

Findings



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The Needle-Exchange Debate

Federal Funds for Needle-Exchange Giveaways

By Robert L. Maginnis

Last year, there was considerable debate over the needle giveaway issue. In April 1998, President Clinton declared that needle-exchange programs (NEPs) slow the AIDS spread without increasing drug use. A public dispute between the drug czar and administration AIDS activists, however, influenced Clinton to deny federal funds for exchanges because the issue was considered too politically risky. Meanwhile, as the number of Americans with AIDS declines and the number of exchange programs climbs, new science further exposes needle giveaways as bad public policy.

Needle-exchange bills will be launched in both the House and the Senate, but lacking strong bipartisan support, they will end up on the cutting floor of a fall conference committee or at best result in yet another one-year ban. The media will replay many of the same sad myths about needle-using addicts and the "importance" of exchange programs while ignoring the social and scientific realities. Meanwhile, the real battles will be fought at the state and local levels, where public policy has a human face. This paper will summarize the highly charged political debate, update the spread of AIDS, review the latest needle science and profile needle-exchange programs across America.

Background

Federal Public Law 102-394 gives the administration the authority to fund needle-exchange programs if there is proof that these programs slow the spread of the AIDS virus and don't lead to more drug use. In April 1998, Secretary of Health and Human Services Donna Shalala announced, "A meticulous scientific review has now proven that needle-exchange programs can

reduce the transmission of HIV and save lives without losing ground on the battle against illegal drugs."¹ Barry McCaffrey, director of the Office of National Drug Control Policy, publicly disagreed with Shalala's statement. "Above all," said McCaffrey, "we have a responsibility to protect our children from ever falling victim to the false allure of drugs. We do this, first and foremost, by making sure that we send them one clear, straightforward message about drugs: they are wrong and they can kill you."² McCaffrey's strong views influenced President Clinton not to approve federal AIDS money for needle exchange

“Published research has found that these programs may actually promote the spread of AIDS.”

programs, though Clinton made it clear that he agreed with Shalala and that his decision was made purely for political reasons.

On April 29, 1998 the House of Representatives reacted to Clinton's pro-needle leanings by passing a permanent ban on federal funds for free needles. Representative Gerald Solomon, a New York Republican, framed the issue for many of the House members saying free-needle programs are "part of the intolerable message to our nation's children—sent by the White House—that illegal drug use is an acceptable way of life."³

The House's ban faltered in conference in the Senate and was reconfigured into fiscal year 1999 appropriations language for the Department of Health and Human Services. That bill states, "Notwithstanding any other provision of this act, no funds appropriated under this act shall be used to carry out any program of distributing sterile

needles or syringes for the hypodermic injection of any illegal drugs."⁴ Both chambers passed the single year needle-funding ban.

On a related issue, the fiscal year 1999 omnibus-spending bill included a provision that bans government funding for any organization that operates a needle-exchange program in the District of Columbia.⁵ This bill shut down the Whitman-Walker Clinic's 17,000-needles-per-month exchange program, but a nonprofit NEP quickly assumed the exchange mission.

Classic Arguments Against Needle-Exchange Programs

Some of the best arguments against federally funded needle-exchange programs come from Dr. Mitchell S. Rosenthal, president of the Phoenix House, a substance-abuse treatment and prevention network based in New York. On April 10, 1998, Dr. Rosenthal wrote to drug czar McCaffrey with the following arguments:

- *There is no consistent evidence that the availability of needle exchange reduces the transmission of the HIV virus among intravenous drug users. There is no evidence that needle exchange programs are necessary to reduce the spread of HIV infection through needle sharing, for the rate of infection has fallen among addict populations denied such programs.*
- *Government "enabling" of drug use sends a dreadful message to young people and undermines prevention efforts.*
- *The most effective means of combating the spread of HIV infection by IV drug users is through treatment that addresses their characteristically antisocial, self-destructive, and reckless behavior.*
- *By enabling drug abuse in this manner, the federal government would be helping*

many drug abusers to resist the treatment they need to overcome their addiction and curb their addictive behaviors.

