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Public Hearing on Evaluation of Needle Exchange Programs as a Way to Combat AIDS

Senate Committee on Health and Human Services

CALIFORNIA LEGISLATURE

SENATE COMMITTEE ON HEALTH
AND HUMAN SERVICES

SENATOR DIANE WATSON

Public Hearing On

EVALUATION OF NEEDLE EXCHANGE PROGRAMS AS A WAY TO COMBAT AIDS

Museum of Science and Industry
Kinsey Auditorium
700 State Drive
Los Angeles, California

PUBLIC HEARING

STATE OF CALIFORNIA

SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

In the Matter of:

Evaluation of Needle Exchange Programs as a Way to Combat AIDS

ORIGINAL

Museum of Science and Industry
Kinsey Auditorium
700 State Drive
Los Angeles, California

Tuesday,
November 21, 1989

Informational hearing regarding the above-entitled matter was conducted in a public hearing at 1:35 p.m.

APPEARANCES:

Senate Health and Human Services Committee
Senator Diane Watson - Chairperson

I N D E X

AFTERNOON SESSION

(1:35 p.m.)

SENATOR WATSON: Good afternoon and I'd like to welcome all of you to this special hearing of the Senate Health and Human Service Committee. We have convened this afternoon to explore one question, "Are needle exchange programs effective in combating AIDS?".

Needle exchange programs on a one to one basis, needles on the street for uninfected needles, is something that we want to hear more about. In other words, dirty needles are exchanged for clean ones without adding to the total number of needles on the streets.

These programs have become a subject of intense debate in the field of AIDS prevention and substance abuse treatment. Proponents claim needle exchange programs may decrease the spread of HIV infection among HIV users. Opponents argue that such programs condone and promote illegal drug use. We will have the opportunity to explore this controversy over the next few hours as we hear from expert witnesses on the beneficial and harmful effects of needle exchange programs in efforts to curb HIV or IV drug use and the spread of AIDS.

Early in July of this year, the California AIDS Leadership Committee issued its strategic plan for the California continuing response to HIV disease. The

committee identified the problem of the rise in HIV infection among IV drug users due to the sharing of drug injection paraphernalia among users. The committee recommends to this problem, -- The committee recommendation to this problem is the enactment of legislation to establish and fund pilot paraphernalia exchange projects in California. The committee, however, does caution and emphasize that such programs are not an end in themselves. The report states that paraphernalia exchange programs should be viewed as merely one component of a comprehensive program designed to discourage drug abuse as well as prevent further spread of HIV infection among IV drug users, their sexual partners, and their offspring. There is no easy solution to address the rise of HIV infection among IV drug users. It would be short-sighted for the legislature to set the policy direction for health officials in this state on needle exchange programs without public input and exploring and understanding the controversy surrounding these programs.

So, I want to thank all of you for coming and I'd like now to begin the dialogue between the proponents and the opponents of the needle exchange program.

I'd like to introduce now our first speaker, George Clark. Mr. Clark is the Coordinator of Prevention Point, a needle exchange program currently operating on an

ad hoc basis in the city of San Francisco. I believe, Mr. Clark, that you have some slides that you want to show?

MR. CLARK: Yes.

SENATOR WATSON: Okay, that may be seen over our heads or should we --

MR. CLARK: I think you can see them. You'll turn around when the slides come on. They'll dim the lights when it happens, or they'll dim them now, and they'll be ready.

SENATOR WATSON: Okay.

STATEMENT BY GEORGE CLARK

MR. CLARK: Hi, I'm George Clark. I'm one of the people who work with Prevention Point, a street-based needle exchange in San Francisco, California. I've come here today to present information on the issue of needle exchange as an HIV intervention and, in particular, about Prevention Point, San Francisco's street based needle exchange. However, before I do that I would like to make two requests of you.

The price of needle exchange as an HIV prevention/intervention is a complex issue. It demands your full attention to weigh and analyze the pros and cons. However, I believe it is important that we don't lose sight that it is a completely human problem. The decisions that you make about this issue will affect the

lives of hundreds of individuals. It's important that we present these individuals into the process. This can only remain an academic, moralistic and intellectual debate in the absence of the injection drug users. The effects of our needle exchange can be heard in the words of Nancy, a 32-year-old heroin user who has been using for 10 years. She said this in a recent interview: "You know, a lot of people here are using clean needles now, whereas before they weren't. Everybody was sharing needles before. You know, I've got to have my own because I'm positive, and you know, if I didn't have them here they'd use mine; I know it. But now it's not like that anymore." So, if you listen to the information you get today from the different presenters, present Nancy in your mind and the effect of what having access to sterile injection equipment does to her.

I also want to request you to be prepared to do some difficult evaluation. Some of the findings in needle exchange research are counter-intuitive; they only make sense after deeper analysis. So don't be prone to jump to quick decisions. People are quick to conclude that needle exchange promotes drug use. However, in the Netherlands where needle exchange has been implemented since 1980 for and continues as an intervention during the Hepatitis B epidemic, and now for HIV, there have been exchanges of

hundreds of thousands of syringes, and there is no evidence that it promotes drug use. The number of drug users in Amsterdam remains stable from the period of 1983 through 1988. The average age of an injection drug user has risen from 26.8 in 1983 to 30.8 in 1988. That happened while the percentage of young drug users, those are drug users under the age of 25, diminished from 14.4 percent of the injection drug-using community to 3.4 percent in '88. This contradicts the argument that access to sterile injection equipment will promote needle use among users. The fact is that 38 percent of the people who participated in Amsterdam's needle exchange have reduced their drug use.

During the period of 1983 to 1987, the number of drug users seeking drug-free treatment doubled. This indicates that it may even be that needle exchange is assisting people to choose out of the drug life.

What is true wherever needle exchange has been implemented as an HIV intervention is that participants have reported safer needle use. Data gathered by John Waters of the Urban Health Study in early 1989, only 18 weeks after the beginning of our intervention, indicated that the more often the injection drug user used our program, the more likely they were not to share.

Prevention Point is a coalition of community-

based AIDS prevention organizations and people which includes the Third World Advisory Task Force and the Latino Coalition on AIDS. Its members include health care workers, people in recovery, social scientists, HIV-infected people, teachers, lawyers, painters and community organizers. Prevention Point is supported entirely by private donations. Our objective is to intervene in the spread of HIV among high risk communities that are at risk through contaminated needles. Used needles are accepted into a bio-hazardous waste container, and new sterile insulin syringes are dispensed on a one-for-one exchange basis.

The syringes in the past were marked and monitored to establish return rates, and several independent experienced AIDS research organizations are conducting evaluations and studying Prevention Point.

Prevention Point sees needle exchange as but one part of a comprehensive HIV prevention program. Bleach, condoms, cultural and linguistic-appropriate education, outreach, risk reduction counseling, greater access to primary health care, perinatal care and a wide range of drug treatment are all necessary. We began because we knew that there was shortages of injection equipment that were promoting sharing. In the research and the literature, the major reason for sharing syringes given by

injection drug users are shortages of equipment and having laws against possession of sterile injection equipment.

A number of us who are working on a research project and as part of an interview that we administered to injection drug users, asked for their ideas about how to stop the spread of AIDS in their communities. Again and again people spoke of being forced to share by shortages of syringes and suggested that we make sterile injection equipment more available.

Let's see, does this work?

SENATOR WATSON: While you are trying to get that to work, what do you do with the needles that you collect?

MR. CLARK: We currently take them to the Department of Public Health who disposes them as bio-hazardous waste.

SENATOR WATSON: Are they taking them?

MR. CLARK: Yes.

SENATOR WATSON: Could they incinerate them or melt down the metal that's in the needle?

