



THE CITY OF SAN DIEGO

CLEAN SYRINGE EXCHANGE PROGRAM TASK FORCE

FINAL REPORT

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CLEAN SYRINGE EXCHANGE PROGRAM TASK FORCE

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I. EXECUTIVE SUMMARY

BACKGROUND

In October 1999, Governor Gray Davis signed Assembly Bill (AB) 136, which exempts from criminal prosecution public entities and their agents and employees who distribute hypodermic needles or syringes to participants in clean needle and syringe exchange projects authorized by the public entity pursuant to a declaration of a local emergency due to the existence of a local public health crisis.

An ever-increasing number of cities and counties throughout California have authorized clean needle and syringe exchange programs in their jurisdictions. The public health crisis in each jurisdiction is the same: the spread of the Hepatitis C virus (HCV) and human immunodeficiency virus (HIV), exacerbated by the shared use of needles and syringes by injection drug users. Some of the jurisdictions declared a state of local health emergency well before the enactment of AB 136, but since its enactment, the number of such declarations has more than doubled, as set forth below:

Ventura County	December 19, 2000
Los Angeles County	August 29, 2000
Santa Barbara County	June 6, 2000
Humboldt County	January 1, 2000
San Mateo County	December 21, 1999
Contra Costa County	December 14, 1999
Alameda County	December 9, 1999
City of Salinas	October 11, 1994
Santa Clara County	September 13, 1994
City of Los Angeles	May 31, 1994
City of Oakland	February 14, 1994
City of Berkley	December 7, 1993
Marin County	November 23, 1993
City and County of San Francisco	March 15, 1993

In October 2000, the San Diego City Council joined this growing list of jurisdictions in California by declaring a local health emergency and authorizing the City Manager to convene a task force to develop the practices and procedures for a one-year clean needle and syringe exchange pilot program.

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DISCUSSION

In addition to City staff, six individuals with many years of relevant experience and expertise in this area agreed to serve on the Clean Syringe Exchange Program Task Force.

Over the past several months, many issues associated with operating a clean syringe exchange program in San Diego have been discussed and explored by the task force. Issues surrounding the availability of substance abuse treatment opportunities within San Diego County were discussed at length. Members of the task force traveled to the cities of Baltimore, Maryland and Los Angeles, California, to meet with city staff, police staff, substance abuse treatment providers, and clean syringe exchange program staff currently operating programs within these two cities.

The task force has discussed in detail the components of a model for implementation within the City of San Diego. This discussion focused on issues including whether to recommend a fixed or mobile site; the availability of substance abuse treatment opportunities; where and when to operate the program; information to be collected from, and provided to, program participants; and the impact the program might have on specific communities. Information related to each of these issues is discussed in more detail in this report.

Hepatitis C Infection

Hepatitis C (HCV) infection is the most common chronic blood-borne infection in the United States. HCV is transmitted primarily through exposure to contaminated blood. The overall prevalence of HCV infection in the United States is 1.8%, corresponding to an estimated 3.9 million persons nationwide and an estimated 50,000 infected individuals in the County of San Diego. Presently, HCV is the cause of 8,000-10,000 deaths per year in the United States and HCV-related deaths are expected to triple in the next two decades. In 1999, the Centers for Disease Control and Prevention (CDC) predicted that HCV will be “the epidemic of the next millennium,” killing more people annually than AIDS by the year 2010. There is no vaccine, nor truly effective treatment for HCV infection. Injection drug use is now the major mode of transmission of HCV through the sharing of contaminated syringes and needles or drug preparation equipment. Recent studies have demonstrated that injection drug use accounts for 60% of HCV transmission in the United States. Sexual activity, tattooing and body piercing, and perinatal transmission from mother to unborn child account for most of the remaining 40% of cases. Injection drug use is indirectly the major cause of children being infected with HCV through perinatal transmission either because the mother is an injection drug user (IDU) or because her sexual partner is an IDU. In San Diego, on average six new pediatric patients with HCV infection are seen at the University of California, San Diego (UCSD) Medical Center annually.

HCV infection is now a reportable disease, meaning that health providers and diagnostic laboratories are obligated to report all new diagnoses of HCV infection to the County of San Diego Health and Human Services Agency (HHSA). Between 1998 and 1999 there was a 50% increase in the number of reported HCV cases countywide and in the City of San Diego. The increase in San Diego County was from 1,936 cases in 1998 to 2,999 cases in 1999, and in the

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City of San Diego from 978 cases in 1998 to 1,514 cases in 1999. In addition, HCV testing was offered to participants attending county sexually transmitted disease (STD) clinics during August 1998 through September 1998, and September 1999 through February 2000. The results of testing showed that 45% of injection drug users attending STD clinics were infected with HCV. In discussing these results, it is noteworthy that a recently published County HHSA report states:

Effective prevention helps injection drug users and benefits society as a whole. Reduced transmission among injection drug users means reduced transmission among their sex partners, their children, and among the general population. CDC recommends that all syringes used for injections be sterile.

HIV/AIDS

Between 1981 and June 2000, a total of 754,000 cases of AIDS have been reported to the CDC. During the 1990s the AIDS epidemic shifted steadily toward a growing proportion of AIDS cases in African-Americans and Hispanics, who continue to be disproportionately affected by the AIDS epidemic. The proportion of women with AIDS has also increased steadily, reaching 23% of total AIDS cases in 1999. In 1999, 21,419 cases of HIV infection were reported in the 34 states and territories with name-based HIV reporting. This figure is consistent with the estimate that the rate of new HIV infections in the United States continues to be approximately 40,000 annually, and has not significantly declined.

The 1999 HIV/AIDS Surveillance report from the CDC lists 13 metropolitan areas of residence in California with 500,000 or more population. Of these, the rate of AIDS cases in the San Diego metropolitan area, of 19.5 per 100,000 population, is the third highest in the state, exceeded only by Los Angeles (22.3 cases per 100,000) and San Francisco (50.8 cases per 100,000). A report of the status of San Diego County HIV/AIDS cases prepared by the County of San Diego HHSA (June 2000), was publicly released late last year. The report opens with the statement:

In San Diego County HIV/AIDS continues to be a major preventable source of illness, disability and death...

The report notes that 10,244 AIDS cases have been diagnosed in San Diego County through December 1999, and comments that San Diego County has the highest cumulative incidence of AIDS in Hispanics in Southern California. Only Los Angeles has a higher number than San Diego of total AIDS cases per 100,000 population among African-Americans. As in other parts of the country, people of color in San Diego are disproportionately affected by the HIV/AIDS epidemic. In a section entitled: "AIDS and Injection Drug Use: A Continuing Scourge," the County report states that the proportion of AIDS cases in the county attributable directly or indirectly to injection drug use continues to increase each year to almost 25% of total cases in 1999. Between 1995 and 1999, approximately 1% of individuals tested for the first time at County HIV testing sites were infected. The HIV epidemic is, therefore, likely continuing unabated in San Diego County, with injection drug use accounting for at least 25% of new HIV infections.

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Economic Costs of HIV and HCV infections

The economic costs of HIV infection have been characterized in the County HHS/AIDS Status, June 2000 report as “enormous.” The lifetime cost of medical care for an HIV-infected individual was estimated to be \$155,000; in 1997 total hospital charges to treat HIV-infected patients was more than \$13.5 million. The recent cost of drugs provided through the AIDS Drug Assistance Program (ADAP) was more than \$9 million countywide.

HCV infection is the major cause of liver disease requiring a liver transplant. The cost of a liver transplant is over \$250,000 with a subsequent annual cost of \$26,000 for anti-rejection medications. Standard treatment for HCV infection, that is often ineffective, is \$17,000 per patient, per year.

Drug Use in San Diego

San Diego has a longstanding drug problem that continues to persist. Despite the formation by the San Diego County Board of Supervisors of a Methamphetamine Strike Force in 1996, methamphetamine use in San Diego has continued unabated. San Diego ranks first in the nation in female adult arrestees (36%) with methamphetamine in their system at the time of booking, while San Diego is second in the nation for male arrestees (26%) testing positive for methamphetamine. San Diego is first in the nation by a wide margin for both male and female juvenile offenders testing positive for methamphetamine (16% of boys and 18% of girls). A major problem is that San Diego has limited drug treatment spaces.

Clean Syringe Exchange Programs: Science-Based Data and Misconceptions

The U.S. Surgeon General recently reviewed all of the peer-reviewed, scientific studies of clean syringe programs since April 1998 and issued a report on March 17, 2000 that stated:

Syringe exchange programs as part of a comprehensive HIV prevention strategy are an effective public health intervention that reduces the transmission of HIV and does not encourage the use of illegal drugs.
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These scientific studies and others showing that syringe exchange programs also reduce the transmission of HCV are discussed in detail in this report. Some opponents of syringe exchange programs often make assertions that are not supported by any critical analysis of science-based evidence. For example, scientific studies have shown that clean syringe exchange programs do not increase criminal activity in the vicinity of the syringe exchange; do not attract IDUs into the area; do not encourage youth to use illegal drugs; and do not increase the numbers of discarded syringes in the vicinity of the syringe program. Such programs do, however, reduce risk behaviors of participants such as sharing syringes, and serve as an effective bridge to drug treatment.

Another benefit of clean syringe exchange programs is that they reduce the risk to the police, emergency personnel and the general public of needle sticks from contaminated syringes discarded in streets, parks, beaches and other public places.

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Some opponents of syringe exchange programs also claim that the programs are “immoral.” However, scholars, including ethicists, members of the legal profession, physicians and theologians, using the ethical principles of modern medicine, have concluded that syringe exchange programs are ethically justified. This view is also based on the principle:

Most major religious traditions including Christianity are concerned for the preservation of human life and dignity.
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Public support for syringe exchange programs in San Diego County, California, and nationwide remains very strong. These and other issues germane to establishing an effective clean syringe exchange pilot program in San Diego are also discussed in this report.

TASK FORCE RECOMMENDATIONS

The task force has developed recommendations for a Clean Syringe Exchange Pilot Program that are the subject of this report. The recommendations are based on the expertise of the task force members and their knowledge of local issues concerning drug treatment and prevention, transmission of infectious diseases by blood-borne pathogens, and the enforcement of drug laws. In addition to visiting the cities of Baltimore and Los Angeles, the task force conducted a review of the scientific literature dealing with the evaluation of clean syringe exchange programs to assess the different models used in other cities, their strengths and weaknesses, and their transferability to the City of San Diego. Other data that were considered included position papers from professional societies and letters stating the opinions of law enforcement and other professionals on clean syringe exchange programs (please refer to Section IV of the report for justification of the recommendations).

The task force recommends:

- 1. The declaration of a state of emergency in the City of San Diego (see Appendix F).**
- 2. The implementation of a privately-funded one-year pilot clean syringe exchange program.**
- 3. The inclusion of the following program elements:**
 - A. A mobile system with the use of a small motor home for the following reasons: reduced visual impact of the program on the neighborhoods and the ability to process participants and deliver services in an efficient and confidential manner.**
 - B. A laminated identification card to be issued to participants of the program in order to track participants and enable them to provide proof of participation to police officers.**
 - C. An on-site computer for real-time documentation of participant characteristics and outcomes.**

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- D. A standardized script that describes guidelines for participation in the program and provides a consistent risk reduction educational message.**
 - E. Risk reduction services and kits to be provided in the vehicle. These kits include a one-time baseline harm reduction kit with two sterile syringes, given the success of the Baltimore program at enrolling and retaining new participants by this outreach strategy. The number of syringes exchanged per visit should be sufficient to provide the typical client with a clean syringe for each injection for one week. Based upon the types of drugs commonly used in San Diego (methamphetamine, heroin, heroin/cocaine combinations), no more than 50 syringes will be exchanged per visit.**
 - F. A variety of printed educational materials to be available on the mobile unit for distribution to participants.**
 - G. Case management as an integral part of the services provided through the program, including active referrals into detoxification and recovery programs.**
 - H. Written guidelines for the selection and training of program staff.**
 - I. Training of all staff in universal precautions following the Centers for Disease Control and Prevention recommendations.**
- 4. The identification of external evaluators to work with program staff to determine effectiveness at reducing sharing of injection equipment, utilization of services by program participants and, to the extent possible, trends in criminal activity at the sites.**
 - 5. Based on recommendations from Police Department staff, two areas of the City where drug use levels are high enough to warrant establishing such a program will be evaluated for participation in the pilot program.**
 - 6. The establishment of cooperative relationships between pilot program staff and Police Department staff, in particular with officers stationed at the nearest area stations.**

PROGRAM COSTS

The costs associated with operating a one-year pilot Clean Syringe Exchange Program are estimated to be approximately \$334,000. There would be no use of City funds since the costs would be completely funded through private sources.

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CONCLUSION

Conclusive, science-based evidence demonstrates that comprehensive harm reduction programs which include clean syringe exchange, are effective in reducing the transmission of infectious viral agents without increasing the prevalence of substance abuse or crime.

Therefore, the Clean Syringe Exchange Task Force recommends that the San Diego City Council declare a state of local emergency and authorize the implementation of a privately-funded comprehensive harm reduction pilot program, which includes clean syringe exchange.

Submitted by:

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II. BACKGROUND

In October 1999, Governor Gray Davis signed Assembly Bill (AB) 136 relating to the distribution of needles and syringes. The bill exempts from criminal prosecution, “public entities and their agents and employees” involved in the distribution of “hypodermic needles or syringes to participants in clean needle and syringe exchange projects authorized by the public entity pursuant to a declaration of a local emergency due to the existence of a local public health emergency.”