- Needle exchange programs are not a useful route to treatment. They are essentially noncoercive, and addicts who most need treatment are those most likely to resist it — particularly treatment that is demanding enough to help them recover.
- Communities rightfully resist needle exchange programs, for these are sites where addicts will concentrate, often leaving behind litter that may include infected needles.
- Considering the shortage of treatment capacity, particularly the shortage of comprehensive, residential treatment for hard-core substance abusers (the most economically and socially costly abusers), it would be hard to justify spending federal dollars to subsidize addiction rather than to provide treatment.⁶

Rosenthal labeled needle-exchange programs "more a cause than a cure." He believes that they unjustifiably allow advocates "to feel they are doing something assertive to combat AIDS."⁷ In fact, cities with long-standing NEPs continue to have the highest AIDS death rates.⁸

Dr. James L. Curtis, director of Harlem Hospital Center's Department of Psychiatry, is also critical of exchange programs. Curtis explains that "a genuine show of compassionate concern for intravenous drug users" would include regular HIV testing, medicine for HIV-positive addicts, and comprehensive treatment for their drug addiction. "To withhold treatment of HIV disease, and of addiction, from intravenous drug abusers in these NEPs," said Curtis, "is bad medicine, bad public health, possibly illegal, and certainly unethical and immoral."⁹

Peter Verniero, New Jersey's attorney general, assembled an outstanding booklet that responds to legislative proposals "that would authorize the state to use taxpayer dollars to fund needle exchange projects and that would exempt hypodermic syringes and the ambit of New Jersey's drug paraphernalia laws. ... By legalizing — literally legitimizing the possession, purchase and sale of drug paraphernalia — these bills would constitute an endorsement by the government of the insidious and false notion that injectable drug use can be done 'safely.'"¹⁰

The following summarizes Verniero's anti-NEP arguments:

- "[M]ost intravenous drug users die not

from HIV-tainted needles, but rather from other health problems, overdoses, or homicide."¹¹

- Studies used to show that needle-exchange programs reduce the spread of AIDS suffer methodological shortcomings. For instance, the participants were not randomly assigned, and there was a lack of control for many of the factors or variables.¹²
- The debate over NEPs and other types of drug legalization distract the public from issues like drug treatment and the criminal justice system.¹³
- "[N]o one has explained satisfactorily why enhanced needle availability in and of itself would discourage needle sharing. There is no absolute proof that an intravenous drug user will use a clean needle when faced with the immediate physical or psychological craving for an addictive drug."¹⁴
- "We remain skeptical that a drug user ... willing to share injection equipment that is provided by a drug dealer would be any less inclined to do so simply because the needle happened to have been provided by a government-sponsored program."¹⁵
- "Addicts under the influence of or subject to the intense cravings for drugs such as heroin and cocaine may also be unable to follow the advice to refrain from using risky injection practices that greatly increase the risk of spreading disease."¹⁶
- "[D]ecriminalization of hypodermic needles is essentially a kind of drug decriminalization, and thus implicates many of the same concerns raised by the proposal to abandon the war on drugs altogether."¹⁷
- "We believe that education and awareness initiatives designed to convince users not to share syringes or needles would have more impact than simply increasing the number of hypodermics that are available for illicit drug use."¹⁸
- "[A]n official endorsement of needle exchanges would only reinforce widespread public attitudes that are already too tolerant and permissive with respect to substance abuse. For one thing, needle decriminalization would send the wrong signal about the government's 'official' position concerning the harmfulness of drug use."¹⁹
- "We believe that NEP [sic] can serve unwittingly as 'buyers' clubs,' facilitating drug use and associated crime by providing a place where addicts can

'network' in order to find the best drug buys and where they can more easily and conveniently make their connection [sic] with drug dealers."²⁰

- A Connecticut health official urged New Jersey officials to decriminalize syringes but conceded that NEPs and over-the-counter sales programs can only work "if law enforcement officers agree not to arrest participating" drug users.²¹

AIDS Update

As of December 1997, 641,086 Americans have been reported with AIDS, and more than half (385,000) have died. The federal government's Centers for Disease Control and Prevention estimates that at least 40,000 new HIV infections occur each year.²²

As of June 1998, the CDC reported that 26 percent of Americans with AIDS likely contracted the virus from dirty needles. That same report, which follows HIV infection cases from 31 states with confidential HIV infection reporting, found that 17 percent of new cases were attributed to injecting drug use.²³