MR. CLARK: I don't know exactly -- Doctor Werdegar will present later -- I don't know exactly how that kind of bio-hazardous waste gets dealt with.

SENATOR WATSON: Because they are ending up on beaches and in other places and I'm wondering why they

don't try to melt the metal.

MR. CLARK: I think when they end up on beaches they're being disposed of illegally and not properly as bio-hazardous waste. So I think, especially on the East Coast, that was the case of people that were just taking them and putting them into garbage when it should have been bio-hazardous waste.

SENATOR WATSON: Right, okay.

MR. CLARK: On November 2nd we began our intervention. On that day we exchanged 13 needles. On November 16th, 1989, so that's a year later, in a single two hour period, we exchanged over 2100 syringes with more than 360 individuals. That is in three locations in the streets of San Francisco. In total, since we started in 1988, we have exchanged 31,448 syringes and have made 7,352 client contacts. These total client contacts, some of them are duplicated, we can't tell how many are --

Initially, we began with two teams. Here are some of the syringes we first got. This, in fact is what we call -- sort of, you know how people always hang up the first dollar they got? That was one of the syringes we first got, so you can see the condition of the syringe. So these are initially the syringes we got the first time.

SENATOR WATSON: Do you know if those needles actually are contaminated?

MR. CLARK: We don't, but in cooperation with the University of California, we're attempting to better understand the technology. The people in Australia -- it is possible to do PCR's on syringes, to test for HIV prevalence. We're also interested to do it as a verification of self-report measures, since most of the evidence is self-report.

This is the take from that night where we did 2100 syringes so you can see.

SENATOR WATSON: My goodness. You did this in one night in an exchange program?

MR. CLARK: 2100 in one night in two hours at three different locations. The total client contacts that night were 360 individuals. We'll exchange one-to-one up until ten.

Go to the next slide. This is our Prevention Point needle exchange program work by month so you can see how quickly -- well, it looks like a normal curve. It ends the month of October, the data was only in up until October 18th; in fact, in October we exchanged slightly over 6,400 syringes, so it looks like the beginning of a normal curve that keeps going on.

The next slide please.

SENATOR WATSON: Are they using more because they can get clean needles?

MR. CLARK: I think they use a needle less times so in a way they're using more needles physically. There's no evidence in the literature that people shoot up more. We only have preliminary data. John Waters of USC staff and the Urban Health Study has a grant through AMFOR, and it will in the beginning of December gather more data about, self-report data --

SENATOR WATSON: Now is this mostly heroin used or is this a mixture?

MR. CLARK: Our location in -- it's interesting. The two different types of -- one team is a roving team that goes place to place. In fact, if you go to the next slide we'll look at the street scene. Again, another slide, this is more needles. We have lots of pictures of needles.

Here's the street location. That's in the tenderloin on Taylor and Ellis. Initially, we did this two ways. We did a stationary team that stays in one place and people come to, and a roving team that moves through civic center, down UN plaza and then down to 6th Street. That was done because we wanted to see how it would work.

SENATOR WATSON: Do you get hassled? Are you hassled by law enforcement?

MR. CLARK: We have been hassled on two

occasions. One was when we were having what we called the "media circus" which was when the media wanted to come on site. We said all right, we'll do it one night, because we weren't able to contain them, and they were showing up on the site anyway. So we had this -- and that night one of the people got a citation which was very much like a ticket, and when they went to court that was dropped. The next week someone called, and we got two more citations, but other than that we haven't been hassled.

If you could go to the next couple of slides. These are just street scenes.

SENATOR WATSON: Tell us what we're seeing here.

MR. CLARK: This is the needle exchange.

SENATOR WATSON: Is that your vehicle?

MR. CLARK: Actually, that is one of our cars. But at the feet of the person -- the woman on the right with the hat is dropping a syringe into a bio-hazardous waste container. The woman on the left with the black jacket is actually giving her alcohol wipes, I believe. There's a guy that's obscured behind them, he's taking data and the woman over to the right is basically doing what we call crowd control.

You can go to the next picture.

SENATOR WATSON: So let me just ask you about

it. You have three people out there?

MR. CLARK: This night there were probably -- Usually on a team there are five or six. At this point two of the team members have gone out into the street to tell people in the street that the needle exchange is happening. We are dealing with a group of people who are famous for not showing up on time. That's when you think about 2100 syringes, 360 people in a two hour period, it's pretty incredible that these people, who are famous for not getting anywhere within two hours, show up.

SENATOR WATSON: Now, you don't touch the needle yourself? They take the needle and put it into --

MR. CLARK: No, we ask them to show it, and as they drop them in, we count. So, in fact, you can't really see it -- these are not great photos -- but there's a basket with a bio-hazardous waste container. So, we don't ever come close to the syringes.

There's another couple of slides of this street scene. Here is the roving team on 6th Street. The bio-hazardous waste container in this situation is over here in the baby buggy. If you'll show the next slide.

SENATOR WATSON: Are you camouflaging it, disguising it?

MR. CLARK: Well, when we first did this our purpose was to interrupt the spread of HIV, we were not

interested in gaining anybody's attention so we, in fact, figured this was something the street people would know and it wouldn't be that unusual. That's a 1943 perambulator, a dolly perambulator.

SENATOR WATSON: That's unusual, for sure.

MR. CLARK: Yes. So, if you show again, you can see -- and if you'll show one more slide you'll get to see -- the code word on the street is "we want to feed your baby".

SENATOR WATSON: Oh, I see.

MR. CLARK: So people say, "Oh, if you want to feed the baby it's right there, and you can deposit your needles in there and we'll give you" -- Basically, the model is street-based, and it's based on the existing Tacoma, Washington model.

What we feel is that the model should be street-based and that the program should supply sterile injection equipment, cotton, alcohol wipes, AIDS prevention information, bleach and condoms, and it should be available in an non-judgmental, user-friendly environment. We believe that there should be no requirement for participation other than the possession of a syringe and the willingness to exchange.

SENATOR WATSON: Now, you supply all of these supplies?

MR. CLARK: Yes.

SENATOR WATSON: And that's through the donations?

MR. CLARK: Yes. Initially, this was not -- in fact, initially up until May 24th when I was writing a poster that we presented in Montreal about the exchange, we had exchanged 4,500 syringes. It looks like in the month of November alone we're going to break 8,500.

SENATOR WATSON: So, if you have those, you have to give one in exchange. How do you buy your supplies in that bulk?

MR. CLARK: There are only eleven states in the District of Colombia that demand a prescription to buy syringes and, of course, I would never do such a thing, but -- I did at one point, I was an employee at the University of California, San Francisco as a buyer of medical supplies, so I kind of know how to do that sort of thing, but I would never do anything like that.

SENATOR WATSON: Of course not.

MR. CLARK: We basically reach out to the injection drug user as a valuable and respected individual, which is different than most people reach out to injection drug users. They confuse the war on drugs with the war on drug users, often, and regardless of what we evaluate their choices -- Like, I myself as a person in

recovery do not think using is the best thing, but I also know that recovery is a process of attraction and not promotion. One can't badger someone else into recovery; they have to be ready to move towards recovery.

We view addiction and substance abuse as a social, economic and public health problem and believe its solutions are to be found in a social context. Our major concern, and the most difficult thing for injection drug users or for all drug users for that matter in this culture, is that there is no access to treatment. We always talk about just say "no", but just say no for a person who is addicted is not enough. It may work as an early intervention among adolescents, and I think it's questionable at that. But we believe there should be treatment on demand with no waiting list. We do referrals to treatment, but it's incredibly hard to tell somebody, "Well, you can go here six or seven days, 7:00 in the morning, show up dope sick and maybe you'll get in on the eighth day."