As mandated by AB136, the implementation of a clean syringe exchange program requires the declaration of a local emergency due to the existence of a local health emergency. Section 8558(c) of the California Government Code specifically identifies an epidemic as one of the conditions warranting the declaration of local emergency. As discussed in this report, there is compelling evidence that San Diego has an AIDS epidemic and a more recently recognized hepatitis C epidemic, that constitute a local public health emergency requiring immediate action. It is important to realize that both HIV and the hepatitis C virus (HCV) cause diseases with long asymptomatic latency periods. Some HIV-infected individuals do not progress to AIDS for more than 10 years, and HCV-infected individuals may not progress to clinical disease for more than two decades. For this reason, delaying action to prevent the transmission of HIV and HCV infections through injection drug use until a dramatic increase in clinical disease is seen is ill advised. Recognizing this reality, since the passage of AB 136, seven counties throughout California have declared a state of local emergency. Below is a list of the California counties and when they took this action:

Ventura County	December 19, 2000
Los Angeles County	August 29, 2000
Santa Barbara County	June 6, 2000
Humboldt County	January 1, 2000
San Mateo County	December 21, 1999
Contra Costa County	December 14, 1999
Alameda County	December 9, 1999

Prior to the passage of AB 136, the following cities and counties also declared a state of local emergency:

City of Salinas	October 11, 1994
Santa Clara County	September 13, 1994
City of Los Angeles	May 31, 1994
City of Oakland	February 14, 1994
City of Berkley	December 7, 1993
Marin County	November 23, 1993
City and County of San Francisco	March 15, 1993

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In October 2000, the San Diego City Council joined this growing list of jurisdictions in California by declaring a local health emergency and authorizing the City Manager to convene a task force to develop the practices and procedures for a one-year pilot clean syringe exchange program.

III. RATIONALE AND EVIDENCE

In addition to City staff, six individuals who have many years of involvement in closely related issues and who bring their individual and relevant expertise on this issue agreed to serve on the Clean Syringe Exchange Program Task Force.

The first meeting of the Clean Syringe Exchange Program Task Force was held on November 15, 2000. Since that time, as directed by the City Council, the task force has met regularly to discuss the development of a one-year pilot program for implementation within the City of San Diego. Members of the task force have also traveled to the cities of Baltimore, Maryland and Los Angeles, California to meet with city staff, substance abuse treatment providers, and clean syringe exchange program staff currently operating programs within these two cities.

Over the past several months, many issues associated with operating a clean syringe exchange program in San Diego have been discussed and explored by the task force. Issues surrounding the availability of substance abuse treatment opportunities within San Diego County were discussed at length. In addition, County of San Diego Health and Human Services Agency (HHS) staff from the Alcohol and Drug Services Division, provided the task force with information related to the types of treatment programs and the number of treatment slots that are currently funded by the County.

The task force also discussed the components of a model for implementation within the City of San Diego. This discussion focused on issues including, whether to recommend a fixed or mobile site; information to be collected from, and provided to, program participants; the availability of substance abuse treatment opportunities; where and when to operate the program; and the impact the program might have on the specific neighborhoods.

Members of the task force traveled to Baltimore, Maryland in January 2001 to meet with the city's Health Commissioner, the Director of the Baltimore City Clean Syringe Exchange Program, staff from two substance abuse treatment centers, the head of the Baltimore Police Department's Narcotics Section, City Attorney staff, and researchers at the John Hopkins University School of Public Health, who evaluate the efficacy of Baltimore's clean syringe exchange program.

Baltimore's program, operated by the health department since 1994, was uniformly judged to be very successful by everyone the task force met with. While in Baltimore, task force members were able to discuss at length with city staff and others who have been directly involved in the development and/or operation of the Baltimore program, a variety of issues surrounding clean syringe exchange programs. Members of the task force were provided with information related

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to specific issues that must be considered in order for a program of this type to operate successfully. The importance of the program's linkage to treatment opportunities was highlighted, as well as the importance of measuring the effectiveness of the program.

During the visit to Los Angeles, task force members observed two clean syringe exchange programs in distinct parts of the city that were operated by two different providers, one of which was a substance abuse treatment provider, contracted by the city to provide services. In addition, the task force met with staff from the City of Los Angeles Office of AIDS Coordination, which administers the city's clean syringe exchange program, and the Los Angeles City Attorney's Office.

While in Los Angeles, members of the task force had the opportunity to closely observe the operations of the two programs and evaluate the individual aspects of each of these programs to determine how and whether they could be successfully applied to a program in San Diego. This visit provided the task force with additional information to consider in the development of a pilot program for the City of San Diego.

By visiting the cities of Baltimore and Los Angeles, the task force was able to obtain firsthand information about these cities' clean syringe exchange programs and the treatment facilities operating in these communities. These site visits also provided the task force with the opportunity to meet with public health officials, law enforcement and city attorney staff in both of these cities to obtain their perspectives on the clean syringe exchange programs operating in their jurisdictions. These site visits proved critical in developing a program that would be successful in the City of San Diego.

The task force has developed recommendations for a Clean Syringe Exchange Pilot Program that are the subject of this report. The recommendations are based on the expertise of the task force members and their knowledge of local issues concerning drug treatment and prevention, transmission of infectious diseases by blood-borne pathogens, and the enforcement of drug laws. In addition to visiting the cities of Baltimore and Los Angeles, the task force conducted a review of the scientific literature dealing with the evaluation of clean syringe exchange programs to assess the different models used in other cities, their strengths and weaknesses and their transferability to the City of San Diego. Other data that were considered included position papers from professional societies and letters stating the opinions of law enforcement and other professionals on clean syringe exchange programs.

Following is a discussion of critical data and statistics related to the transmission of Hepatitis C and HIV. It is important to consider this information in evaluating the need for a clean syringe exchange program in San Diego.

HEPATITIS C INFECTION

Hepatitis C virus (HCV) infection is the most common chronic blood-borne infection in the United States. HCV is transmitted primarily through exposure to contaminated blood. The overall prevalence of HCV infection in the United States is 1.8%, corresponding to an estimated 3.9 million persons nationwide [1] and an estimated 50,000 infected individuals in the County of

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San Diego. Almost three-quarters of persons infected with HCV become chronically infected and of these 25-30% will progress to end-stage liver disease, either cirrhosis or cancer, requiring liver transplantation. Currently, HCV is the cause of 8,000-10,000 deaths per year in the United States and HCV-related deaths are expected to triple in the next two decades. In 1999, the Centers for Disease Control and Prevention (CDC) predicted that HCV will be “the epidemic of the next millennium,” killing more people annually than AIDS by the year 2010. There is no vaccine, nor truly effective treatment for HCV infection.

Treatment of HCV infection currently involves treatment with either Interferon alpha-2b (IFN) alone or in combination with an anti-viral drug, Ribavirin. A new long-acting form of IFN, pegylated IFN, has recently been approved by the Federal Drug Administration for treatment of HCV infection. Sustained response rates with combination therapy for 48 weeks for previously untreated patients with Hepatitis C are approximately 40%. However, for patients with the predominant strain seen in the United States (Genotype 1), response rates are lower (28%) [2]. The cost of a one-year course of the combination therapy is estimated to be \$17,000 [2]. The cost of a liver transplant is estimated to be \$269,000 in the first year and \$26,000 in subsequent years for anti-rejection drugs [2]. Current estimates of the medical and work-loss costs of HCV-related acute and chronic liver disease nationwide are greater than \$600 million annually [3].

HCV was identified in 1988 and a test to screen the blood supply was developed in 1992. Prior to a diagnostic test for HCV, the disease caused by the virus was included in the category known as non-A, non-B hepatitis, and blood transfusions were the leading mode of transmission. After 1992, the risk of post-transfusion hepatitis declined from 1 in 5,000 to 1 in 100,000 [3] and, consequently, blood transfusions currently account for very few new cases of HCV infection.

Injection drug use is now the major mode of transmission of HCV through the sharing of contaminated syringes and needles or drug preparation equipment [3]. Rates of HCV infection are four times higher in young injection drug users (IDUs) than rates of HIV infection. After five years of injecting, as many as 90% of IDUs are infected with HCV. Recent studies have demonstrated that injection drug use accounts for 60% of HCV transmission in the United States, with sexual activity, tattooing and body piercing, and perinatal transmission from mother to unborn child accounting for most of the remaining 40% of cases. The CDC estimates that 15-20% of patients with acute HCV infections report sexual activity as the only risk factor [3]. Other modes of HCV transmission with lower risk include sharing razors or toothbrushes, sharing straws while snorting cocaine and manicures/pedicures. Injection drug use is indirectly the major cause for children being infected with HCV through perinatal transmission either because the mother is an IDU or because her sexual partner is an IDU. The transmission rate of HCV from mother to unborn child is approximately 10%. Unlike HIV, there is no effective treatment for preventing perinatal transmission of HCV. A recent article in *The New England Journal of Medicine* reports on three children under the age of ten with end-stage liver disease; two have already received liver transplants while the third is awaiting transplantation [4]. In San Diego, on average six new pediatric patients with HCV infection are seen at the UCSD Medical Center annually (Joel Lavine, M.D., Ph.D., personal communication, 2001).

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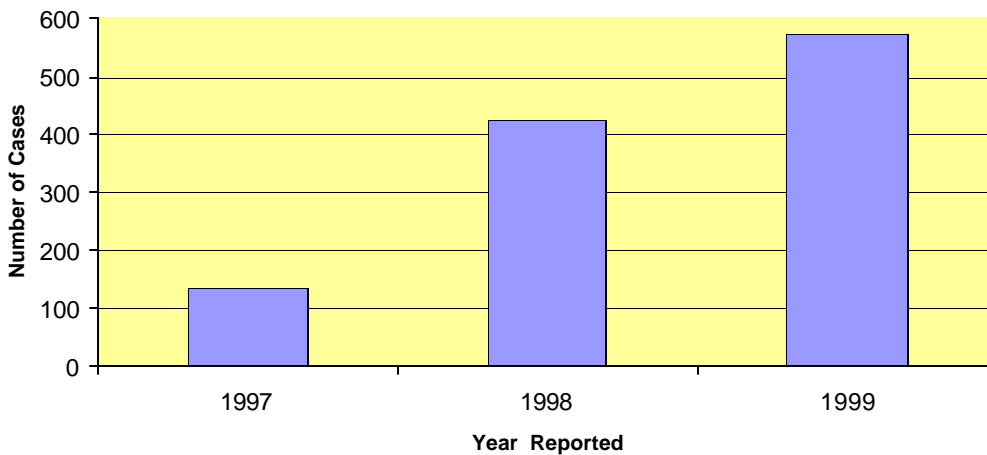
PUBLIC HEALTH RESPONSES TO THE HCV EPIDEMIC IN MAINE AND SAN MATEO COUNTY, CA

Reports from public health departments in Maine and San Mateo County, California, published in March 2001, document that these areas have HCV epidemics comparable to San Diego County [5, 6]. The public health departments of these two jurisdictions, with the support of elected officials, have been much more proactive than the County of San Diego in tracking the HCV epidemic in high risk populations and planning public health policy based on the epidemiological data obtained.

In 1997, the Maine Bureau of Health initiated mandatory case reporting of HCV infection. In 1999, in response to growing concern that a comprehensive approach to the HCV epidemic was required, the Maine Bureau of Health convened a committee to develop a needs assessment for the state. (Based on the U.S. Census, 2001, the state of Maine had a population of 1,253,040, a population less than half that of the County of San Diego). The public health concern was based on a similar increase in newly reported HCV cases in Maine (Figure 1) to that recently observed in San Diego County.

FIGURE 1

Maine Chronic HCV Cases Reported 1997-1999



Source: Maine Bureau of Health, 2001

In Maine, it was found that a high proportion of HCV infections (54%) were associated with injection drug use, a figure again strikingly similar to the limited data available for San Diego County (see Figure 2 on pg. 17). As a result of the Maine HCV needs assessment, rapid implementation of a comprehensive strategy to prevent and treat HCV infection was recommended, including additional efforts to track the epidemic, to increase prevention efforts, and to ensure access to affordable drug treatment programs for IDUs. As part of this effort a

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clean syringe exchange program was initiated in Portland, Maine in 1999 and at least one other program is planned [5].

San Mateo County's response to the HCV epidemic was equally vigorous. In December 1999, the San Mateo County Health Services Agency initiated a study to determine the prevalence of HCV and to increase awareness of HCV in high-risk populations (injection drug users, prison inmates, clients of the San Mateo AIDS Clinic, and individuals seeking HIV testing at the County's Alternative Testing Sites). HCV seropositivity was highest among IDUs (52.9%), followed by jail inmates (30.1%), HIV clinic patients (28.6%), and Alternative Testing Site attendees (22.8%). These results were incorporated into a comprehensive report presented to the San Mateo County Board of Supervisors on March 6, 2001 [6]. Included in the report was a recommendation that the County adopt a stronger emphasis on "harm reduction" in relation to substance abuse in the County and that a task force be initiated to review and make recommendations on the current status of, and the long-term plan for, syringe exchange programs in the County. In response to the report, the Board of Supervisors voted to allocate \$85,000 per year of general fund monies to help those most at risk of HCV infection [7] by providing education and prevention services.

HIV INFECTION AND AIDS

Between 1981 and June 2000, a total of 754,000 cases of AIDS have been reported to the CDC. During the 1990s the AIDS epidemic shifted steadily toward a growing proportion of AIDS cases among African-Americans and Hispanics, who continue to be disproportionately affected by the AIDS epidemic. The proportion of women with AIDS has also increased steadily, reaching 23% of total AIDS cases in 1999 [8]. Midway through the 1990s, effective therapies became available for the treatment of HIV disease, leading to dramatic decreases in the incidence of AIDS and AIDS-related deaths. Further, the rapid implementation of the use of the AIDS drug zidovudine (AZT) to prevent perinatal transmission of HIV has dramatically reduced perinatally acquired AIDS.

Although California does not yet, many states report HIV infections as well as AIDS cases. The HIV data give a more current picture of the AIDS epidemic in terms of affected populations and modes of transmission. In 1999, 21,419 cases of HIV infection were reported in the 34 states and territories with name-based HIV reporting [8]. This figure is consistent with the estimate that the rate of new HIV infections in the United States continues to be approximately 40,000 annually and has not significantly declined. Women account for 32% of the new HIV cases reported in 1999. Among women, African-Americans and Hispanics account for 77% of cases; among men, African-Americans and Hispanics account for 59% of cases. Significantly, persons aged 13-24 accounted for 15% of reported HIV cases, with women accounting for half this number. While injection drug use accounts for 25% of the AIDS cases nationally, an increasing number, currently about one-third, of newly diagnosed cases of HIV infection are associated with injection drug use.