There is encouraging news, however. The CDC reports that the AIDS incidence in 1997 was less than 1996. The decrease is attributed to the use of new therapies; AIDS deaths declined 42 percent between 1996 and 1997.²⁴ Meanwhile, the federal government continues to pour significant funds into AIDS research, prevention, care and assistance for AIDS patients. In 1998, the federal government spent \$8.7 billion for these AIDS-related services, a 23 percent increase over FY 95. Most (71 percent) of the AIDS spending is for care and assistance.²⁵

Exchange Science Update

David Murray, director of research for the Statistical Assessment Service, a nonprofit group in Washington, D.C., explains, "The problem for [needle exchange] science is that no study has used the most effective method for settling such issues—a randomized control trial. Moreover, needle-exchange programs are usually embedded in complex programs of outreach, education and treatment, which themselves affect HIV."²⁶

Two published Canadian studies demonstrate that the better the study design, the less convincing the evidence supporting needle giveaways. Another study, done in Chicago, suggests that providing addicts with a host of social services but no free needles slowed the spread of AIDS. That research is summarized below.

- A February 1, 1999, *American Journal of Epidemiology* study looked at the incidence of the blood-borne pathogens hepatitis B virus and hepatitis C virus among injecting drug users at a Seattle exchange program. The authors found that the "[h]ighest incidence of infection occurred among current users of the exchange, even after adjustment for confounding variables."²⁷ HBV and HCV are perhaps 10 times easier to transmit than the AIDS virus, and when considered with the findings of this study, the effectiveness of the NEP is less believable.²⁸
- A May-June 1998 *Journal of Substance Abuse and Treatment* study sought to determine whether a New Haven, Conn., exchange program expedited drug treatment requests. The authors concluded, "A majority of those requesting treatment [among the intravenous drug-using community] did not use the SEP [syringe exchange program] to obtain sterile syringes."²⁹ A key objective of NEPs should be to get addicts into treatment.
- A July 1998 *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* study sought to determine community attitudes on NEPs in Baltimore, Maryland. The study's sample, which was more likely to be female, black and college-educated than the city's 1990 census population, strongly believed (72 percent) that NEPs would attract drug users to their neighborhood, but 65 percent still favored them.³⁰ Baltimore is marked by high AIDS rates and drug abuse. Apparently, residents are willing to accept the consequences of NEPs in exchange for the promised reduction in HIV.
- Another July 1998 *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* study investigated the cost of increasing access for injecting drug users to sterile syringes and the HIV infection cost averted. The authors suggest that for 100 percent coverage of syringes for drug users, 954.8 million syringes would be required at a cost of \$423 million or \$34,278 for each addict. The per-addict cost for treating a person with HIV (\$108,469) was much more. The authors concluded, "Providing syringes would therefore save society money."³¹ The study did not consider the collateral costs associated with NEPs.
- A September 1998 Federal government

Services Research Outcomes Study found that five years after drug treatment, many addicts live healthier lives, committing fewer crimes and spending less time on the street. "Our message today is . . . treatment is effective and recovery is possible," said Nelba Chavez, administrator of the federal Substance Abuse and Mental Health Services Administration.³² McCaffrey used the study announcement to explain, "We probably have 52 percent of the [needed] treatment capacity in this country." Without new money for treatment, "we'll have problems in the coming year," said McCaffrey.³³

- Crack cocaine injection has radically altered the NEP equation. Leah Boelhouwer, a counselor at an exchange program in Vancouver, British Columbia, reports that she has seen increasing evidence of crack injection and that this increase may foster the rapid spread of HIV. Injecting heroin users use several times daily whereas injection cocaine users may use up to 40 times a day. Eighty percent of injecting drug users in a Vancouver study preferred cocaine, with 82 percent responding similarly in Ottawa and 70 percent in Montreal. As HIV spreads among IUD users, the age of infection has declined even though the addicts have no daily needle limit.³⁴

Needle-Exchange Programs Across America

The "Xchange Point" in Cleveland, Ohio, advertises that it embraces a harm reduction model that "suggests that complete abstinence from drug use and sexual behavior is not always preferred or possible." "Xchange" workers strive to be "non-judgmental, non-stereotypical and culturally appropriate."³⁵

This "compassionate" but naive view of addictive behavior dooms injecting drug users to an early death. Consider what addicts say about their lives.