Nancy, the woman who I quoted in the beginning, talked about, I don't have her quote with me, but she talks about her heroin habit as she's either well or she's sick. In her frame work it is not about being high. It's either she's sick, she needs the drug; or she's well, she's gotten her fix. So, telling someone to wait seven

days and show up sick -- I mean we tell them to show up sick because you have to demonstrate need to get into treatment -- just doesn't work.

SENATOR WATSON: Do you do anything with prevention when you talk with them?

MR. CLARK: I talk about, in the context -- I basically view what I do in the context of 12 steps as in any 12 step program which is "reach out to the addict that still suffers" and I talk about what my process of recovery was about and talk about how I managed to stay eight years clean and sober. People like to hear that; a lot from me often because I don't look like an ex-injection drug user.

SENATOR WATSON: How did you come to the rehabilitation process?

MR. CLARK: I was -- in a lot of ways it was just dumb luck. I didn't think I had a problem. I was pretty much in denial. I'm sort of an interested person. I went to an NA meeting just to hear and sort of experience what it was like because somebody I knew was in recovery, so I said I'll go check this out. This isn't about me, but I'll go check it out. I heard speaking at that meeting somebody who was about 20 years older than I am, had my exact story but was speaking from 20 years down the road, and talked about not knowing whether or not -- knowing

there had been a hit and run, but not knowing whether their vehicle was the one because there had been blood on their bumper.

I like listened to it and said, "Oh my God, this could be me", and I looked at my family history in which there were a number of -- an Aunt of mine died in the Bowery, a single-room occupancy hotel, and I said I don't want to know if the end of cocaine and alcohol for me is going to be there, or is it going to be like my father who is sort of a nice, controlled drinker. He sort of has his problems, gets better. I just didn't --

SENATOR WATSON: Addictive personality?

MR. CLARK: Yeah, I didn't want to find out. That's how it worked for me. I basically consider myself incredibly lucky because I didn't reach a bottom like a lot of people have to. I just sort of went, and I looked and I was 32 at the time, and I said I'm not going to do this. I don't want to find out.

SENATOR WATSON: What were you ingesting?

MR. CLARK: I mostly did cocaine and alcohol. Not often injecting cocaine but occasionally because as the quantity of cocaine I was using was expensive, and it was a more efficient means of getting high.

SENATOR WATSON: Do you do them both at the same time?

MR. CLARK: Mostly, I would do them both at the same time sort of to take the edge off. The alcohol would take the edge off the cocaine.

SENATOR WATSON: Then more cocaine to put it back on?

MR. CLARK: Yeah, it's incredibly -- It's sort of your professional's drug of choice. It's a lot of those people that you don't know have the problem. That's what they're doing.

SENATOR WATSON: I do know.

MR. CLARK: Right, but you know sometimes you don't know.

SENATOR WATSON: You can tell in behavior. You don't know but you can certainly see --

MR. CLARK: I always liked to think that nobody could tell. You know, the denial lasts even after.

So, basically what I think, you know, interdiction has not worked. The funds available for the Reagan/Bush -- and the article that Nadleman had in Science is incredibly interesting. In 1987 alone, the governments of this country spent 10 billion dollars on interdiction. That's a hell of a lot of treatment. And during that period, the price of a kilo of cocaine dropped by 80 percent. During that period also, the quality of cocaine on the street went from 12 percent pure to 60

percent pure. So, the drugs are getting better, getting cheaper, and yet we're spending 10 billion dollars on interdiction, and there's no money for treatment or recovery.

So, we know that needle exchange and distribution programs have been operating in New York City; Tacoma, Washington; Boulder, Colorado; San Francisco, California; Vancouver, British Columbia; Montreal, Quebec, Toronoto and Ontario. Programs abroad include England, Scotland, the Netherlands, Australia, Sweden, Poland and Italy. In places where needle exchange has been implemented, participants have reported safer needle use, and there has been no evidence of increased drug use.

Syringe exchange schemes attract participants that are not reached by other public health interventions. These participants may indeed be persuaded to opt for treatment, although I feel needle exchange should be treatment-based, I mean treatment-linked but not treatment-based. It should not be mandatory. In New York it is mandatory that you be on a waiting list to go to treatment. In New York it is methadone maintenance where people are being sent which some people want. I don't know how valuable a modality of treatment that is substituting one opiate for another. So, we don't believe

that it should be treatment-based, but we think it should be treatment-linked. That through needle exchange one should be able to have the option to get into any number of modalities, such as some interesting and new modalities that are being developed, such as by Bayview Hunter's Point in San Francisco which is treatment that includes acupuncture, symptomatic detox, or a Haight Ashbury Free Clinic which uses clonodine patches. So there's other things going on that aren't getting funded other than methadone detox.

Basically, internationally needle syringe exchange -- I was in Montreal in June. There was like syringe exchanges in non-HIV intervention. It's not argued; the data's in. In places as diverse as Holland and England, the data's in, and it's an accepted intervention. We're here sort of waiting and arguing and moralizing about this issue, and I know there are people out there getting infected today. I used to think I did this for me. I'm an HIV pre-test and post-test counselor as part of my work, and it's really about me not having to tell another person that they're HIV positive. The hardest time I ever gave a result to was to a black woman in her mid-30's with two children. She had been clean for eight months, and I had to tell her that she was HIV-positive, and I had to see her cry when she was saying, "Am

I going to be able to survive to see my kids live?". I don't want to have to do that anymore. So it used to be about somebody else, but I know it's about how I'll keep my balance throughout this epidemic. I'll know that I've done everything that I could, and I want to challenge you to do everything you can because there's no time to argue and moralize about it.

SENATOR WATSON: Are you through with the slides?

MR. CLARK: Actually there's a couple of more if you want to go through them quickly. There's a slide at the end that will end.

SENATOR WATSON: Okay, we'll let you.

MR. CLARK: This is a team in a mission and I think there's -- These are the syringes and the data, and I said there's a box of alcohol wipes but there isn't, and that's the whole --

SENATOR WATSON: Could we have the lights up please?

Now, if you were able to design a program under law, a sponsorship of government, how would you structure it?

MR. CLARK: In San Francisco, now I can only talk about my community, I basically think it has to be community-based.

SENATOR WATSON: Where in the community? Would you have the Public Health Department, the doctors' offices --

MR. CLARK: No, I would have it street-based. Holland has locations within clinics and also out in what they call the methadone buses because they also do low-threshold methadone; the ones that work are the ones that are out in the street.

I would have it street-based. I would have culturally appropriate, ethnically appropriate education that gives you the outreach workers. I think it's appropriate to have a number of people that are recovering. One thing that I think is real important is to open up access to treatment. That when people talk about genocide; there is genocide happening in this country. It is happening in the systematic denial of people to recovery services,and if you don't give them better access to recovery, a better economic opportunity, greater social availability of the options in their lives, the only gain is going to be drugs. So, I think you have to do a lot of other stuff like giving available treatment and also giving training and opening up economic opportunities for the people. Because, like, Nancy has never worked.

SENATOR WATSON: How old is she?

MR. CLARK: 32.

SENATOR WATSON: Is she capable of working? Holding a job?

MR. CLARK: Not as a heroin addict.

SENATOR WATSON: Does she have other problems?

MR. CLARK: I'm not a clinician.

SENATOR WATSON: No, but do you know if she has other problems. You said she's never worked. Is drug addiction a result of not working or --

MR. CLARK: It's mostly drug-related. Her not working is due to her being in the "life". She's also HIV-infected although she's asymptomatic. The way she found out -- she said she would never have gotten tested; however, her boyfriend had been diagnosed and recently died, so that's how she came to know.