Despite advances in the treatment of HIV disease, the outlook remains guarded. Current treatments do not represent a cure and the cost of triple combination therapies is \$12,000 to \$17,000 per patient annually. As deaths have decreased, AIDS prevalence has steadily increased

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from year to year, a trend that will continue as long as the number of persons with new AIDS diagnoses exceeds the number of persons dying each year. An increasing number of individuals are being infected with strains of HIV that are resistant to one or more of the drugs used in combination therapies, making effective therapy more difficult. As patients are treated with combination therapies for longer periods of time, significant toxicities associated with treatment are becoming more apparent. These new developments underscore the need for continued prevention efforts to reduce new cases of HIV infection.

HEPATITIS C AND HIV/AIDS EPIDEMICS IN SAN DIEGO

Hepatitis C: “Epidemic of the Millennium” in San Diego

Unquestionably, the United States is experiencing an HCV epidemic with injection drug use as the major mode of transmission [1]. Based on the evidence that in 1996, almost 4 million people nationwide were infected with HCV, it can be calculated that at least 50,000 residents of San Diego County (representing 1.8% of the population) are infected with HCV, and, based on national data, most of those infected do not know they are infected.

Although much more needs to be done to track the HCV epidemic, two sets of County data confirm that San Diego is experiencing a severe HCV epidemic that may be rapidly spreading through injection drug use:

First, HCV infection is now a reportable disease, meaning that health providers and diagnostic laboratories are obligated to report all new diagnoses of HCV infection to the County of San Diego Health and Human Services Agency (HHSA). Between 1998 and 1999 there was a 50% increase in reported HCV cases countywide and in the City of San Diego (see Figure 2 on pg. 17). The increase in San Diego County was from 1,936 cases in 1998 to 2,999 cases in 1999, and in the City of San Diego from 978 cases in 1998 to 1,514 cases in 1999 [9]. The magnitude of the medical problem of having 2,999 new diagnoses of potentially fatal HCV infections in 1999 can be appreciated by comparing this number to the 1,848 cases of breast cancer predicted to be identified in San Diego County in 2000 [10]. The newly reported cases of HCV infection are almost exclusively chronic infections, just as newly reported cases of HIV infection are not recent infections. However, these data give the best indication whether an epidemic is increasing in severity absent direct measurements of incidence, and an increase of such magnitude in reported HCV cases is a matter of great concern.

Second, HCV testing was offered to clients attending County sexually transmitted disease (STD) clinics during August 1998 through September 1998 and September 1999 through February 2000. The results of testing showed that 45% of IDUs attending STD clinics were infected with HCV [11].

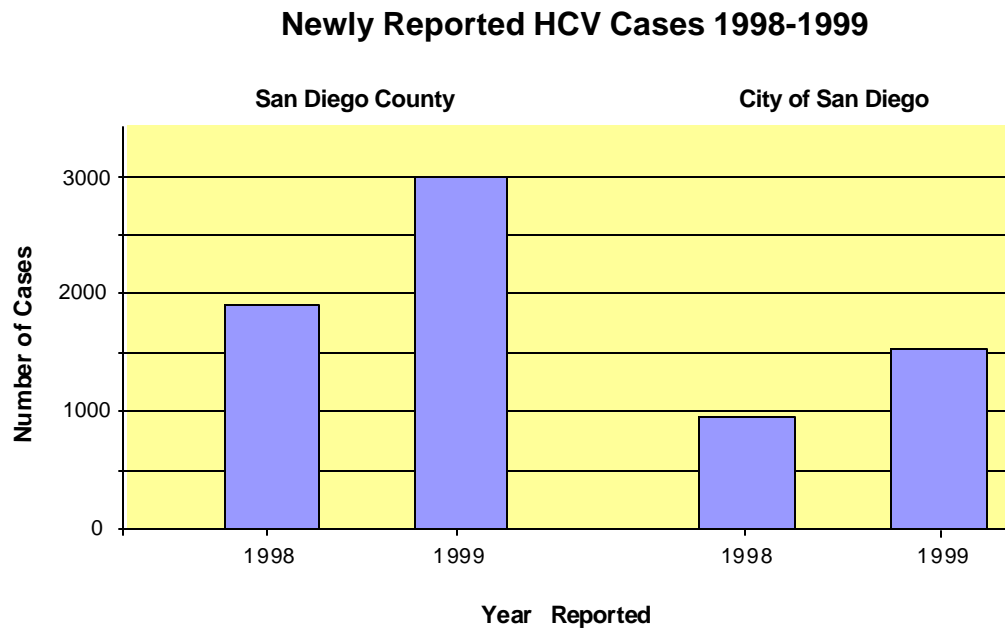
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In discussing these results it is noteworthy that the recently published County HHSA report (Ref. 11, see below) states:

Effective prevention helps injection drug users and benefits society as a whole. Reduced transmission among injection drug users means reduced transmission among their sex partners, their children and among the general population. CDC recommends that all syringes used for injections be sterile.

The task force concurs with this statement.

FIGURE 2



Source: San Diego County Health and Human Services Agency, 2000

San Diego Has One of the Highest Rates of AIDS Cases in California

The 1999 HIV/AIDS Surveillance report from the CDC lists 13 metropolitan areas of residence in California with 500,000 or more population [8]. Of these, the rate of AIDS cases in the San Diego metropolitan area of 19.5 per 100,000 population is the third highest in the state, exceeded only by Los Angeles (22.3 cases per 100,000) and San Francisco (50.8 cases per 100,000). Oakland (14.7 cases per 100,000), Orange County (9.6 cases per 100,000) and San Jose (9.2 cases per 100,000) all had significantly lower rates of AIDS cases in 1999 than San Diego. This recent data reflect the fact that San Diego has consistently had the second or third highest rate and prevalence of AIDS cases of large California metropolitan areas. State estimates of HIV prevalence in San Diego paint a similar picture. It is noteworthy that most of the other California

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communities that have declared states of local emergency because of the effects of the AIDS epidemic have lower rates of AIDS cases than San Diego.

San Diego HIV/AIDS Status

A report of the status of San Diego County cases was prepared by the County of San Diego HHSa and publicly released late last year [11]. The report opens with the following statement:

In San Diego County, HIV/AIDS continues to be a major preventable source of illness, disability and death...
--

The task force concurs with this statement.

The report notes that 10,244 AIDS cases have been diagnosed in San Diego County through December 1999. The report also notes that San Diego County has the highest cumulative incidence of AIDS in Hispanics in Southern California, and only Los Angeles has a higher number of total AIDS cases per 100,000 population among African-Americans. As in other parts of the country, people of color in San Diego are disproportionately affected by the HIV/AIDS epidemic.

In a section entitled “AIDS and Injection Drug Use: A Continuing Scourge,” it is reported that the proportion of AIDS cases attributable directly or indirectly to injection drug use continues to increase each year, to almost 25% of total cases in 1999 [11]. Women represent one-third of injection drug use-related AIDS cases and more than one-half of injection drug use-related AIDS cases are people of color. Six out of ten women attribute their HIV infection directly to injection drug use or being the sexual partner of an IDU. The highest rates for AIDS cases occur in communities located in the County’s Central Region, which includes those city locations where police records indicate most narcotics arrests are made.

Unfortunately, because there are no recent surveillance studies of HIV incidence in at-risk populations in San Diego County (which would include IDUs), current rates of HIV infection cannot be directly determined. However, there has been no decline in the rate of positive test results for those individuals seeking HIV testing for the first time at County testing sites between 1995 and 1999 [11]. During this period, approximately 1% of this population tested positive for HIV each year, with the number of newly diagnosed persons ranging from 38 to 74 each year.

The HIV epidemic is, therefore, likely continuing unabated in San Diego County, with injection drug use accounting for at least 25% of new HIV infections.

Local HIV/AIDS Annual Expenditures: Impact is Enormous

County HHSa staff has characterized local HIV/AIDS annual expenditures as having an enormous impact [11], with current estimates for all medical-related expenses approximately \$152 million annually. In San Diego County, the total hospital charges to treat patients with a primary diagnosis of HIV/AIDS exceeded \$13.5 million in 1997, with an average charge of

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\$25,561 per case. The lifetime per patient cost associated with HIV care was estimated by County staff to have grown to \$155,000.

As another indication of the rising financial burden of the AIDS epidemic in San Diego County, the County has the third largest population in California, behind San Francisco and Los Angeles, that uses the AIDS Drug Assistance Program (ADAP) to pay for drugs. The total cost to provide pharmaceuticals to San Diego residents through ADAP was \$9,565,988 in 1999, according to County figures.

Occupational Risks of HCV and HIV Infection for Emergency Personnel

An issue that is receiving increasing attention in San Diego and nationwide is the risk to emergency personnel, such as police officers, firefighters and paramedics, of infection by blood-borne diseases as a result of occupational exposure to contaminated blood. Because HCV is transmitted approximately ten-fold more efficiently than HIV and survives in a syringe much longer, the major concern is the transmission of HCV through needle sticks.

The CDC has reported on five studies of firefighters and other emergency personnel in Philadelphia, Atlanta, Connecticut, Miami-Dade County and Pittsburgh [12]. The percent of emergency personnel testing HCV positive in the three studies performed in 1999 or 2000 ranged from 2.7% to 3.2%. In Philadelphia, 4.9% of firefighters aged 40-49 tested positive for HCV. Although the CDC has remained cautious about recommending routine testing of emergency personnel, the San Diego City Council last year recognized the concern of City firefighters that they were at risk of HCV infection on the job. In July 2000, the Council approved new funds to provide hepatitis screening for San Diego firefighters to help measure the current severity of this public health issue.

In Philadelphia, where about 200 of the city's 4,400 retired and active firefighters and paramedics are infected with HCV, *The Philadelphia Inquirer* published an article entitled "Phila. lags in protecting its firefighters" on February 4, 2000 describing the hepatitis C epidemic in firefighters. The article states that their analysis exposed severe shortcomings in how the city fire department educates and trains workers about the disease and its prevention [13]. The article goes on to report that, "To date, 62 active firefighters have notified [the Fire Commissioner Harold B. Hairson] that they believe they contracted hepatitis C on the job. Six have filed claims against the city for workers' compensation."

In San Diego, attention has been focused on this issue by a scientific study by Dr. John Lorenz and his colleagues at UCSD and SDSU entitled "Occupational Needle Stick Injuries in a Metropolitan Police Force" [14]. The study found that nearly 30% of San Diego police officers responding to a survey reported at least one needle injury while on the job, and nearly 28% of this group reported two or more needle sticks. Strikingly, only 39% of those officers sought medical attention for the injuries even though almost 83% of respondents felt that the risk of on-the-job needle stick injuries were either very or extremely significant.

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The senior management staff of the City of San Diego Police Department seems to recognize the hazard posed by discarded contaminated syringes to the general public and police officers. In a recent letter to one of the task force members [15], Chief David Bejarano wrote:

The spread of infectious diseases such as HIV and hepatitis by intravenous drug users is not only a public health threat, police officers also have to concern themselves with these diseases during the regular performance of their duties due to accidental needle sticks.

Drug Use in San Diego

San Diego has a longstanding drug problem that continues to persist. In 1990, San Diego received federal designation as a “high-intensity drug trafficking area”[16]. In 1994, Department of Justice data placed San Diego first in the nation for methamphetamine production and use, first for poly-drug use and third for heroin use. The use and production of methamphetamine in the county in the early 1990s earned San Diego the dubious distinction of being known as the “Methamphetamine Capital” of the United States [17]. In San Diego County, three out of ten arrestees booked into County jails in 1995 had methamphetamine in their systems [17]. As a result, in 1996, the County Board of Supervisors convened a Methamphetamine Strike Force consisting of members from law enforcement and the health care and education communities to combat this problem. For the last five years, the strike force has issued an annual report card that monitors changes in methamphetamine use in the county. Criteria used include positive methamphetamine tests for adult and juvenile arrestees, number of arrests for methamphetamine sales and possession, methamphetamine-related deaths, and methamphetamine-related drug treatment admissions. Despite continued seizures of methamphetamine and destruction of methamphetamine-producing laboratories, examination of these data show that there has been no significant impact on methamphetamine use in San Diego County since the strike force has been in operation [18].

The number of injection drug users (IDUs) in San Diego County cannot be directly determined for many reasons, primarily due to the difficulty in accessing active substance abusers in general and challenges in collecting accurate information. Data collected by the National Institute of Drug Abuse (NIDA) through household surveys across the United States reveal that about 1% of the general population are IDUs. This translates into an estimated 25,000 to 28,000 IDUs in San Diego County [16]. According to a Robert Wood Johnson Foundation study in 1993 [16], between 75% and 80% of IDUs are not in treatment, while another 20% may be ready to enter treatment but have difficulty accessing services.

Data on current drug use trends in San Diego are primarily obtained from the Arrestee Drug Abuse Monitoring (ADAM) system of the Department of Justice, administered through the San Diego Association of Governments (SANDAG), and from the Department of Alcohol and Drug Services of the San Diego County HHSA. Data from the September 2000 ADAM report indicate that in 1999 [19], female adult arrestees (36%) ranked first in the nation for the presence of methamphetamine in their system at the time of booking, while San Diego was second in the nation for male arrestees (26%) testing positive for methamphetamine. Male (9%) and female (11%) arrestees testing positive for heroin in San Diego now rank eleventh and twelfth,

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respectively, in the nation. Even though San Diego did not rank in the top ten cities for cocaine use, 17% of adult male arrestees and 23% of female arrestees tested positive for cocaine. Of individuals testing positive for illicit drugs, 22% of males and 31% of females tested positive for the presence of more than one drug (poly-drug use).