Ronn Constable, who likes NEPs because they save him money for drugs, explained, "An addict doesn't want to spend a dollar on anything else but his drugs."³⁶ Canzada Edmonds, a heroin user for 27 years, said, "I was in love with heroin. I took it into the bathroom. I took it into church. I was living a fantasy. I was living in a world all to myself."³⁷

Terry Horton, Phoenix House's medical director, explains the addict's lifestyle. "When addicts talk about enslavement, they're not exaggerating," said Horton. "It is their first and foremost priority. Heroin first, then breathing, then food."³⁸ These are

the people who participate in more than 100 exchange programs found in 32 states, the District of Columbia and Puerto Rico. In 1998, an estimated 17,186,508 syringes were exchanged by 100 NEPs that participated in a survey conducted by the North American Syringe Exchange Network (NASEN).³⁹

NASEN's 1998 NEP survey provides valuable insights into the daily operation of the typical American exchange program. Most (73 percent) varied their one-for-one exchange policy, and 84 percent had no limit on the number exchanged per person per visit. Only 29 percent had an age minimum.⁴⁰

Half (52 percent) operate legally in a state that has no law requiring a prescription to distribute hypodermic syringes. Nearly a third (32 percent) operate illegal underground operations.⁴¹ California leads the nation with 19 NEPs and 32 percent of exchanged needles.⁴²

Most exchange programs provide a variety of services. HIV testing is provided at three of every four legal exchange programs. "Spiritual healing" and acupuncture are available at 12 percent and 20 percent of legal exchange programs respectively. Most (94 percent) provide STD treatment, and most (88 percent) provide mental health treatment—drug abuse counseling.⁴³

The Chicago Recovery Alliance is perhaps typical of large exchange programs. Addicts can get two syringes for each one exchanged up to the first five and then one for one with no limit. The NEP offers referral to health care, addiction treatment, and HIV tests. It gives out copies of a 23-page booklet titled "Safer Injection, Better Vein Care," which was funded by a grant from the Drug Policy Foundation. The seven-days-a-week operation provides services from a storefront and at various street locations across Chicago.⁴⁴

The San Diego Clean Needle Exchange takes a different approach. It operates on a housecall or as needed basis. There is no limit on syringes exchanged, and it claims to offer information on drug treatment services.⁴⁵

Baltimore is a drug-soaked city that has embraced needle giveaways. A flyer from a Baltimore city-sponsored NEP states, "This program is free and confidential. No identification is needed. There is no minimum age requirement. All that is needed is a desire to live healthier."⁴⁶ Unfortunately, the facts about Baltimore's needle-using population are far from healthy.

Baltimore Health Commissioner Dr. Peter Beilenson distributed nearly 2 million syringes to more than 7,000 addicts in five years. He claims that addicts in his needle programs have a 40 percent lower HIV infection rate than the "general addict population."⁴⁷ Baltimore has the ninth highest annual AIDS rate in the nation, and based on survey data, the majority (65 percent) of local citizens approve of NEPs.⁴⁸

Baltimore County has the highest mortality rate in the state. Although the number of heroin-related treatment admissions in Baltimore County declined by seven percent last year, it continues to account for the largest proportion of heroin-related admissions statewide.⁴⁹ Additionally, heroin rates among Baltimore City arrestees are the highest in the nation. Thirty-seven percent of males and 48 percent of female arrestees in the city of Baltimore tested positive for opiates, compared to six to 23 percent of arrestees in Washington, D.C., and Manhattan.⁵⁰

Conclusion

"Once they [addicts] start pumping their system with drugs," says Dr. Eric Voth with Drug Watch International, "judgment disappears."⁵¹ Public policies that address irrational injecting drug users must take into account the patient's self-destructive lifestyle. Prudence dictates tough love, not coddling.

Policy leaders should keep in mind that NEPs act as a slippery slope that could lead to outright drug legalization. These programs promote the breakdown of law and order and encourage drug use. Just as bad, needle exchange programs postpone treatment and fail to prevent HIV infection. The compassionate public policy position is to make treatment available to addicts and to deny funding for exchange program.¶

Based in Washington, D.C., Mr. Robert Maginnis is the Family Research Council's, senior director for national security and foreign affairs. Mr. Maginnis has researched needle-exchange programs extensively in the United States and Europe, and he also lectures on this subject. This paper was originally published by the Family Research Council, "Insight Magazine," February 1999.

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