I think that the other thing is I would make it extremely easy for the injection drug user to get tested because that, as an HIV pre-and post-test counselor, I know that knowing you're negative helps you change or gives you the motivator to change your behavior. Knowing your positive gives you a motivation to not infect other people.

Also, my hesitancy about -- It's very hard for me to say somebody, "Well, you should know that you're

positive because there's AZT trials going on." But yet I know that it's very hard for an injection drug user to make those trials. So, it's sort of like, I don't know if without giving them access to greater primary health care that for them knowing that they're positive doesn't mean that they're going to get good health care. So, I would do that.

So, it's increase the amount of treatment, get better access to health care, have it street-based, have it non-judgmental, treatment-linked, but not treatment-based.

SENATOR WATSON: Would you have a health care provider as part of it or volunteers that are paramedics?

MR. CLARK: I would like to see there being some sort of street - like, you know, there's a van, well it's more than a van, it's an RV vehicle, that Haight Ashbury Free Clinic uses to do street triage, because often we'll see people with abscesses on the street that won't go to the emergency room because of the way they're treated in the emergency room for an abscess, and that's really the only place where people get medical care. So, I'd like to see that happen.

SENATOR WATSON: You want an allied health person or a paramedical person there as part of the program so they can be triaged?

MR. CLARK: I'm not sure exactly of the professional level. Yes, I think abscesses need to be treated.

SENATOR WATSON: You do probably very casual triage, but you need somebody there who can say it looks like you have jaundice, you know, get thee to the doctor.

MR. CLARK: Exactly.

SENATOR WATSON: Okay.

MR. CLARK: When you consider the costs of treating an HIV infected person, this is a cheap intervention. I mean it can be done at the rate it's being done now in San Francisco.

SENATOR WATSON: How are you being accepted in San Francisco in terms of government and law enforcement?

MR. CLARK: Incredibly schizophrenic. A little bit bizarre. The Department of Public Health, Doctor Werdegar will present and speak in favor of needle exchange. The Mayor's Task Force on HIV supports needle exchange. We know that the Board of Pharmacy in the state of California supports needle exchange. The California Medical Association supports needle exchange. But yet, that important public health intervention falls into the hands of what could be categorized as rank amateurs. We have some expertise that we bring to the issue, but we

bring it out of our experience and our commitment, not that nobody ever said I could do this, but I do it.

The police basically, because of the threat of needle stick on the street, they're happier -- If you notice between the two slides, the ones in the beginning where we were showing syringes at the beginning of our intervention. They were incredibly funky items that were almost entirely uncapped. When you look at the end almost all of those syringes are capped and they're in much better shape. So, the police, the beat cop, often feels that they're at less risk because if an injection drug user does have a syringe it's most likely to be capped. That information came mostly out of the Tacoma police department, though we've had similar kinds of -- We've had beat cops salute us on the streets while we're doing what could be an illegal act. So there's this very sort of schizophrenic, sort of, this is a very important intervention. Internationally you go and you hear about it, and then it's left to us to do.

SENATOR WATSON: Thank you. I'm going to have to move this along a little quicker because we're behind.

MR. CLARK: Okay, right.

SENATOR WATSON: We do appriciate the information that you've brought to us, and we thank you for

coming.

MR. CLARK: Okay, thank you.

(Witness was excused.)

SENATOR WATSON: I'd like to ask Doctor Michael Smith and Mark Madsen to come up. Doctor Smith is Chairperson of the Chemical Dependency Committee for the California Medical Association, and Mark Madsen is the Physician Education Department Manager, California Medical Association.

STATEMENT BY MICHAEL SMITH, M.D.

DOCTOR SMITH: Thank you, Senator Watson. I come here wearing several hats today. I suppose one of them is the official hat as a member of the California Medical Association, as the Chairman of the California Medical Association Committee on Chemical Dependency, and as a representative from the California Medical Association to this hearing to present to you the California Medical Association policy on clean needle and syringe exchange.

I also come as a physician who treats patients with Acquired Immune Deficiency Syndrome, AIDS. The gentleman who preceded us provided an eloquent discussion of some of the tragedy that we witness in dealing with AIDS and some of the costs in human terms that we have and we see on a daily basis in dealing with AIDS.

You and legislature know somewhat about our

budgets, budget constraints and what goes on in the expense of caring for people and, in particular, caring for people with AIDS. It's an enormous expense. I'm not going to review that at this time, but the expense is more than money. It's time lost from work; it's the amount of nursing care required; it's the shortage of hospital beds; it's physician fees; it's medications that are incredibly expensive, and it's an ongoing process.

We, at the California Medical Association, feel that with the policy that I will present to you in a moment, we can reduce the risk of intravenous drug users' high-risk behavior. Mark Madsen, who is here with me, is a staff person from the CMA, and will provide for you some of the statistics that he has put together and some of the experience from other needle exchange programs. We need to look at where we, in California, are in the AIDS epidemic, where other people have been, and where we may get to, God forbid.

Education, intervention and awareness in the gay population in San Francisco and elsewhere in the state of California seems to have made a significant difference in the high-risk behavior in those groups. We feel that the same approach can be made in the intravenous drug users, but that we need to bring into this scenario one further piece of equipment, that is a needle exchange program.

I'm going to read to you now, if I may. You may have up there a copy, and if you don't, we'd like to pass to you now the CMA policy.

SENATOR WATSON: Is it short? If you'd like to summarize rather than read it --

DOCTOR SMITH: It's fairly short. It's half a page.

SENATOR WATSON: Very good.

DOCTOR SMITH: "The CMA supports needle and syringe exchange programs to reduce transmission of HIV infections among intravenous drug users with the following caveats: Since we are concerned that such a program might be incorrectly perceived to be a complete solution, we feel that it is not. The California Medical Association believes needle and syringe exchange programs are likely to be effective only when part of a comprehensive approach which includes, (1) priority on treatment programs for opiate and stimulant users, (2) the use of outreach programs for hard-to-reach addicts such as was just presented to you. We feel that these people should be referred, but not linked to treatment. That there should be training on safer injection practices and the use of bleach for sterilization. At the same time, we feel that these people should be counseled on safe sex and safe sex practices. We feel that if we're going to be providing

injection equipment, we should be sure that we are providing safe injection equipment. We feel that we should provide voluntary, confidential and anonymous HIV testing and counseling and medical follow-up for infected persons and their sexual partners. We feel there should be confidential counseling, testing and appropriate treatment programs in jails and prisons as another source of frequent IV drug use. We feel there should be social services to support families of the HIV-infected drug users, and we feel that this program should be evaluated on an ongoing basis. We feel that community, both particular communities that are involved and the community at large, should be involved in decisions as how this program will be carried out."

There are studies, as I mentioned, which Mark will present. I'll ask him to speak at this point and I'll do a brief summary when he's through.

STATEMENT BY MARK MADSEN

MR. MADSEN: Thank you for having me here, Senator Watson and members of the Committee. Let me review for you, if I just might momentarily, the packet of information I gave you. The first one which holds everything is the AIDS Advisory, and if you'll notice the date, it was July 1989 that that was published. That was after approximately two years of really looking at the

issue and seeing where the literature was taking us and what kinds of results we're seeing from the programs going on, some underground and some condoned by government.

The needle exchange policy which Doctor Smith has just read to you comes next. It was just adopted by the council in November of this year, and I've included for you the references, all of which come from the Montreal International AIDS conference. I'm sorry about the reproduction, but they're still readable; all of them showing positive results of needle exchange.