Sadly, San Diego is first in the nation by a wide margin for both male and female juvenile offenders testing positive for methamphetamine (boys at 16% and girls at 18%) compared to the other eight cities for which data are available. Additionally, 16% of juveniles tested positive for the presence of more than one illicit drug at the time of booking.

Demographic data from the September 2000 ADAM report [19] reveal that about one-half of adult arrestees testing positive for an illicit drug were over the age of 32, with adult females slightly older than their male counterparts. Four out of ten arrestees were Caucasian, one-quarter were African-American, one-third were Hispanic, and the remaining were other ethnic groups. With respect to juvenile arrestees, close to one-half of the boys testing positive for illicit drugs were Hispanic, 25% were Caucasian, 17% were African-American, and the remaining 7% were other ethnic groups. Female juveniles were similar to the boys with respect to ethnicity. Nearly one-half of boys taken to juvenile hall were between the ages of 15 and 16, one-quarter were 17 to 18 years, and the remaining 25% were less than 15 years of age. In contrast to the boys, 35% of the girls were 14 years or less, 41% were 15 to 16 years, and 24% were 17 or 18 years.

Data from the County Alcohol and Drug Services Division [20] indicate that of substance abusers in a treatment setting, those reporting a history of injection drug use tended to be older (methamphetamine: mean age 34 years; heroin: 36 years; cocaine: 38 years). Differences were seen in route of administration of the drugs, with 19% of methamphetamine users reporting injecting the drug compared to 84% for heroin and 4% for cocaine. Methamphetamine users were predominantly Caucasian (80%), with approximately 18% being Hispanic. Of heroin users in treatment, just over half were Caucasian, 40% were Hispanic and approximately 8% were African-American. Cocaine users were 60% Caucasian, 20% African-American, and 20% Hispanic.

CLEAN SYRINGE EXCHANGE PROGRAMS

Misinformation to contradict the peer-reviewed scientific studies demonstrating the efficacy of clean syringe exchange programs continues to be disseminated in San Diego and nationally. In light of this situation, the task force considers it necessary to review these studies and discuss the assertions that seek to contradict them.

The U.S. Surgeon General recently reviewed all the peer-reviewed, scientific studies of clean syringe programs since April 1998 and issued a report on March 17, 2000 [21] (see Appendix A) that stated:

Syringe exchange programs, as part of a comprehensive HIV prevention strategy, are an effective public health intervention that reduces the transmission of HIV and does not encourage the use of illegal drugs.
--

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This report summarizes the most important of these and earlier studies and addresses additional issues of concern raised by critics of clean syringe exchange programs that have been answered by scientific studies.

Clean Syringe Exchange Programs Reduce the Transmission of HCV and HIV

The first evidence that clean syringe exchange programs reduce the transmission of blood-borne diseases was a 1993 study by researchers from Yale University studying the needle exchange program in New Haven, Connecticut [22]. Subsequently, a study published in 1995 of the Tacoma, Washington clean syringe exchange program showed that the risk of HCV infection in participants of the program was seven-fold less than the control group of IDUs that did not use the program [23]. In New York, it was found that IDUs using city clean syringe programs were significantly protected against HIV infection [24] and the rate of new HIV infections among all IDUs in New York City declined during the 1990s [25]. Studies by Johns Hopkins University researchers, described by the Baltimore City Commissioner of Health, Dr. Peter Beilenson, in a recent Op-Ed piece published in the *San Diego Union-Tribune* [26] (see Appendix B), found that the incidence of HIV infections in participants of the Baltimore clean syringe exchange program was reduced by 40%, compared to all other IDUs in the city [see also Ref. 35].

These are not isolated cases of successful syringe exchange programs. A survey of 81 cities worldwide with available data on injection drug use estimated that HIV prevalence declined 5.8% per year in cities with established clean syringe exchange programs but increased by an average of 5.9% per year in 51 cities without such programs [27].

Misrepresentation of the Vancouver Data

However, to reject the scientific findings that clean syringe exchange programs reduce the transmission of HCV and HIV, critics with no medical or public health training continue to misrepresent the initial studies of clean syringe exchange programs in Vancouver and Montreal, Canada [28, 29]. They argue that studies of those clean syringe exchange programs showed that the implementation of a clean syringe exchange program caused an increase in new HIV infections in participants who used them [30, 31]. In subsequent scientific papers, Op-Ed pieces and correspondence published in the *New York Times* and *San Diego Union-Tribune*, the authors of these studies have rebutted these claims and pointed out that more recently the incidence of HIV infections has plummeted in Vancouver [32-34]. Indeed, in public testimony before the Public Safety and Neighborhood Services Committee of the San Diego City Council in September 2000, the senior author of the Vancouver study, Dr. Martin T. Schechter of the University of British Columbia, Vancouver, explained in detail how data from his studies had been misrepresented.

Clean Syringe Exchange Programs Provide Health Services, Education and Referrals to Drug Treatment

A survey by Dr. Don des Jarlais and colleagues at the Beth Israel Medical Center in New York City of services offered by 87 syringe exchange programs operating throughout the United States in 1996, is cited in the Surgeon General's recent report [21]. It was found that 97% provided

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referrals to substance abuse treatment, 80% provided education to reduce risk of STDs, and many also provided HIV counseling and testing, primary health care, and tuberculosis screening in addition to exchanging sterile syringes for used ones. A subsequent survey was conducted by the CDC in 1997 of 100 syringe exchange programs operating in 80 cities in 30 states, the District of Columbia, and Puerto Rico [21]. Most of the programs provided public health and social services; 99% provided instruction to prevent sexual transmission of HIV and other STDs; and 94% provided referral to substance abuse treatment programs. Health care services offered on site included HIV counseling and testing (64%), tuberculosis skin testing (20%), STD screening (20%), and primary health care (19%).

In Baltimore, it was reported that the clean syringe exchange program successfully refers participants to substance abuse treatment programs (51% of referrals were admitted to treatment). In addition, there are high retention rates (75%) for participants referred by the syringe exchange program despite the fact that the participants are “among the most hard core, difficult to reach addicts in the city” [21, 26, 35].

Task force members were able to see firsthand how the clean syringe exchange program in Baltimore provided these ancillary health services, and were uniformly impressed with the efficiency and quality of the services provided by the program.

A report to the National Institute on Drug Abuse of the evaluation of the Baltimore clean syringe exchange program by Johns Hopkins University researchers summarizes other benefits of such programs [35]. For example, clean syringe exchange attendance was associated with a decrease in risky syringe sharing, and those participants who entered treatment reduced their drug use and engaged in less criminal activity for profit.

The Baltimore clean syringe exchange program’s linkage to drug detoxification and treatment centers is so successful that it has been a public health challenge to provide enough treatment slots. However, in a city with a population of 680,000 residents, 7,000 to 8,000 treatment slots have been created, funding for drug treatment has tripled in the last three years, and 300 treatment slots have been specifically reserved for participants of the syringe exchange program. In Baltimore, substantial numbers of drug users are in court-mandated treatment and referrals from clean syringe exchange programs are seen as complementary to the court-mandated approach of getting drug users into treatment.

CLEAN SYRINGE EXCHANGE PROGRAM MISCONCEPTIONS

Misconception 1: “Clean Syringe Exchange Programs Increase Crime.”

An oft-cited concern of law enforcement, fueled primarily by misrepresentation of the effects of the Vancouver clean needle exchange program, is that the proximity of clean syringe exchange programs leads to an increase in crime. The Vancouver clean syringe exchange was placed in downtown Eastside Vancouver, long a high crime area, because that was the area of the city where IDUs were concentrated. Therefore, the inference that the clean syringe exchange program promotes crime is incorrect [32]. Representatives from Baltimore and Los Angeles during task

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force visits indicated that their syringe exchange programs were also placed in high intensity drug use and drug transaction areas.

In fact, scientific studies have concluded that clean syringe programs do not increase crime in the neighborhoods where they are located [35, 36]. Trends in arrests were compared in clean syringe exchange areas and equivalent areas without such programs before and after a clean syringe exchange program was introduced in Baltimore. Arrests were categorized into four types of crime: drug possession, economically motivated, resistance and violence. No significant differences in arrest trends were seen in any of the arrest categories. The head of the Baltimore Police Department's Narcotic Section, Major Jesse B. Oden, stated during the task force site visit that crime neither increased nor decreased in neighborhoods with clean syringe exchange sites; he described the effect as neutral.

Misconception 2: "Clean Syringe Exchange Programs Attract Injection Drug Users into a Neighborhood."

The concern has also been raised that a clean syringe exchange program will attract IDUs into a neighborhood, resulting in an increase in crime, discarded syringes and other undesirable problems. This issue, known as the "magnet effect," has been carefully studied in Baltimore using acceptable objective scientific and Baltimore City police department criteria. In Baltimore, 85% of the participants attending a clean syringe exchange program lived in the same zip code as the location where they visited the mobile clean syringe exchange program [35, 36]. In Los Angeles, staff at one of the exchange sites told task force members that 75% of their participants lived in the same neighborhood. As discussed above, crime was not increased in the vicinity of the mobile programs, and in a carefully controlled scientific study it was shown that the number of discarded syringes did not increase in the vicinity of clean syringe exchange programs [35, 37].

As discussed earlier, task force members visited a clean syringe exchange program site on their visit to Baltimore. It was inconspicuously located on a street corner in a small motor home. There was a short, orderly line when the clean syringe exchange first opened that was serviced quickly. The participants left the area within a few minutes of accessing services. In Los Angeles a large van was used. As in Baltimore, participants left the area soon after receiving services.

In Baltimore, the clean syringe exchange program records the zip code of participants as part of the demographic data they collect. At locations close to the city boundaries, individuals who are residents of the nearby county compose a minority of participants. However, in Baltimore, Johns Hopkins University researchers and Major Jesse B. Oden, the head of the Baltimore Police Department's Narcotics Section, expressed the opinion that the only "magnet" for IDUs was the availability of drugs. The Baltimore police are aggressively enforcing drug laws in the city and as a result, homicides, of which 90% are drug-related, were dramatically reduced last year. Major Oden also stated that he viewed the "supply side" of illicit drugs to be a law enforcement issue while the "demand side" he saw primarily as a public health issue.

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Misconception 3: “Clean Syringe Exchange Programs Send the Wrong Message to Children.”

Another assertion that is not supported by objective evidence is the slogan, “Clean syringe exchange programs send the wrong message to children.” The concern that clean syringe exchange programs send a message to youth condoning illicit drug use has also been investigated by Johns Hopkins University researchers [35]. A survey of high school students from four Baltimore City high schools was conducted to determine what factors influenced their attitudes about illicit drug use. Among the 1,110 students who responded to the survey, 49.9% thought that peers using drugs promoted drug use, and 43.5% thought parents using drugs promoted drug use. In contrast, 11.1% thought that clean needle exchange programs promoted drug use, only 5% higher than the proportion (6.1%) who thought that anti-drug TV advertisements promoted illicit drug use. Finally, nearly half of the students (46%) viewed seeing drug users at clean syringe exchange sites as a deterrent to drug use and almost as many (43%) viewed seeing drug users at a clean syringe exchange site as having no impact. These data refute the claim that clean syringe exchange programs send the wrong message to youth.

Misconception 4: “Clean Syringe Exchange Programs are Immoral.”

Opponents of clean syringe exchange programs often argue that such programs are immoral because they appear to condone drug use. However, this view has been challenged by physicians, lawyers and theologians based upon consideration of widely accepted ethical principles. The claim that clean syringe exchange programs are immoral reflects an absolutist moral view that no action that causes harm can be countenanced. This ethical stance might be seen to be supported by the well-known medical maxim *primum non nocere*, “Above all, do no harm.” However, a literal interpretation of this maxim has been replaced in modern bioethics by the concept of beneficence. Beneficence, one of the three ethical principles (beneficence, justice and respect for autonomy) that comprise the modern code of bioethics the medical community uses to resolve ethical dilemmas, supports harm reduction programs across a variety of public health issues [38].

The principle of beneficence has been explained in the following terms [38]:

Those engaged in both medical practice and research know that risks presented by interventions must constantly be weighed against possible benefits for patients, subjects and the public. The physician who professes to “do no harm” is not pledging to never cause harm but rather to strive to create a positive balance of good over inflicted harm.

and:

When a life is at stake, it may be justified to take high risks of harm.
--

When these modern ethical principles of medicine are applied to clean needle exchange programs, the benefits to the public in preventing the spread of blood-borne lethal diseases need to be weighed against any harm they may suffer. In addition, any perceived harm that may be

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inflicted on the injection drug user by participating in a clean syringe exchange program must be weighed against the benefits that may result from participation in such a program.

Jon Fuller, S.J., M.D., Assistant Director of the Adult Clinical AIDS Program at Boston Medical Center and the Margaret Pyne Professor of Theology at the Weston Jesuit School of Theology in Cambridge, Massachusetts published a detailed analysis of the ethics of clean syringe exchanges [39] (see Appendix C). Fr. Fuller points out that a scientific advisory panel of the National Research Council and the Institute of Medicine observed that there is no credible evidence that drug use increases among participants of syringe exchange programs or that such programs increase the number of new initiates to injection drug use. He also alludes to the fact that in February 1997, a consensus panel of the National Institutes of Health indicated that syringe exchange programs led to a reduction in risk behavior of drug-injecting participants as high as 80%, with estimates of a 30% reduction in HIV infections. Thus, he concludes that the consensus of scientific and public health opinion supports clean syringe exchanges as providing significant benefits without causing harm. Fuller also evaluates the morality of clean syringe exchange programs using the principle of cooperation [39]. This principle recognizes that in a complex world we are faced with the prospect of cooperating to some degree with individuals or groups whose goals we may not fully share. He concludes that permitting or even cooperating with clean syringe exchange programs would be allowed by traditional moral principles.

