virologically linked with neurologic disease designated as chronic progressive myelopathy.

The great majority of infections with HTLV-I appear to be asymptomatic and probably persist for life. HTLV-I is endemic in southern Japan, Africa, the Caribbean basin and parts of South American and the U.S. Because there is an apparent low disease-to-infection ratio, a long latency period (up to 40 years) and limited seroprevalence data, the impact of the virus in many countries has not yet been noted or properly assessed.

Transmission of HTLV-I occurs by sexual contact, exposure to contaminated blood (e.g., blood transfusion and needle/syringe sharing) and perinatally. Because transmission modes for HIV and HTLV-I are essentially similar, the high seroprevalence rate of HTLV-I antibodies in IVDUs would seem to be an indicator for what could happen with HIV if effective prevention measures for blood and sexually transmitted agents are not widely practiced among IVDUs and their sexual contacts.

Method

A pilot study for antibody to HTLV-I in selected California counties was conducted on 3,349 coded anonymous sera collected in 1986-87. Because HTLV-I test kits were not licensed at the time, these were screened by developmental test methods (enzyme immunoassay and indirect immunofluorescence). Sera came from 940 IVDUs from 19 counties and 2,409 individuals without a known or stated history of IVDU from juvenile halls, prenatal and sexually transmitted disease clinics, marriage license applicants, voluntary blood donors, patients with encephalitis or meningitis and HIV antibody-positive homosexual/bi-sexual men.

Results

The study showed high rates of HTLV-I in persons attending IVDU treatment programs. Twenty percent (191/940) of the IVDU group were HTLV-I seropositive. The seropositivity rates ranged from 0 percent in several small counties to 38 percent in Alameda county. Results in the group with unstated or non-IVDU use status showed only 0.4 percent positive for the HTLV-I antibody.

Information on ethnicity and sex was available in 731 IVDUs. The highest seropositivity rates were seen in blacks with 53 percent (71/134) followed by Hispanics with 26 percent (41/159) and whites with 13 percent (71/134). There was no significant difference in seropositivity rates by sex.