I also included for you on the buff paper the San Francisco Medical Society's policy on needle exchange as well as the AIDS Foundation. And then, an excellent editorial review of needle exchange programs throughout the world by Gerry Stimson that really provides a framework for understanding the whole notion behind needle exchange which is somewhat -- Really we should be talking about HIV prevention programs which include clean needle and syringe exchange. That's the basis of the CMA policy. It's just one aspect of HIV prevention. That also includes a morbidity/mortality weekly report that talks about a program in Boston called Project Trust. And, to let you know that obviously the U.S. Public Health Services sees needle exchange as something viable and worth talking about in its mortality weekly report.

Although some of you know me as the AV technician today, I come to you from CMA, having spent the last six years working with CMA Task Force on AIDS, developing virtually the entire packet of policies that the CMA now holds as its official position paper. The needle exchange is the latest piece to that puzzle. And I want to emphasize that it really is on the programs that we see as important for HIV control.

I'm going to forego talking about statistics in a detailed way because there are many more people here today to speak, and they have a much better handle on the statistics then I do.

Let me just say a few things. Why is it CMA policy? We felt it was important that CMA take a leadership role here to provide medical and scientific data to support an overall HIV prevention program which includes needle exchange. A tendency is, as we all know very well, to emotionalize the issues surrounding the HIV epidemic. One of the major forces here, and we felt to be a major force, would be to provide that data and to help de-emotionalize some of it and to help provide guidance for the programs that are going on around the country, particularly in California obviously, at the local and state government.

As I said, we've studied the issue for more than

two years. Needle exchange is not the whole answer, just part of the program. As I said, it needs to be part of a larger program. The state of HIV infection now in California is what I would call at a window of opportunity that's closing fast. In the literature that I've given you, you can see what's happened in New York and New Jersey where that window of opportunity has closed. They started out somewhere with a five to fifteen percent HIV infection rate among IV drug users, and it increased to 30, 40, 50 percent. It's now at 70 percent. There is no program for needle exchange there that's going to have a big impact like it can in California. We are now looking at the window of opportunity.

Doctor Werdegar, I'm sure, will talk about statistics in San Francisco, but in the beginning we saw somewhere less than five percent infected, and now we're up to somewhere around 15 to 17 percent infected. I don't know that we ever got data out of New York City that showed something less than five percent. The moment we started to look, it was around 15 to 20 percent. That's where we are right now. We've got a good look at it. We've been able to follow, and in San Francisco particularly, the statistics on who has been getting infected.

Most importantly, I think, the people who are

going to be affected by a comprehensive program are the lovers, the sexual partners, the children of IV drug users, who have become infected during that time when an IV drug user was not considering recovery as an opportunity for them. That really is the key issue and that is providing an opportunity.

You cannot communicate with these groups of people, IV drug users, in the same way that you do with the person who is looking to buy an automobile or looking to find out what politics are going on in the state. They don't read Time Magazine. They don't watch TV. Late night TV maybe. They oftentimes don't have TV's. There needs to be a way of communicating with them. We feel the needle exchange program is the incentive to get them to talk and to offer them opportunities, and that's really the thrust of the CMA policy today.

SENATOR WATSON: Well, let me just ask you about the policy. Would CMA support the syringes being sold without a prescription?

MR. MADSEN: That's a specific question. Sold? Our policy talks about needle exchange, not someone coming in and buying a syringe, off the street wanting to buy a syringe. We feel it's important that exchange be a part of it. You need to be able to demonstrate that you're using a needle. We certainly wouldn't want to be

misperceived that someone could come in and buy, for fear that we might get sort of an attitude that somebody is just experimenting with drugs, they could just come in and buy a needle. I don't think that's what we meant by the policy.

Doctor Smith you might like to comment.

DOCTOR SMITH: Well, I think that's part of it. The other part of it is that we want to intervene with these people at each time that we see them and that intervention doesn't have to be "we're taking you off the treatment"; that intervention can be you're using cleaner techniques, you're cleaning up your act, you're getting your life together. You use the counselors, and they can be at whatever level we decide is appropriate on the street; most importantly people who are "12 stepping", people who have been there and are now getting well or who are on the road to recovery and who can say to the addicts, "I've been where you are, I've walked in your shoes, now walk with me."; and that's effective. It isn't necessarily effective the first time you see the person; it may be effective after a couple of months of trust.

SENATOR WATSON: It's like the alchoholic anonymous mode.

DOCTOR SMITH: Absolutely the same thing.

SENATOR WATSON: Okay, let me ask you

something about this particular advisory position. It says that this advisory group has prompted city public health authorities to announce that they will go to the state and seek permission to institute a program of needle exchange. How committed is CMA to that proposal, that concept? Would CMA, if such a bill were introduced, a policy proposed, would CMA be willing to come and be an advocate and lobby us for that particular policy?

MR. MADSEN: Yes, they would, and that's exactly why we wanted to set the foundation and the framework with the clean needle exchange policy program.

SENATOR WATSON: So, you're not talking about selling needles so we'll drop that piece off.

MR. MADSEN: That's a very specific kind of thing. If a program was developed and a component of it was needles were sold and there somehow was an intervention model, it wasn't just selling needles, then we really would have to look at that and evaluate that and compare it to our policy.

SENATOR WATSON: I just threw that out.

MR. MADSEN: Let me just give you a couple of statistics that I think nobody else is going to mention today. That was part of the California Department of Health Services family of surveys they conducted in 1987 and followed up in 1988, revealed some startling

statistics. 128,000 adult Californians reported needle use during some time in their lives. 45,000 reported needle use during --

SENATOR WATSON: Illegal use?

MR. MADSEN: Illegal use, needle use, IV drug use. 45,000 reported needle use during the last 12 months and 30,000 reported needle use during the last 30 days.

SENATOR WATSON: These are all potential persons with AIDS?

MR. MADSEN: All potential with HIV infection and the ability to pass it on through their sexual partners --

SENATOR WATSON: Do you know of this 28,000 adults who have used, if there's any number that shows those have been identified as having HIV?

MR. MADSEN: No.

DOCTOR SMITH: Senator Watson, that was 128,000.

SENATOR WATSON: Yes, 128,000.

MR. MADSEN: No, in order to conduct a survey of this kind there has to be complete confidentiality and anonymous, and so there's no way to ascertain other data that you might want to know.

SENATOR WATSON: This is high-risk behavior.

MR. MADSEN: It's high-risk behavior. Then let's look at 191,000 women having had at least one IV

drug-using sexual partner sometime during 1987. We also have 32,000 men having had sex with a partner who used IV drug use. So you can see we begin the progression.

I'll just close with one statement which I've heard and I've adopted. I can't help but say it at a time like this and that is, "Just say no" to the IV drug user is like "Have a nice day" to the clinically depressed. It doesn't work.

SENATOR WATSON: I think we all picked up on that early on.

All right, did you want to conclude, Doctor Smith?

DOCTOR SMITH: Well, I just want to say that in the studies that have been done and we have reviewed, there are four facts that have come out. (1) Needle exchange programs do not increase IV drug use, (2) they do increase referrals and stays at treatment programs, (3) that there is a theoretical reduction in the risk of HIV transmission which has not yet been borne out by the long term studies, and (4) that there is a definite reduction in high-risk behaviors. They use clean needles, or they clean their needles or they don't share their needles. These facts are proven in studies.

SENATOR WATSON: You got your point over.

DOCTOR SMITH: Thank you.

SENATOR WATSON: I certainly thank the two of you, and I am very pleased to know that CMA has looked at the issue, has researched it, and has taken a position. I want you to be ready to be called on because I think that this is going to grow. I see it as a desperately needed program, because of the statistics, Mr. Madsen, that you just gave. We don't even know who in this population, but I would expect that a very high percentage of the 128,000 and the 191,000 are potential HIV positive. So, thank you for the work you've done, and we'll be in touch with you at another time.