Scott Burris, J.D., and colleagues also have concluded that clean syringe exchange programs can be justified by the ethical principle of beneficence [40]. They state that the ethical principle of justice would also be satisfied to the extent that the provision of sterile syringes to IDUs also reduces HIV transmission to IDUs' partners and children.

The Society of Christian Ethics (SCE), a nondenominational scholarly association that draws its members from the faculties of universities, colleges and theological schools primarily from the United States, Canada and Europe, took the unusual step of endorsing a public policy resolution supporting one-for-one clean syringe exchange programs last year [41]. The resolution reviewed the scientific evidence that syringe exchange programs do not increase drug use among addicts nor lead to injection behavior in non-addicts, but do save lives by decreasing HIV infections and providing a bridge to general medical care, detoxification and drug recovery programs. The resolution of support was also based on the principle that:

Most major religious traditions including Christianity are concerned for the preservation of human life and dignity.
--

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James F. Keenan, S. J., co-convenor of the SCE's Educating for AIDS interest group, stated in a recent press release [42] that:

The clean syringe exchange program resolution was presented and passed after consideration of the fact that while many medical, scientific, public health, civil, and legal professional associations and organizations have endorsed clean syringe exchange programs, the Presbyterian Church of the U.S.A. is the only ethical or religious professional association to have also made such an endorsement. In part because of this void, this absence, this silence, opponents to clean syringe exchange programs have insisted that the ethical and moral perspectives are with those who oppose clean syringe exchange programs. We ask the SCE to endorse this resolution so as to recognize and validate as ethical the claims of professional associations that have also endorsed clean syringe exchange programs, such as the American Medical Association, the American Nurses Association, the National Academy of Sciences, the Centers for Disease Control and Prevention, and the U.S. Conference of Mayors among others. We need to send the right message that clean syringe exchange programs are an ethically necessary, medically needed and socially urgent response to the growing trends in HIV transmission in the United States.

The task force concurs with these ethicists and believes that the benefits of clean syringe exchange programs far outweigh any harmful effects, and therefore, are morally and ethically justified.

Misconception 5: "The Public Does Not Support Clean Syringe Exchange Programs."

A public opinion poll of San Diego County registered voters regarding attitudes about clean syringe exchange programs was conducted in July and August of 1996 [43]. The poll was conducted by the Social and Behavioral Research Institute at California State University San Marcos using a computer-aided telephone interview system. A total of 1,015 registered voters were surveyed with approximately 200 respondents from each supervisorial district. The results of the survey indicated strong support for a clean syringe exchange program. Of those surveyed, 85% either fully supported syringe exchange programs or felt that San Diego needed a syringe exchange program provided it reduced the transmission of HIV and served as a bridge to drug treatment. In addition, approximately 70% of respondents believed that syringe exchange programs save taxpayers money on health care and protect children and the community from the spread of AIDS.

This result is similar to other surveys that have been conducted nationwide or in California. A national random-sample telephone survey of 1,511 adults funded by the Henry J. Kaiser Family Foundation in March 1996, surveyed the attitudes of Americans to HIV/AIDS. The survey found that 65% of respondents supported providing clean syringes to IDUs [44]. A survey of Californians regarding needle exchange conducted by the Field Institute, a private non-partisan, non-profit public policy research organization, in August 1999, revealed that 69% of

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Californians support syringe exchange programs in order to stop the spread of HIV and AIDS. In San Diego, 58% of participants favored syringe exchange [45].

IV. CLEAN SYRINGE EXCHANGE TASK FORCE RECOMMENDATIONS

IMPLEMENTATION MODEL

After visiting the programs in Baltimore and Los Angeles, and researching models currently in operation in other California cities and counties, the task force has identified several essential components of a pilot program for operation within the City of San Diego. Given that under AB 136, a local jurisdiction must declare a state of health emergency so that a clean syringe exchange can legally operate, the task force recommends:

1. THE DECLARATION OF A STATE OF EMERGENCY IN THE CITY OF SAN DIEGO (See APPENDIX F).

The task force recommends that upon declaration of the state of emergency, the City authorize:

2. THE IMPLEMENTATION OF A PRIVATELY-FUNDED, ONE-YEAR PILOT CLEAN SYRINGE EXCHANGE PROGRAM

As part of the authorization of the pilot program, the task force recommends,

3. THE INCLUSION OF THE FOLLOWING PROGRAM ELEMENTS:

A. Mobile Versus Fixed Sites

Most programs, including those visited by the task force, use a mobile system for providing services. Mobile sites offer an opportunity to provide a full range of services, including referral to drug treatment, social service and medical referrals, and HIV/HCV/STD testing and counseling, in a confidential manner at venues that are readily accessible to participants. The mobile system also allows the program the flexibility to change sites when necessary and reduces the overall impact on a neighborhood, since it only operates for short periods of time each week (generally two hours per site per week). In other communities in California and the United States, the mobile programs have been well accepted by the community. In addition, mobile programs are a cost-effective way to provide a variety of services where the target population is located, and eliminate the need to find rental space.

The task force had the opportunity to view programs that use different mobile units to provide services. In Baltimore, the program uses small motor homes (two currently, with a third in the process of being purchased), which allow rapid and confidential data collection from the participants, space for HIV/HCV/STD testing and counseling, and education of

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participants. The motor home allows two participants at a time to be served, thereby providing orderly and rapid processing of participants out of sight of the community.

In Los Angeles, both programs visited use a commercial cargo van to provide services. This model requires that confidential counseling be provided either in another vehicle (e.g., Tarzana Treatment Center's testing van at the Bienestar location) or that the outreach worker step to one side with the client. With this model, because of the visibility of services being provided and the length of time an individual may spend at the site, the variety of services that may be provided can be limited.

The task force recommends a mobile system with the use of a small motor home for the following reasons: reduced visual impact of the program on the neighborhoods and the ability to process participants and deliver services in an efficient and confidential manner.

B. Tracking of Participants

Both sites visited use standardized intake processes. Both programs use unique identifiers (a combination of numbers and letters well known to participants such as the month and day of birth, last four digits of their social security number, initials of parents' names) to track participants, and provide participants with identification cards. These identification cards enable individuals to provide proof to police officers that they are participants in the program. The locations and times of operation of the program would be displayed on the reverse side of the card to help participants use services on a regular basis.

The task force recommends a laminated identification card, such as the one below, be issued to participants of the program in order to track participants and enable them to provide proof of participation to police officers.

City of San Diego
Clean Syringe Exchange Program (SEP)

Participant # _____

This card has been issued to a participant in the City of San Diego's SEP. As long as the SEP is in effect, the participant is exempt from prosecution by the San Diego City Attorney's Office for a violation of California Business and Professions Code section 4140 only, and only if the violation occurred within the City of San Diego. This immunity does not extend to any activities not authorized or approved by the SEP, or that are otherwise unlawful.

C. Documentation Procedures

When a client requests services for the first time, demographic information (including age, date of birth, gender, ethnicity, zip code, primary language, drug of choice, and number of years injecting) is collected. In Baltimore, this information is directly entered into the

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database using a laptop computer at the time of the interview in the mobile unit. In Los Angeles, the information is collected manually on a standardized form and then entered into the database at the office. According to staff of both programs, the collection of demographic data does not deter participants from accessing services. The advantage of direct data entry, the procedure used in Baltimore, is accuracy and completeness of the client database, and the ability to review the complete history of the client during subsequent visits to the mobile unit.

The task force recommends an on-site computer for real-time documentation of participant characteristics and outcomes.

D. Consistent Enrollment and Education Messages

The Baltimore and Los Angeles programs both use a standardized script to explain to participants the guidelines for participating in the program. The programs make it explicit that absolutely no drug use nor drug dealing are to take place during or after accessing services in the neighborhood; that participants are expected to behave in an orderly fashion while waiting for services and to leave the vicinity immediately after receiving services; and that participants are expected to take care of the area by not littering or engaging in other antisocial behaviors. Observations of clean syringe exchange participants in both Baltimore and Los Angeles indicated that participants do respect the guidelines.

Program staff reports that participants view the program as a valuable resource, which they understand they may lose if the guidelines are violated. Few problems with participants have been reported by either program, and some participants actually police the behavior of other participants.

At subsequent visits, the date of service, number of syringes exchanged, description of other services provided, and description and outcome of referrals are noted in each client's file. Over time, the staff of clean syringe exchange programs develops a relationship of trust with participants which facilitates their entry into treatment.

The task force recommends a standardized script that describes guidelines for participation in the program and provides a consistent risk-reduction educational message.

E. Risk Reduction Services

Both programs visited provide baseline harm reduction packets to new participants, but limit each client to one packet. The unique identifier system and identification cards ensures that participants only receive a baseline harm reduction packet on their first visit to the syringe exchange program. In Baltimore, packets included two sterile syringes, while the Los Angeles packet contained five.

In addition to a one-for-one exchange of used syringes for sterile syringes, risk reduction kits will be provided if requested. Baseline harm reduction and risk reduction packets will be

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pre-packaged with items that have been recommended by the CDC to prevent the transmission of HIV/HCV/STDs among IDUs and their spouses, partners, and children.

The task force recommends that risk reduction services and kits be provided in the vehicle. These kits include a one-time baseline harm reduction kit with two sterile syringes, given the success of the Baltimore program at enrolling and retaining new participants by this outreach strategy. The number of syringes exchanged per visit should be sufficient to provide the typical client with a clean syringe for each injection for one week. Based upon the types of drugs commonly used in San Diego (methamphetamine, heroin, heroin/cocaine combinations), no more than 50 syringes will be exchanged per visit.

F. Prevention Education

Written educational materials will be distributed with the packets to reinforce the verbal risk reduction information provided by staff at each visit. Information on reducing the risk of HIV and HCV infection as well as other infectious diseases associated with injection drug use (e.g., endocarditis, sepsis, abscesses at injection sites) will be part of standardized scripts used by program staff. In Baltimore, program staff commented that the print materials are taken by participants and distributed to IDUs not enrolled in the program. This serves two purposes: first, it reduces risk in broader injection drug use networks and second, it introduces the program to individuals who are reluctant to access any type of formal health or social services.

The task force recommends that a variety of printed educational materials be available on the mobile unit for distribution to participants.

G. Case Management and Referrals

In addition to educational activities, intensive case management services and referrals will also be provided to participants. Case management services allow staff to provide individualized attention to participants, and help empower them to understand and accept responsibility in reducing the risk that they become infected or pass the infection on to syringe-sharing or sexual partners. Staff discusses specific situations with the participants, and follows up on issues when participants return to the mobile unit for continuing services.

Referrals are most effective when the client has indicated to staff a need and interest in addressing that need. Referrals are frequently made for medical care, emergency food and clothing, housing, counseling, detoxification services, and treatment programs.

Referrals to detoxification and treatment services

According to the Alcohol and Drug Services Division of the San Diego County Health and Human Services Agency, the county currently funds 938 residential treatment slots, approximately 3,000 non-residential treatment slots and 50 detoxification slots. In addition, there are five clinics in the county with capacity for 1,800 participants that provide

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methadone treatment for heroin users. These clinics are not funded by the county, although the State of California does provide limited funds to Medi-Cal eligible participants. Access to methadone treatment is limited to those who can afford the cost of treatment (estimated at \$270 to \$300 per month). This information was provided to the task force at the February 28, 2001 meeting.

The attached flow chart (see Appendix D) shows a normal depiction of the steps an IDU seeking treatment might follow. It is important to keep in mind that drug addicts are diverse in their presenting problems and needs. While this chart shows the typical course of action the majority of substance abusers seek, it is by no means meant to be the only scenario a client would follow to achieve recovery. This chart reflects a continuum of services available to clients; the services provided are determined after a thorough and complete assessment of each client's unique needs.

The majority of substance abusers, once they decide to seek help, need some type of detoxification program to clear their system of the substances they are using. In a medical residential program or an outpatient medical clinic, medication to ease the withdrawal symptoms is provided. In a medical non-residential program, medication is not provided. The current waiting list for an IDU to enter a detoxification program is five to seven days. Detoxification is required prior to acceptance into either residential or non-residential treatment.

Following detoxification, many clients need a more structured short- (30 to 90 days) or long- (six to nine months) term residential program. Residential program waiting lists average two weeks, while non-residential lists are a one to two day wait. Upon completion of the short- or long-term residential recovery program, some clients chose to move into a sober living environment and/or continue in outpatient services, while others will return to their home or find appropriate housing. Sober living programs offer individuals in recovery a drug-free living environment, although they do not offer recovery services on site. Residents of the sober living facility are expected to participate in outpatient recovery programs and follow the housing rules.

Clients who have a safe living environment (i.e., a non-drug using environment) may live at home and participate in outpatient treatment following detoxification. Those who do not have a safe environment may move to a sober living program coupled with outpatient treatment. Other clients are able to detoxify themselves without the assistance of a residential program and enter recovery either through outpatient treatment and/or sober living.

The following list of potential obstacles to referrals into treatment has been identified by the task force:

1. A lack of detoxification programs and beds;
2. The county does not have a centralized database to track available detoxification and drug treatment slots as individuals move into the system; and

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3. Under current procedures, clients on waiting lists for treatment are required to telephone the provider every day to maintain their position on the waiting list.

The task force recommends case management be an integral part of the services provided through the program, including active referrals into detoxification and recovery programs.

H. Training of Staff

Issues to be addressed during the selection and training of staff include cultural competency with the target population; sensitivity to neighborhood issues; ability to work with all the collaborating partners and members of a program facilitation committee; and respect for, and adherence to, the program guidelines as discussed in this report.

The task force recommends written guidelines for the selection and training of program staff.

I. Safety Protocols

The implementing agency will be required to provide instruction on the proper collection and disposal procedures for used needles, syringes and other hazardous waste materials. All personnel will be required to be vaccinated against hepatitis A and B and encouraged to undergo HIV and hepatitis C testing. Tetanus shots should be up-to-date (less than five years since vaccination). Staff will be provided with instructions of how to proceed in the event of an accidental needle stick based on CDC recommendations.