MR. MADSEN: I just want to let the audience know that I'm going to put packets of information over here for their use.

SENATOR WATSON: Very good.

(Witnesses were excused.)

SENATOR WATSON: Doctor Werdegar, who is the Director of the Public Health Department, City and County of San Francisco.

STATEMENT BY DOCTOR DAVID WERDEGAR

DOCTOR WERDEGAR: Senator Watson, thank you very much for holding these hearings and for inviting me to participate. I'm going to share my brief presentation with Doctor Patricia Evans who is the Associate Medical Director for AIDS office. Doctor Evans is a pediatrician

and AIDS expert.

SENATOR WATSON: Doctor Evans, welcome.

DOCTOR EVANS: Thank you.

DOCTOR WERDEGAR: In my testimony I've attached a report prepared by Doctor Evans for our San Francisco Health Commission.

SENATOR WATSON: Do we have a copy of that?

DOCTOR WERDEGAR: I have them here.

SENATOR WATSON: Okay, can I get one of the sergeants to pick them up, please?

DOCTOR WERDEGAR: In this report Doctor Evans has really summarized the world's scientific literature and points out as previous speakers have that the weight of scientific evidence shows that needle exchange programs, when part of a comprehensive drug abuse and AIDS prevention program, are effective, that they cause no harm, no increase in substance abuse, and are really effective for AIDS prevention.

You asked earlier and I'll just say parenthetically, "How are needles disposed of?". They would be disposed of the way hospital infectious wastes are disposed of which, in most communities, is by incineration. In California there are special rules for disposing of infectious waste.

SENATOR WATSON: Have they ever considered

recycling?

DOCTOR WERDEGAR: Recycling the needles? No, because they're filled with blood and other things. The simplest way is really to ensure they're --

SENATOR WATSON: The immense heat will kill all the germs?

DOCTOR WERDEGAR: Yes, the best way is just to be rid of them and use new products.

SENATOR WATSON: What do they do with the waste?

DOCTOR WERDEGAR: They are reduced to ashes eventually.

SENATOR WATSON: What do they do with the ashes?

DOCTOR WERDEGAR: The ashes can be safely put into ground fill or whatever after it's been -- well, once it's been reduced to ash you've got a safe product to dispose of.

These are the some of the points that I want to make. As the head of the Health Department in San Francisco for the last five years, I direct health activities in our community that has the worst AIDS epidemic in the country. We not only fight the AIDS epidemic, but simultaneously, the drug abuse epidemic, and simultaneously, what I call the epidemic of people who have

inadequate insurance or no access to primary care. Those three epidemics are very much intertwined.

The needle exchange program is just part of an overall program. When it's a stand alone, there are many criticisms, but when it's part of a comprehensive program, it's very helpful. My concern really has been that the clock is ticking, and we know from epidemiological studies that in East Coast communities, IV drug abuse, AIDS, has spread very rapidly so that in the IV drug abuse community in New York City, Newark, New Jersey, two-thirds of IV drug users are already HIV positive and that their partners are infected and their children are born infected, and it's really a social disaster. The fact is that in California, the rates of HIV among IV drug users is still relatively low. In the Los Angeles area the figures are around five percent. In San Francisco, I'm sorry to say, it's as high as 15 to 20 percent. These are not like the Eastern figures, and we have a chance to do something about it, and we need very vigorous programs that include all of the things that have been described by Mr. Clark, by the previous speakers from the CMA, and which you'll hear more about.

If we had a vigorous program and that includes needle exchange, bleach outreach, access to health care, access to drug treatment, we have a chance to do something

about the epidemic.

Another point I want to make -- So, time is of the essence, and that means that legislative time is of the essence.

Another point I want to make is this -- very simply, that right now if we had utter unanimity, if everybody agreed that having needle exchange programs was beneficial for health, social welfare and for our community, there is no mechanism up in San Francisco for authorizing pilot needle exchange programs. The State Health Director, legal counsel says the State Health Director is not empowered to authorize and approve such programs. Legal counsel says the same. You'll hear this from Mr. Cavanaugh when he speaks for the State Board of Pharmacy. I testify at their hearings and heard their discussions. The State Board of Pharmacy endorsed the concept of needle exchange as part of a comprehensive program unanimously, and their legal counsel again said that they are not empowered to authorize pilot needle exchange programs, any kind of needle exchange programs.

So, we have no agency of government in Sacramento that can authorize such programs and make them legal so that health departments like my own could conduct them. We would conduct street-based programs. We admire the work of Mr. Clark and his group and what they have

done. I have talked to our police chief and told him how much I admire their work and what I think it is doing positively for our community. But I as a health director, our department, cannot initiate such programs because we need permission from Sacramento, and nobody in Sacramento can give it to us.

So, even if the legislature did not decide whether the needle exchange is of benefit or not, well the government need not decide if it's of benefit or not, I think at a minimum what the legislature has to decide is that there should be some respected agency of government, the department of health or the pharmacy board that could have the authorization to review the proposed pilot needle exchange programs, evaluate them, and make them legal. At the moment, we have no mechanism to do that.

That, in a sense, is my bottom line. Because our health commission very carefully reviewed this whole issue. We had scientific testimony, public testimony, and the San Francisco Health Commission said that they want to go ahead with pilot needle programs as soon as they become legal, and they, in fact, urged that I, as the Director and our Mayor and Board of Supervisors, seek what help we could from the state legislature to make such programs legal. I've attached a beautifully written resolution with all of its very pertinent "whereas's" in the

testimony from the San Francisco Health Commission.

One of our Commissioners, and your staff asked me about this, one of our Commissioners, Commissioner Gray, was against the program. I guess my comment briefly -- I have high respect for Commissioner Gray. She is loyal to her causes and her community. Her principal concern was that if we had needle exchange programs, that right now they're not legal, and in a memo that she wrote, and I believe you and your staff have copies, you'll see that one of her principal concerns related to the legality of such programs. I think if we had legal programs, because we had state authorization to conduct them, 90 percent of her concerns would go away.

There was no question that she was also concerned about the views in some of the black churches that needle exchange might be viewed by the community as condoning the use of drugs. The answer, of course, and it's an education process working with the black ministry and the black churches, is that actually the availability of needle exchange programs in the long run does the opposite. It opens new avenues for access to health care; new avenues for access to drug treatment; new ways of saying to the drug addict, "We care about you and want to take care of you," and in that sense it really doesn't encourage or condone; it provides a way of offering

relief. I think we have to work with the black churches, the black ministries. It's very important if we're going to reach into the community, and we have been involved in dialogue with the churches on just this point.

So that's the gist of my testimony. Most of it is written. I would emphasize that the weight of scientific evidence certainly now favors the needle exchange for AIDS prevention. Some have said, "Is the proof absolutely conclusive?". In science the proof of anything being absolutely conclusive takes a long, long time and we don't have the luxury of a long, long time. The weight of evidence, there's no question where that is. Time is of the essence. We've got a five to fifteen percent prevalence rate; they've got a 65 to 70 percent rate on the East Coast. We can spare a lot of grief and suffering and social disaster if we act quickly. At a minimum, the legislative help we need is to give to some respected agency of government, whether it's one agency, the Health Department or the Pharmacy Board, or some committee that includes those two and the University of California, but we need some agency up there that can say "okay" to a pilot program if it's designed properly and if there's a proper way evaluate it.

SENATOR WATSON: Let me ask you this. Of a pilot program you'd have to have an evaluation, pre-and

post-testing. How would you set that up?

DOCTOR WERDEGAR: I'm going to ask Doctor Evans to tell you about that.

SENATOR WATSON: Okay, very good.

STATEMENT BY DOCTOR PATRICIA EVANS

DOCTOR EVANS: I'll skip to that and go immediately to that.

My name is Doctor Patricia Evans and it is a pleasure to be before you again, Senator Watson. It's been awhile, but I'm pleased to be here and honored also.

In terms of evaluation, I have for you here an example of a protocol which certainly could be used. This is a scientific protocol which was pulled together by myself at the request of Doctor Werdegar, and I've also received some input from some of the researchers who are involved with intravenous drug users in the San Francisco area; so I'll pass this out.

In terms of the research questions, you really need to look at what specifically are you interested in, because that will determine what the cost of the program is. In San Francisco, Doctor Werdegar's and other researchers in San Francisco have indicated that there's about a three percent seroconversion rate per year amongst intravenous drug users. If you want to prove the needle exchange effects that you're going to have to have an

extremely large sample size which is going to increase the cost of the program.

We do know the evaluations from around the world, as well as here in the United States, have looked at self-report behavior change, and so we certainly can look at those particular parameters, and that becomes less costly than just looking at HIV seroprevalence and seroconversion rates.

We can also look at secondary data set analyses of other parameters such as, hospital admissions for bacterial endocarditis for intravenous drug users, admissions for abscesses in terms of intravenous drug users as well. So it really depends upon what sort of research questions you want to ask as to which is the best way to set up. I think that what I have provided to you will really look at behavior change over time -- between time one, time two, time three and time four --

SENATOR WATSON: Well, one of the things that we'd be interested in seeing is if our needle exchange program is working for an individual; does that individual test HIV positive?

DOCTOR EVANS: The test should certainly be offered to anyone coming into the program, and what I have proposed there is that anyone who does participate in the evaluation -- because I think there is a difference

between participating in the evaluation component versus those who are in the program exchanging needles. You need to take a random sample of those participating in the program to really do a good evaluation. HIV antibody testing should be offered to them. Individual people should not be coerced to take the test, though.

SENATOR WATSON: See, our opponents, and I was just reading the letter here, feel that in some way it's making illegal activities or promoting illegal activities. In Ms. Gray's letter there's some reference to making the use of drugs or preventing the use of drugs or making them legal if you're going to make the exchange program legal.

DOCTOR WERDEGAR: Well, as you know, I talked to Commissioner Gray on this point quite a bit as has Pat, because at the moment there is no way at the Health Department, she's one of our Health Commissioners, conducting the program legally because we have no way of getting the authorization from any agency of state government; she feels that exchanging needles encourages people to engage in illegal behavior. That's why I said that I think 90 percent, maybe not all, of Commissioner Naomi Gray's objections are solved by our being able to put such programs on a legal footing by having appropriate authorization to the Health Department.

SENATOR WATSON: And I think one of the ways of doing that is by showing some data that says that it does have a positive effect, at least this percentage has not developed HIV yet.

DOCTOR EVANS: That's correct. The other thing, too, is that we are always following the cart before the horse, it seems, because everyone -- the arguments that I get are that needle exchange has not been proven, but how do you ever prove it unless you evaluate the program? So you need to evaluate the program so you can say if it is or is not effective.

We do know that it is effective in terms of positive behavior change. That information is available from around the world. It has also become available here in the United States. Don DesJarlais, who is evaluating the program up in Tacoma, as well as the program in New York City, but we need to evaluate other programs as well, too.

The other thing that I'd like to point out is the fact that instead of talking about needle exchange as a needle exchange, you really need to talk about it as another form of outreach because that's how I really see needle exchange. It is another form of outreach activity, to reach a group of individuals who have been difficult for the current system to reach. It's really our problem

that we cannot reach them. It is not they who have problems. It's really us who have the problems reaching out to them.

This is another form of outreach, and literature certainly does indicate that a number of people, and in fact, there was a study in England that shows there was about a third of those who participated in the needle exchange had never been in contact with the substance abuse treatment programs in that country. So, again, we have access to a patient population which we currently do not have access to and we won't be able to give any messages to no matter what we do, unless we try different forms of outreach. So that's another point that I would like to get across.

The other thing is that you talked about needle exchange in terms of what it should really look like. And, again, if I look at it in terms of outreach, there are other aspects to those outreach activities which need to be included because then you can clearly see where and how this outreach activity will occur. You can also talk about the scope of the interactions, such as discussions of proper needle hygiene as well as safer sex. There can also be a risk assessment done on individuals, not just in terms of medical care, but also in terms of legal housing, nutritional needs, psycho-social needs, because this can

be part of the outreach activity, as well as referrals to the proper agencies which requires that those who are participating in outreach, in terms of the outreach workers, need to be properly trained.

Then there's the whole issue of advocacy that needs to go on in terms of outreach activity. Then we've also talked about a comprehensive program for substance abusers. I have given to you a sample protocol on the very last sheet also indicates what this comprehensive program really should look like. There are a number of areas which I have included in there, and one of them which has been discussed before is treatment on demand. We're really talking about lots of different types of treatment modality, not just methadone, but different types of treatment modality for individuals. We're also talking about prevention of needle-associated transmission, which would include outreach activities not only for bleach and condoms, but also for needle exchange.

There would also be general public education because one of our biggest problems, as I see it, is the fact that the public is ill-informed about the whole issue of addiction and substance abuse and what we're trying to do with needle exchange. There needs to be general public education, as well as provider education.

I, as a practicing physician, really received no

information about substance abuse and addiction when I was going through medical school. If I did not receive it, what about those individuals who went before me, and even after me, who still do not know that much about addiction and substance abuse.

Then there's the whole issue of research in terms of this comprehensive program to make sure that all of the components that we're talking about really do work effectively. What can be done to modify them to work more effectively and efficiently, and how can we best reach the populations what we're really talking about.

SENATOR WATSON: Okay.

DOCTOR EVANS: So thank you very much.

SENATOR WATSON: Well, I want to thank you for your fine work. I mean, you've given us an outline here that we can go back and take a look at and do some additional research. I think this proposal that we're all talking about this afternoon has to be handled very delicately. I can see the reaction of Commissioner Gray, and it's a reaction that's probably shared by many. It sounds like an excessive program that exacerbates the illegal aspects rather than programs that can help. The way we bridge that is to get good information out there, statistical information out there, the benefit of whatever research data we already have, and people speaking to it,

credible people. I think it will help us greatly to have CMA sending their advisory bulletin out and to be talking about this and to hold hearings when they have their statewide convention. To speak to the press. This is what's going to bring this about.

So thank you for your good work. We appreciate it and it's good to see you.

DOCTOR EVANS: Thank you.

(Witness was excused.)

SENATOR WATSON: All right, we've got to move on a little quicker.

Doctor Flynn, M.D., Medical Director with the University of California Davis Medical Treatment Center for AIDS.

STATEMENT BY DOCTOR NEIL FLYNN

DOCTOR FLYNN: Thank you, Senator Watson. I think we're about to be buried in paper here.

SENATOR WATSON: Can you summarize this?

DOCTOR FLYNN: I certainly can.

SENATOR WATSON: That would be very helpful.

DOCTOR FLYNN: I would like to give you a perspective of a medium size city, that is Sacramento, where one would think that the IV drug problem and AIDS problem is not that great compared to San Francisco or Los Angeles. But, I'd like to let you know that there are

approximately 8,000 IV drug users in Sacramento, and you're very familiar with the city of Sacramento.