Participants who exchange syringes will be asked to count the syringes before placing them in a bio-hazardous waste container so that under normal circumstances syringe exchange staff will not handle used needles and syringes. All bio-hazardous waste (any item which has come in contact with blood and/or used syringes) will also be disposed of in the bio-hazardous waste container. In the unusual event staff is required to handle potentially contaminated material, latex gloves will be worn and the materials and gloves will also be disposed of in the bio-hazardous waste container.

Syringe exchange staff will be expected to wear closed-toe shoes (no sandals) and encouraged to wear sturdy clothing that covers the arms and legs.

The task force recommends training to all staff in universal precautions following the Centers for Disease Control and Prevention recommendations.

4. PROGRAM EVALUATION

External evaluation to be conducted by an academic institution(s) to be identified

Using the basic elements of the Johns Hopkins University School of Hygiene and Public Health evaluation model, the following issues will be addressed over the first year:

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1. Has needle sharing among participants been reduced?
2. What has been the impact of the syringe exchange program on the frequency and type of drug use by participants?
3. How frequently do participants use the syringe exchange program and what services do they utilize, including treatment, medical care, etc.?
4. Trends in criminal activities associated with drug use (e.g., breaking and entering, robbery, drug possession, etc.) in the surrounding neighborhood.
5. Tracking of place of residence of syringe exchange program participants.

Given the proposed one-year authorization of the pilot program, it will not be possible to measure an impact on HIV or HCV seroconversion rates. This pilot program will, however, collect seroprevalence data that may serve as a baseline to evaluate such an impact in subsequent years. Researchers at Johns Hopkins have agreed to provide assistance in setting up the external evaluation component and technical assistance during the implementation year.

Process evaluation to be conducted by the implementing agency

In order to assure that the program is meeting the needs of the participants and that services are being appropriately provided, information on a number of demographic and service delivery variables will be collected. For example, the number of participants enrolled; demographics (age, gender, zip code, drug of choice, etc.); frequency of use of the program; types of services provided during the visit; HIV/HCV/STD testing; number of referrals provided; the number of referrals accepted by the participants; the number of individuals referred into treatment by the program and length of stay in treatment; and how participants heard about the program will be collected.

The task force recommends the identification of external evaluators to work with program staff to determine effectiveness at reducing sharing of injection equipment, services used by participants, and to the extent possible, trends in criminal activity at the sites.

5. LOCATION OF THE PILOT CLEAN SYRINGE EXCHANGE PROGRAM

Since programs must be located in areas where the participants live, members of the task force spent several meetings discussing the criteria to be used for identifying possible sites for the pilot program and examining data provided by the City of San Diego Police Department. This data included arrests and citations for possession of narcotics such as heroin, cocaine, and methamphetamine (see Appendix E), arrests for possession of a needle or syringe, and reported drug-related crimes (e.g., burglary, robbery, auto theft, assaults and other thefts). In addition, areas impacted by high rates of transmission of STDs were identified using the STD core transmission area map produced by the San Diego County HHSA, Sexually Transmitted Diseases Control Program.

These areas are: (1) the Mid-City corridor (the area between El Cajon Boulevard and University Avenue, between Park Boulevard and Euclid Avenue), and (2) the Center City East corridor (the

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area on the eastern edge of Downtown and extending east to the Barrio Logan community). Additional sites can be added based on a needs assessment utilizing data from the first two sites.

Before the program is set up in a neighborhood, community leaders will be informed of the location and services to be offered. Residents will be given a name and phone number through which to register comments or concerns once the program is implemented. Concerns are to be reported to the Program Coordinator expeditiously. The Program Coordinator will write the concern in a log, respond to the concern within five working days, and note in the log how the concern was resolved along with any other relevant information.

The task force, based on recommendations from Police Department staff, recommends that two areas of the City where drug use levels are high enough to warrant establishing such be evaluated for participation in the pilot program.

6. COOPERATION WITH LAW ENFORCEMENT

Cooperation includes activities such as meeting with officers to discuss implementation issues, explain the services being provided through the program and describe client participation guidelines. Program staff would work with the Police Chief to develop a policy statement related to no harassing of participants carrying the program identification card or confiscation of either identification cards or syringes. This policy should also include a statement that officers will enforce drug possession and other drug laws if participants violate them.

The task force recommends the establishment of cooperative relationships such as those observed in Baltimore and Los Angeles between pilot program and Police Department staff, in particular with officers stationed at the nearest area stations.

THE CITY OF SAN DIEGO'S ROLE IN PROGRAM IMPLEMENTATION

In order for the pilot program to operate, the City Council would be required to declare a local state of emergency (see Appendix F) during the pilot program period. This resolution would need to be renewed on a regular basis during the pilot program. The City Manager's Office will report program findings to the City Council at the end of the pilot period.

Program Facilitation Committee

The City Manager would appoint a Program Facilitation Committee once the program is in operation. The Committee would meet no more than quarterly to review program status and other issues of relevance to program implementation. Members may include the Program Coordinator, representatives from the affected Police area stations, the City Manager's Office, the City Attorney's Office, the Mayor's Office, local medical experts with expertise in blood-borne infectious diseases and prevention and treatment, and representatives from the private funder(s).

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V. ESTIMATED PROGRAM COSTS

The following table reflects the estimated costs associated with operating a one-year pilot Clean Syringe Exchange Program. All costs would be privately funded, requiring no City funding.

Position	Base salary	Time	Total
PROGRAM STAFF			
Program Coordinator	\$38,000	1 FTE*	\$ 38,000
Outreach Worker	\$23,000	1 FTE*	\$ 23,000
Outreach Worker	\$23,000	1 FTE*	\$ 23,000
Fringe (21%)			\$ 17,640
EVALUATION			
Consultants – JHU SHPH (consulting fees, travel, hotel, per diem)			\$ 50,000
Local evaluation consultants			\$ 30,000
Personnel and consultants, subtotal			\$181,640
DIRECT OPERATING COSTS			
Vehicle:			
Mobile unit purchase or lease (used small Winnebago)			\$ 50,000
Gasoline			\$ 3,500
Maintenance			\$ 2,500
Secure parking lot fee			\$ 750
Insurance & liability			\$ 2,500
Laptop computer			\$ 5,000
Office supplies			\$ 1,000
Duplication costs			\$ 2,000
Telephone			\$ 1,000
Incentives (food coupons, baseball caps, etc.)			\$ 3,000
Risk reduction, hygiene and wound kits			\$ 15,810
Syringes			\$ 45,500
Sharps containers			\$ 300
Educational materials			\$ 19,500
Direct Operating Costs, subtotal			\$152,360
TOTAL			\$334,000

*Full-time equivalent

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VII. APPENDICES

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APPENDIX A

U.S. SURGEON GENERAL'S REPORT

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Surgeon General's NEX Review Text

EVIDENCE-BASED FINDINGS ON THE EFFICACY OF SYRINGE EXCHANGE PROGRAMS: AN ANALYSIS FROM THE ASSISTANT SECRETARY FOR HEALTH AND SURGEON GENERAL OF THE SCIENTIFIC RESEARCH COMPLETED SINCE APRIL 1998

Introduction

The issues of substance abuse addiction and HIV transmission related to injection drug use remain serious public health challenges, and the need to define and implement effective public health interventions remain urgent. The scientific research continues to define the unique role that syringe exchange programs can play in curtailing the expansion of the HIV epidemic in vulnerable communities affected by substance abuse, as part of a well designed and implemented comprehensive HIV prevention strategy.

This paper provides a review of recently published peer-reviewed research on syringe exchange programs completed by senior scientists and public health experts within the Department of Health and Human Services. An overview of the research studies is followed by an annotated bibliography providing the published abstracts, directly quoted, and relevant commentary. In summary, the new studies contribute substantially to the strength of the data showing the following effects of effective syringe exchange programs: a decrease in new HIV seroconversions; an increase in the numbers of injection drug users referred to and retained in substance abuse treatment; and well documented opportunities for multiple prevention services and referral and entry into medical care. The data indicate that the presence of a syringe exchange program does not increase the use of illegal drugs among participants in syringe exchange programs, and in many cases, a decrease in injection frequency has been observed among those attending these programs.

Throughout the literature, the terms syringe exchange programs and needle exchange programs have been used interchangeably in characterizing programs providing sterile injection equipment to injection drug users. This paper will use the term syringe exchange program, except where a published abstract has specified needle exchange program.

Overview

Numerous studies have shown that syringe exchange programs reach and serve the most disenfranchised populations at high risk for HIV infection. In this regard, syringe exchange programs play a unique role in facilitating the engagement of these populations in meaningful prevention interventions and treatment opportunities, when implemented as part of a comprehensive HIV prevention and substance abuse strategy. The scientific evidence accumulated to date provides a basis on which municipalities that are heavily affected by an HIV epidemic driven by injection drug use should consider syringe exchange programs as a tool for the identification, referral and retention of active users of injection drugs into these services, as part of a comprehensive HIV prevention plan.

Serious discussions about syringe exchange programs must be placed in the context of the HIV epidemic in this country. The urgency to address the consequences of substance abuse is clear, as injection drug use continues to fuel the HIV epidemic in the United States. As many as half of new HIV infections are caused by the sharing of injection equipment contaminated with HIV, either directly due to injection drug use, through unprotected sex with someone who acquired HIV infection through injection drug use, or birth to a mother who acquired HIV infection through these means (CDC,

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1999). Women of color and their children continue to be disproportionately affected by HIV/AIDS due to injection drug use. An estimated three out of four AIDS cases among women are due to injection drug use or heterosexual contact with someone infected with HIV through injection drug use, and over 75% of new infections in children result from the consequences of injection drug use in a parent (CDC, 1999). All too often women are unaware of their risk, due to a distant history of drug use in a partner. The ability to halt this devastating epidemic, particularly among minority women and children, requires a three part strategy: (i) preventing substance abuse; (ii) facilitating entry of those with addictions into substance abuse treatment; and (iii) establishing effective outreach to engage active and former drug users in HIV prevention strategies that will protect them, their partners and families from exposure to HIV, and bring them into substance abuse treatment and medical care. HIV prevention and treatment programs targeting HIV-infected injection drug users and their partners, and similar programs within criminal justice institutions, are also important components in preventing the transmission of HIV.

In the Department's prior reviews of the literature on syringe exchange programs in 1997 and 1998, there was discussion of the methodological issues and constraints present across most published studies in this area. These include self-reported measures and difficulty in establishing proper control groups. However, the Department's senior scientists continue to concur with the conclusion of the Institute of Medicine that the pattern of evidence is sufficiently strong to support scientifically clear conclusions regarding the utility of syringe exchange programs, in communities that choose to adopt them, as part of a comprehensive HIV prevention strategy.

A recent national survey of syringe exchange programs (Paone et al, 1999) found that a growing number of local communities have chosen to implement a syringe exchange program to reach injecting drug users who are not in substance abuse treatment, in order to reduce the transmission of HIV through reduction in drug use behaviors and unsafe injection practices. This survey also documented that, in addition to exchanging sterile syringes for contaminated ones, 97% of syringe exchange programs provide a range of other services including referral to substance abuse treatment, prevention education for sexually transmitted diseases, HIV counseling and testing, tuberculosis screening, and primary health care. These trends also were found in a 1997 national survey (CDC, 1998).

The biological rationale for removing contaminated injection equipment from circulation has been demonstrated in a new study by Abdala et al (1999), confirming empirical observations of previous studies. This study showed that HIV-1 can survive over 4 weeks in a contaminated syringe, remaining infectious to individuals who reuse that syringe over this prolonged period. Riley et al (1998) found that 10.9% of used syringes discarded in needle boxes at community locations tested positive for the FUV antibody, while Robles et al (1998) reported that 27% of contaminated syringes returned to a new needle exchange program were positive for HIV. The longevity of the HIV-1 virus, combined with its prevalence in used equipment in some communities, is basic to the public health rationale for removal of used syringes from the community environment.

Knowledge of the effectiveness of syringe exchange programs in reducing the sharing of injection equipment and reuse of contaminated syringes among injection drug users has recently been reinforced by a number of new studies (Heimer et al, 1998; Robles et al, 1998; Bluthenthal et al, 1998). Conversely, the closing of an established syringe exchange program in Connecticut was associated with an increase in reuse and sharing of contaminated equipment among injection drug users, exposing these individuals and their partners and families to an increased risk of preventable blood-borne diseases (Broadhead et al, 1999).

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Recent research studies document the role that effective syringe exchange programs serve as mechanisms to engage very high risk and hard to reach individuals in substance abuse treatment services. Brooner et al (1998) found that half of syringe exchange program clients referred for substance abuse treatment actually entered treatment, with 76% completing the first 13 weeks of treatment. These results were achieved despite the fact that these clients had more severe drug use, more HIV risk behaviors, less employment and greater engagement in illegal activities than clients referred to substance abuse treatment from traditional sources. Hagan et al (in press) reported reduced frequency of injection drug use among current and former users of a needle exchange program, and entry into methadone treatment programs among former, current and new users of a syringe exchange program. Stratthdee et al (1999) showed that attendance at a syringe exchange program was positively associated with individuals entering detoxification services independent of other variables, again representing an important bridge that facilitates entry into substance abuse treatment.

Concerns about elevated HIV seroconversion rates linked to the use of syringe exchange programs remain scientifically unfounded, as the data primarily reflect the impact of multiple high-risk factors among individuals who participate in these programs - a population at extremely high risk that is not engaged in appropriate interventions through traditional mechanisms of outreach and treatment referral. Studies of HIV incidence among two study cohorts in Canada, and some recent data on the incidence of hepatitis B and hepatitis C in Seattle, are relevant as these relate to syringe exchange programs. In the Department's internal review of these data in 1998, careful attention was given to the study data on these Canadian cohorts, with the conclusion that syringe exchange programs were not associated with an increase in HIV seroconversions: Subsequent data from the Montreal cohort (Bruneau et al, 1999) have confirmed this lack of association between HIV seroconversion and attendance at a syringe exchange program, with longer follow-up of the study participants and appropriate availability of sterile injection supplies. Efforts to identify any grounds for a causal relationship continue to show negative results (Schechter et al, 1999), when controlling for risk factors in the statistical model.

Public health scientists have long known about the incidence of hepatitis B (HBV) and hepatitis C (HCV) among injection drug users. These are highly infectious blood-borne diseases that are endemic among some drug-using populations. In Seattle, where there is a high prevalence of hepatitis C among injection drug users (70%-80%), participation in the syringe exchange program did not appear to be protective against new HCV or HBV infection (Hagan et al, 1999). Because of the high background prevalence of HCV in this population, a single exposure to a syringe used by an injection drug user carries a high level of risk that it will be contaminated with HCV. Although syringe exchange programs can greatly reduce the reuse of contaminated syringes, maximal prevention of HCV transmission among this population would require distribution of a sufficient volume of sterile syringes to preclude any reuse of injecting equipment. In contrast to this scenario, since HIV seroprevalence is yet low in this population, the empirical data support the potential of a protective effect for HIV among individuals seeking clean injection equipment at the syringe exchange program.

In summary, injection drug use is a driving force for new HIV infections, disproportionately affecting minority populations. Yet, HIV transmission via injection drug use is preventable. Efforts to halt the HIV epidemic are in part dependent on effective prevention interventions targeted to this population. Prevention will require successfully engaging injection drug users and bringing them into systems of care that offer substance abuse treatment, mental health, medical, and social support services. The availability of medical, social and preventive services alone are often not enough to engage the highest risk populations of active injection drug users, absent effective methods of outreach to this population. The scientific research has shown that well designed and implemented syringe exchange programs have demonstrated efficacy in engaging populations at severe risk for HIV and reducing the further spread of HIV

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among injection drug users, their sexual partners and children. Furthermore, these programs have not been shown to encourage the use of illegal drugs, and fit well into comprehensive substance abuse treatment strategies.

After reviewing all of the research to date, the senior scientists of the Department and I have unanimously agreed that there is conclusive scientific evidence that syringe exchange programs, as part of a comprehensive HIV prevention strategy, are an effective public health intervention that reduces the transmission of HIV and does not encourage the use of illegal drugs. In many cases, a decrease in injection frequency has been observed among those attending these programs. In addition, when properly structured, syringe exchange programs provide a unique opportunity for communities to reach out to the active drug injecting population and provide for the referral and retention of individuals in local substance abuse treatment and counseling programs and other important health services. The scientific evidence accumulated to date provides a basis on which municipalities that are heavily affected by an HIV epidemic driven by injection drug use should consider syringe exchange programs as a tool for the identification, referral and retention of active users of injection drugs into these services, as part of a comprehensive HIV prevention plan.

<http://www.harmreduction.org/surgreview.html>

6/5/2001

APPENDIX B

**DR. PETER BEILENSON'S OP-ED: "MYTH VS. REALITY
IN NEEDLE EXCHANGE PROGRAMS"
*SAN DIEGO UNION-TRIBUNE, APRIL 13, 2001***

CLEAN SYRINGE EXCHANGE PROGRAM TASK FORCE

Myths vs. realities in needle exchange program

By Peter Beilenson

April 13, 2001

As the Baltimore City Health Commissioner and a native Californian, I was very pleased to be involved in hosting a delegation of San Diegans from the health and criminal justice fields recently. They were in our city to look at how we are addressing the overlapping problems of drugs, AIDS and hepatitis C.

Part of the time we spent showing them some of our effective drug treatment programs, the funding for which has tripled in the past three years. We are strong proponents of the notion that a heavy investment in drug treatment and prevention programs is a major weapon in the fight against crime, AIDS and other consequences of drugs. The rest of the time, the delegation looked at our needle exchange program, another component in our drug strategy.

In light of the current debate on needle exchange occurring in San Diego, it might be useful to hear what we have found.

Baltimore implemented a city-run needle exchange program in August 1994. Our program is focused on two priorities: reducing the spread of HIV/AIDS and serving as a bridge to intensive drug treatment. We operate our program out of two vans which go to the same eight locations each week. At each site, addicted individuals exchange dirty, used syringes for sterile, new ones.

They can obtain testing and counseling for HIV, hepatitis C and tuberculosis, and referrals for mental health or medical services at one of our health department clinics or a nearby university.

Just as importantly, we have over 300 drug treatment slots specifically reserved for needle exchange clients who are ready for treatment. Because of these reserved slots, our clients often get into treatment more quickly than other addicted individuals in the community.

What have we found?

Baltimore's needle exchange program has done exactly what it was set up to do: the incidence of HIV among our clients is down 40 percent compared to all other addicts in the city; and we have placed 1,500 of our clients into intensive drug treatment, where over 75 percent are successful in that treatment, despite the fact that our clients are among the most hard-core, difficult to reach drug addicts in the city.

What about the terrible consequences of needle exchange prophesied in recent newspaper editorials --more crime, more dirty needles littering the streets and a dangerous message being sent to kids?

Well, extensive studies by Johns Hopkins University researchers have debunked each of these concerns. In fact, in the areas surrounding our needle exchange sites, there have been significant decreases of both discarded needles and crime, when compared to other drug-infested areas

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without a nearby needle exchange site. And, in a study of over 1,000 students in four Baltimore high schools, including one located only a block from a needle exchange site, needle exchange was not found to encourage drug usage --the overwhelming contributors to that were parental, friend or peer drug use.

Invariably, when presented with both our well-documented evidence of the effectiveness of needle exchange and our conclusive proof that negative consequences of needle exchange do not materialize, opponents of needle exchange turn to Baltimore's drug problem as evidence that Baltimore's needle exchange is a failure. So, before such letters to the editor appear to that effect, let me address that concern.

Baltimore does have a serious drug problem. However, this drug problem is decades old and has not increased since the needle exchange's inception. In fact, our clients have decreased drug usage by approximately 20 percent after enrolling in our program. It is also true that we, like many cities, have a large problem with narcotic overdoses. However, there is no evidence that this is related to needle exchange. Experts here and elsewhere say the main reason for the overdose problem is the tremendous increase in purity of heroin that has occurred on the East Coast over the past few years.

The bottom line: there is absolutely no scientific or medical reason to continue to oppose the implementation of well-run needle exchange programs. San Diegans must understand that it is simply politics that is preventing this life-saving effort from getting under way.

Beilenson, a physician, is commissioner of health for the Baltimore City Health Department.

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http://www.signonsandiego.com/news/uniontrib/fri/opinion/news_le13beilen.html

4/17/2001

APPENDIX C

**FR. JON FULLER'S ARTICLE: "NEEDLE
EXCHANGE: SAVING LIVES"
AMERICA, JULY 18, 1998**

Needle Exchange: Saving Lives

By Jon Fuller

America, New York, July 18, 1998
Copyright 1998, America Press, Inc

Abstract:

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Fuller, a Jesuit physician, issues a forceful call for support of needle-exchange programs in the US, based on the central moral facts of the situation. The Catholic tradition of moral reasoning is particularly well suited to this issue.

IN A REMARKABLE REJECTION of scientific data and its own experts' opinions, the Clinton Administration announced in April its long-awaited decision regarding the expiring ban on Federal support of needle-exchange programs (N.E.P.'s).

The Administration's logic was not immediately obvious. While it recognized that N.E.P.'s reduce H.I.V. transmission and do not increase drug use, it refused to lift the ban but encouraged local governments to use their own resources to fund exchange programs. Since the Administration's stated reason was its concern that lifting the ban might send the wrong message to children, it is not evident why the states are being encouraged to do what the Federal Government should not.

In his reaction to the decision, R. Scott Hitt, an AIDS physician and chairman of the President's Advisory Council on H.I.V./AIDS, was quoted in *The New York Times* as saying that "at best this is hypocrisy, at worst, it's a lie. And no matter what, it's immoral."

As a church we need to consider carefully Dr. Hitt's evaluation, for it reminds us that a fundamental moral issue is at stake: the failure to act to save human lives. Dr. Hitt's criticism can as appropriately be directed toward the churches as toward the Administration: We can seem to be more concerned about potential "scandal" (sending the wrong message about drug use) than with N.E.P.'s ability to prevent lethal H.I.V. transmissions to particularly vulnerable populations.

Our silence or negative attitudes toward N.E.P.'s are puzzling, since the Catholic tradition is particularly well suited for responding to complicated questions such as needle exchange. We have nuanced tools for judging complex moral cases, we have a long tradition of engagement with the forces of society that particularly impinge on the poor and marginated, and we are in a unique position to provide moral leadership on this complex public issue that so confuses and frightens people.

Here I will review briefly the history and merits of needle-exchange programs from a public health perspective, and then demonstrate how, using traditional Catholic moral principles, we may not only tolerate but may even cooperate with these programs. Our particular responsibility to protect the lives of those without voice or power, those trapped in the cycle of addiction and those at risk for being infected should urge us to take a leadership role in the development of public policy on this life-threatening issue.

International Experience.

Based on the assessment that it is impossible to eliminate completely intravenous drug use in society, needle exchanges were first instituted in Amsterdam in 1983 to prevent the transmission of hepatitis B and H.I.V. (human immunodeficiency virus, the causative agent of AIDS), which can occur when needles are shared. While recovery from addiction was still sought as a long-term goal, N.E.P.'s were designed to protect addicts from these viruses in the meantime, and also to prevent secondary transmission to sexual partners and - in the case of pregnant women-

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transmission to developing infants. Needle exchanges have since been credited with a decrease in the number of new H.I.V. infections occurring among drug users in many cities around the globe. Indeed, three Catholic agencies sponsor needle exchanges in Australia. According to David Waterford of the Adelaide Diocesan AIDS Council, Southern Australia (with 55 exchange programs for a population of 1.2 million) has reported no new H.I.V. infections resulting from needle sharing over the past three years.

The U.S. Experience.

In striking contrast to the decline in H.I.V. infections among addicts in these other countries, the United States has seen injection drug use increase as the source of H.I.V. infection among new AIDS cases from approximately 1 percent in 1981 to 31 percent of cases documented in 1997. When transmission from injectors to sexual partners and to infants is also included, 40 percent of new cases may be attributed to drug use. Three- fourths of H.I.V. transmissions to women and children have come from drug injectors, and among injectors who have been diagnosed with AIDS, 77 percent of women and 79 percent of men have come from communities of color.

Because of this increasing threat posed by needle transmissions, more than 100 needle exchanges have now been established in the United States. Many were begun as "guerilla" activities by addicts in recovery who understood the realities of addiction and the potential harm of needle sharing.

However, as opposed to their fairly widespread acceptance in many other countries, needle-exchange programs encountered considerable resistance in the United States when they were first proposed. Neighborhoods voiced concerns about property values, security and the possibility that discarded needles might be left where children could play with them. Some objected that bringing needles into minority neighborhoods was a genocidal act, demonstrating an indifference to the particularly heavy burden of addiction already being borne by these communities. Despite a 1991 U.S. Government Accounting Office study that concluded that needle-exchange programs "hold some promise as an AIDS prevention strategy," Congress passed legislation in 1992 prohibiting the use of Federal funds to support needle-exchange programs until the Surgeon General could certify that they did not encourage drug use and were effective in reducing the spread of H.I.V.

The vast majority of U.S. N.E.P's are designed to be needle exchange, not needle distribution services- providing a clean needle and syringe only in exchange for a used set. In contrast with vending machines that dispense syringes in some European cities, U.S. programs consider human contact a critical aspect of the exchange, with education and referrals to health care and recovery programs being offered at every encounter. The human contact and protection from disease that these programs offer communicates a powerful message to addicts that their lives and well-being are still valued by the community, even though they may not yet be able to break the cycle of addictive behavior.

The U.S. Catholic Response.

In their 1989 pastoral letter on the AIDS epidemic, "Called to Compassion and Responsibility," the U.S. bishops raised serious concerns about needle-exchange programs as a means of limiting the spread of H.I.V. The bishops questioned whether these programs might increase drug use

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instead of reducing H.I.V. transmission and whether supporting them might send the wrong message by appearing to condone or even to make drug use easier. Although a significant scientific literature has developed in support of exchange programs since that letter was written, there has been little further public discussion of needle exchange within the church, and almost no attention has been given to this issue in the ethical and theological literature. Several state bishops' conferences have spoken against exchange programs, but to my knowledge the only U.S. Catholic agency that has actively promoted N.E.P.'s is the Catholic Family Center in the Diocese of Rochester, N.Y.

Scientific Evaluation of Exchange Programs.

Numerous studies of the risks and benefits of needle exchange have now been published, and in 1995 an advisory panel of the National Research Council and the Institute of Medicine was constituted to review the state of the question. The group observed that, although existing drug paraphernalia laws were intended to decrease drug use, by inhibiting users from possessing needles "they unwittingly contribute to the sharing of contaminated ones. ...While the act of giving a needle to an injection drug user has a powerful symbolism that has sparked fears about the potential negative effects of needle-exchange programs... there is no credible evidence that drug use is increased among participants or that it increases the number of new initiates to injection drug use."

After observing that public support for these programs tends to increase over time, the panel concluded that "well-implemented needle-exchange programs can be effective in preventing the spread of H.I.V. and do not increase the use of illegal drugs. We therefore recommend that the Surgeon General make the determination...necessary to rescind the present prohibition against applying any Federal funds to support needle exchange programs."

In February 1997 a consensus panel of the National Institutes of Health indicated that these programs "show reduction in risk behavior as high as 80 percent in injecting drug users, with estimates of a 30 percent reduction of H.I.V." The panel therefore "strongly recommended the lifting of government restrictions on needle-exchange programs and the legalization of pharmacy sales of sterile injecting equipment."

In March of this year the President's AIDS Council also urged that the ban be lifted, noting that every day 33 Americans are infected from dirty needles. Other endorsements of needle exchange have come from numerous groups concerned with the common good and the public health, including the American Medical Association, the American Public Health Association, the American Bar Association and the National Conference of Mayors. As increasing dialogue has occurred between operators of needle exchanges and public health and law enforcement agencies, some previously illegal operations have now become officially sponsored or at least tolerated.

Moral Evaluation of Exchange Programs.

While the consensus of scientific and public health opinion supports needle exchanges as providing significant benefits without causing harm, how do we analyze these programs from a moral perspective? Some judge that we must oppose them lest we be seen as condoning behavior judged to be gravely wrong, while others propose that we tolerate them by not opposing their

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being conducted by others. A third perspective, which can be justified by traditional moral principles, holds that the potential harm of needle sharing is so great that our commitment to the preservation of life and to caring for the most vulnerable members of society urges us to take the lead in supporting these programs.

The Principle of Cooperation.

Our tradition has long recognized that in a complex world we are frequently faced with the prospect of cooperating to some degree with individuals or groups whose goals we may not fully share. The "principle of cooperation" assists us in adjudicating a wide variety of questions, ranging from paying taxes to a government whose activities are not always condoned, to cooperating in an indirect manner with an illicit medical procedure. Although an extensive analysis of the principle and its application is not possible here, for the sake of discussion I propose to describe briefly how cooperation with N.E.P.'s can satisfy the principle's six criteria. (At the risk of employing a few unfamiliar phrases, the technical language traditionally used when invoking the principle has been included in this discussion.)

The first requirement-that the object of our action be good or morally neutral-is satisfied by the fact that simply exchanging a dirty needle for a sterile one is itself morally indifferent.

In the second test we must consider if our cooperation would be intending or promoting illicit activity. Since N.E.P.'s do not encourage or condone drug use-but only attempt to make drug use less harmful-our cooperation would be material and therefore permitted, whereas formal cooperation (explicit support or encouragement of drug use) would not.

The third criterion requires that the illicit activity (in this case, injection of a drug) not be the same as the action in which we are cooperating (exchange of needles). In the principle's technical language, cooperation with needle exchange would be judged as mediate (permitted) rather than immediate (forbidden).

In the fourth test our action must be distanced from the illicit act as much as possible. Since we would be cooperating with needle exchange rather than with drug injection, N.E.P.'s meet the test that our cooperation be remote, not proximate.

The fifth criterion-that cooperation be justified by a sufficiently grave reason-is self-evident in the lethal nature of H.I.V. transmission.

Finally, our assistance must not be necessary for the illicit action to be carried out. Since exchange programs provide no means for injection that a drug user does not already have, N.E.P.'s meet the requirement that our cooperation be dispensable, not indispensable.

This analysis suggests that permitting or even cooperating with N.E.P.'s would be allowed by traditional criteria, and that prudential judgment will be needed in each circumstance to determine the appropriate response of the local church. While toleration and cooperation can both be justified, I would propose that advocacy on behalf of N.E.P.'s is consistent with an ethics of mercy, with our traditional moral principles and with our pastoral mission to help the poor and marginalized. This approach recognizes that addiction is a disease whose natural history includes relapse, and it assists addicts in taking whatever small steps toward recovery are possible while protecting them and society from serious harm.

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Central Moral Facts

I have asked many of my patients who became H.I.V.-infected through needle sharing how they regard exchange programs. While a few have been opposed-out of concern that they could send a mixed message-most wished that someone had cared enough for their welfare to make such an option available when they were in the throes of addiction, possibly preventing the life-threatening condition with which they now struggle.

I urge that we move beyond an understandable concern about sending mixed messages, to recognizing the central moral facts of the case. While neither condoning nor increasing drug use, N.E.P.'s save lives and bring addicts into treatment. A University of California study has calculated that up to 10,000 lives might have been saved thus far if we, as a nation, had supported needle exchange early on. It further estimated that "if current U.S. policies are not changed...an additional 5,150,329 preventable H.I.V. infections could occur by the year 2000." Our mandate to provide special attention to the health and welfare needs of the most vulnerable must certainly include injection drug users and their children and sexual partners. Let us engage our considerable resources in examining and discussing this question, exploring how best to support recovery from addiction while protecting vulnerable lives from life-threatening disease.

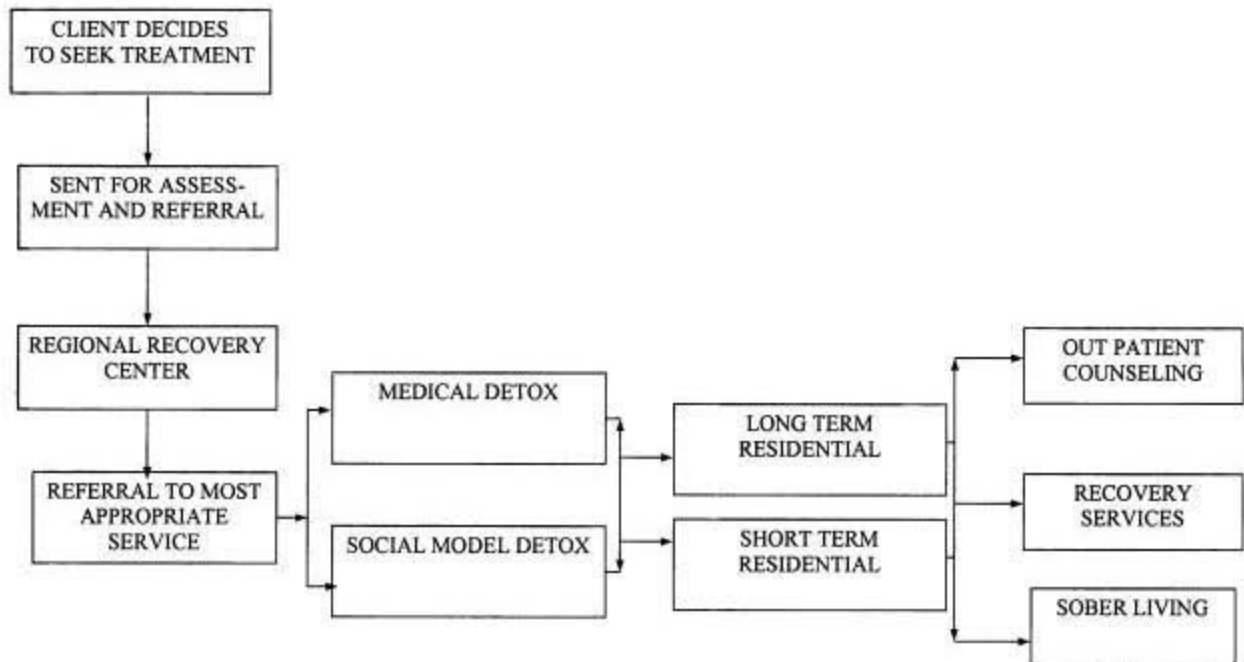
Jon Fuller, S.J., M.D., is assistant director of the Adult Clinical AIDS Program at Boston Medical Center and the 1997-98 Margaret Pyne Professor of Theology at the Weston Jesuit School of Theology in Cambridge, Mass.

APPENDIX D

TREATMENT FLOW CHART

CLEAN SYRINGE EXCHANGE PROGRAM TASK FORCE

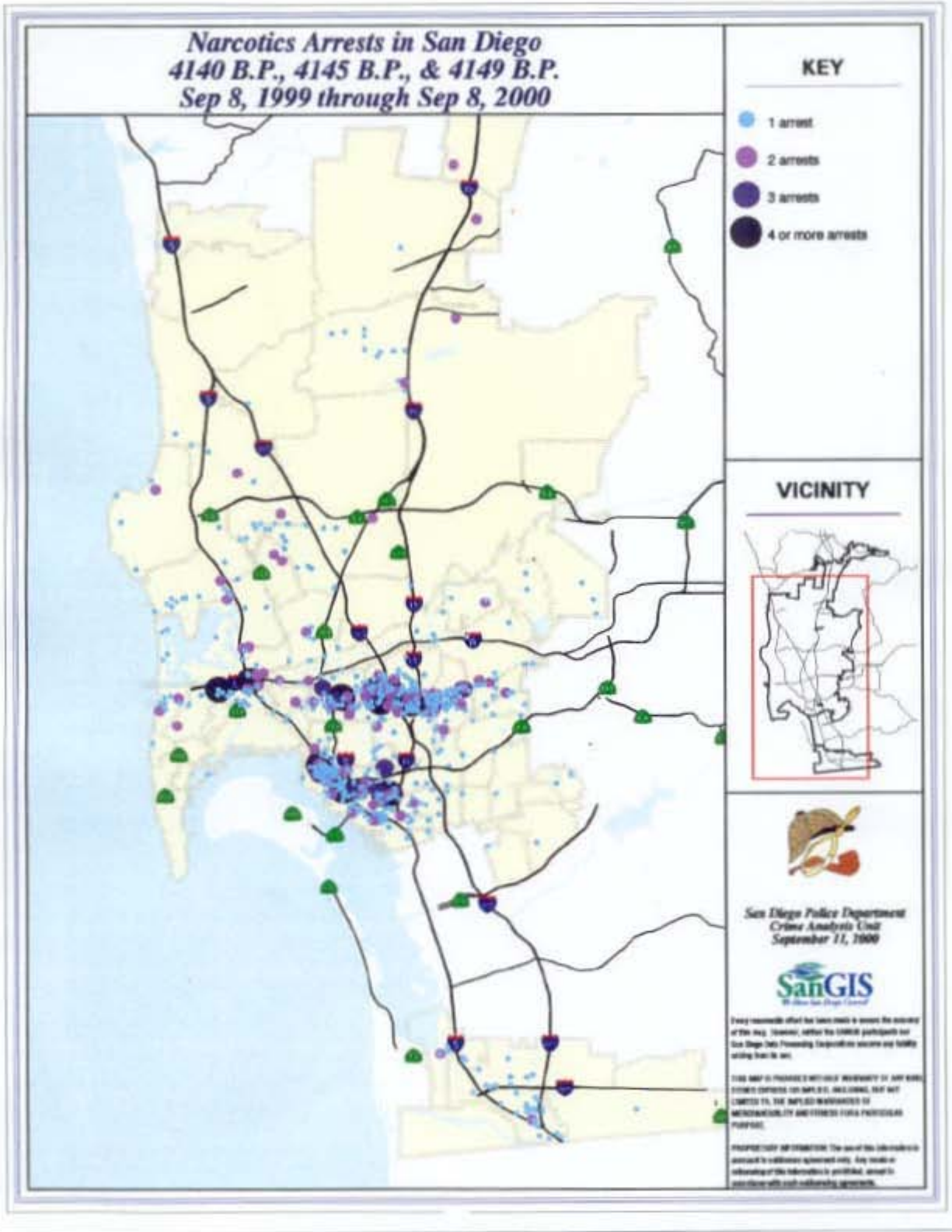
TYPICAL SCENARIO FOR IDU CLIENT SEEKING TREATMENT FLOW CHART



APPENDIX E

**SAN DIEGO POLICE DEPARTMENT:
MAP OF NARCOTICS ARRESTS IN
SAN DIEGO
SEPTEMBER 1999 – SEPTEMBER 2000**

CLEAN SYRINGE EXCHANGE PROGRAM TASK FORCE



APPENDIX F

**SAN DIEGO CITY COUNCIL RESOLUTION
(DRAFT)**

CLEAN SYRINGE EXCHANGE PROGRAM TASK FORCE

(R-2001- XXXX)

RESOLUTION NUMBER R-

ADOPTED ON

RESOLUTION OF THE CITY OF SAN DIEGO DECLARING
A LOCAL HEALTH EMERGENCY DUE TO THE SPREAD
OF HEPATITIS C VIRUS AND THE HUMAN
IMMUNODEFICIENCY VIRUS (HIV) BY INJECTION
DRUG USERS AND ADOPTING A CLEAN SYRINGE
EXCHANGE PILOT PROGRAM

WHEREAS, by amending Health and Safety Code section 11364.7 (effective January 1, 2000), the California Legislature acknowledged the public health threat posed by the sharing of needles and syringes by injection drug users and thereby permitted local jurisdictions to establish clean needle and syringe exchange programs pursuant to a declaration of a local emergency due to the existence of a critical local public health crisis; and

WHEREAS, California Government Code section 8630 authorizes local jurisdictions to declare local emergencies when such events occur as described in California Government Code section 8558(c); and

WHEREAS, in October 2000, the City Council authorized and directed the City Manager to convene a task force to develop the practices and procedures for a one-year clean needle and syringe exchange pilot program linked to drug abuse treatment programs; and

WHEREAS, the task force convened by the City Manager has accomplished its mission and prepared a report of its findings and recommendations, which the Council adopts by this resolution, including the finding that a local health emergency exists due to the spread of the hepatitis C virus and the human immunodeficiency virus (HIV) through the sharing of needles and syringes by injection drug users in the City of San Diego; NOW, THEREFORE,

BE IT RESOLVED, by the Council of The City of San Diego, that pursuant to California Government Code section 8630, a state of local emergency is declared to exist in the City of San

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Diego due to the spread of the hepatitis C virus and HIV, exacerbated by the shared use of needles and syringes by injection drug users.

BE IT FURTHER RESOLVED, that the Council authorizes and directs the City Manager to execute the agreements necessary to establish a one-year clean needle and syringe exchange pilot program linked to drug abuse treatment programs at no cost to the City.

BE IT FURTHER RESOLVED, that at the conclusion of the one-year pilot program, a report shall be prepared for the Council by the program administrator, together with members of a program facilitation committee, analyzing the effectiveness of the program.

BE IT FURTHER RESOLVED, that the state of local emergency shall be reviewed every fourteen days unless and until the Council declares that the emergency no longer exists.

APPROVED: CASEY GWINN, City Attorney

By _____
Michael Rivo
Deputy City Attorney

MDR:ms
XX/XX/01
Or.Dept: PS&NS
R-2001-XXXX