Of those, about three to five percent are currently infected, and you'll see on my bottom table there, comparison among San Francisco, Los Angeles and Sacramento for seroprevalence over the last several years. The striking things are, as Doctor Werdegar and Doctor Evans have pointed out, that San Francisco was where we are today in Sacramento about three to four years ago and are now up to 15 to 20 percent infected level.

If one superimposes these curves on the curve of New York City in the years 1978 through 1983, it is identical and it ends up at 70 percent infected. We are undergoing the same rate of spread currently in San Francisco as was documented in New York City.

There are currently programs for bleach use disinfection, and what I'd like to do is give you some data on 1400 IV drug users who we've interviewed in Sacramento on the use of bleach and other high-risk behaviors. These individuals are interviewed for one hour each, one on one in a private setting. We've now done 1,400 of them, and they are educated for that hour as they are asked questions about their drug use. At the end of that time period, they are given written materials, condoms and bleach, and we pay them to come back about four months or

longer from that time. We pay them $25.00 in order to get them back, and we have currently about a 30 percent return rate for requestioning.

The things I'd like to point out to you in the second table among the high-risk behaviors are that initially 70 percent of individuals obtain their needles, the ones that they used when they shot up last time, from either a connection or friends or peers. So you can understand that those needles are probably used, and those syringes have probably been used before. After education that fell to only 57 percent. It's still high.

Additionally, those who rinse their paraphernalia in either bleach or liquid detergent or alcohol, whatever, went from 54 percent who never used -- I'm sorry, the second part is frequency of sharing their needles -- went from never or sometimes, that is rarely sharing their needles, 54 percent went to 74 percent. So we made progress there with an intensive educational program. Some progress, but certainly not enough.

Of those who often, usually,or always share went from 47 percent to 19 percent of the follow-up people.

One last point with regard to the third wave of HIV infection, the first one being gay men in this state, the second one being IV drug users, and the third wave being their sexual partners and their children. The

second and third waves are potentially preventable at this point in time.

Look at the last three entries on that table. One sees that they rarely, if ever, use condoms, and that behavior does not change after education. They do not like condoms. It's one thing to disinfect the needle. That doesn't interfere with your pleasure at all, but they do not use condoms, suggesting that our educational efforts are ineffective in terms of condom use; and that once IV drug users get this virus, they will transmit it to their sexual partners and their children, resulting in the third wave of infection, such as has been seen already in New York City where one in sixty babies born is born with HIV, two percent of babies born.

I will simply summarize my recommendations and say that they have been already articulated by the previous speakers. You have a list there of what we, in Sacramento, after two years of studying this issue have felt some basic components of needle and syringe exchange to be, and we agree with others that it should be only a part of a very comprehensive and very well-funded program for prevention of HIV spread.

I would like to also state that while I agree with the previous speakers on not necessarily linking, but making available drug treatment for people in these

programs, the issues of AIDS spread, HIV spread and drug addiction must be separated in our minds. We can do something immediately about the spread of HIV for relatively little money. We cannot at the same time expect to do very much about IV drug use. We can begin the process, but these two issues must be separated in our minds. I think this is one of things that our opponents of needle exchange fail to do in their minds. To them it's okay, apparently, if IV drug users get the virus so long as we don't do anything to condone or make the appearance of condoning IV drug use. Those issues must be separated. AIDS is too large an issue and too important to be tied to success in drug treatment.

Finally, I'll give you a summary of the objections that our task force came up with. They are as the others have said, it is currently illegal. One of our law enforcement agencies, I think, would accept the fact of it becoming legal and would support us. The other is adamantly against the legalization of possession of paraphernalia or of legalization of needle exchange programs.

Secondly, the wrong message, and I think we have alot to do in the way that we phrase these programs with whether the wrong message gets out or not, whether it's seen as condoning drug use or not, we can phrase these

programs in such a way that they actually contribute both perceptually and actually on the street to decrease drug abuse and increase drug treatments.

Finally, that there is no evidence currently that these programs will increase either drug use or make it more difficult for law enforcement to prosecute for illegal use of drugs. Another objection has been that law enforcement will lose a tool, that is, the criminal possession of paraphernalia law is a tool for law enforcement for bringing in a drug user, and our law enforcement people do not use it as a tool. They have told us that it would not result in fewer arrests for illegal drug use if they were deprived of the illegal possession statute.

SENATOR WATSON: There are certainly a lot of safeguards that would be part of any public policy and just so that we can enforce laws and so we can keep down the growth so that we can prevent -- So all of these areas will take separate kinds of safeguards, so that we're not creating a larger problem than we're trying to solve.

DOCTOR FLYNN: And I think it can be done.

SENATOR WATSON: Thank you so much for coming. Did you conclude?

DOCTOR FLYNN: Yes.

SENATOR WATSON: Thank you so much and we

appreciate the paperwork you've given us.

(Witness was excused.)

Okay, Jay Cavanaugh, State Board of Pharmacy and Director, Inter-Agency Drug Abuse Recovery Programs.

STATEMENT BY JAY CAVANAUGH

MR. CAVANAUGH: Good afternoon, Senator. I'm Jay Cavanaugh from the California State Board of Pharmacy and our Board President, Glenn Yokohama is kind enough to join us.

I'm really thrilled that we have an opportunity to talk with you about this important issue. California Board of Pharmacy in 1988 reviewed some of the problems about hypodermics, and at that time, the Board felt, for a number of reasons, didn't want to move ahead on any recommendations for needle exchange. The two major reasons at that time were the information that we had been given was that this was primarily an East Coast problem, and we were afraid of sending the wrong message on drug abuse. Those are legitimate reasons.

In the intervening year, however, the Board went ahead and reviewed the issue scientifically. I remember reading personally over 200 scientific papers, some 3,000 pages long, I mean talk about getting snowed with paper, but we wanted to find out the truth. Truth is very important when people's lives are at stake.

One of the things we saw was that we tracked the

outbreak of AIDS and intravenous drug users, not just in New York City, but outbreaks of AIDS in Stockholm, in Milan, Italy, in Bangkok, Thailand, in Edinborough and in other places, so the idea that it can't happen here just wasn't so. It just hadn't happened here yet.

The other thing was, and I was persuaded to this because I'm an anti-drug person. I'm an appointee of Governor George Deukmejian, and I've spent 20 years fighting substance abuse, but I was persuaded that the posturing of being anti-drug is no longer important. The primary victim of the intravenous drug user who has AIDS is their child.

Scientifically, there is no debate over whether we should have needle exchange. The World Health Organization, California Medical Association, California Board of Pharmacy, State Department of Health, on down the line, scientifically support needle exchange.

The problem has not been a scientific one; it's been a moral question, and the moral question that I wish to raise, because everyone's danced around it and I'm going to address it very directly and that is, that the primary victims are the newborn infants of infected mothers. On what moral grounds can we say that in order to avoid giving a pro-drug message we will allow these people to suffer? It's not supportable. It's a

fundamental ethical question.

That question was raised and presented in the Montreal International AIDS conference, and it certainly persuaded me. I don't want to suggest that anybody use drugs or continue to use needles.

I know also that the scientific evidence showed four key points and these are them, mentioned before but I want to reiterate them because they're important that they be on the record; (1) Needle exchange programs as part of an overall AIDS education and drug treatment effort reduced the spread of HIV, reduced the degree of needle sharing, did not result in any increase in people abusing drugs intravenously --

SENATOR WATSON: Where was this research done?

DOCTOR CAVANAUGH: Oh, this research has been done from approximately 1984 through 1989.

SENATOR WATSON: And where did it take place?

DOCTOR CAVANAUGH: In England, a great deal of it in England. A great deal of it in Australia. You know Australia has needle exchange throughout the entire country. The whole country has needle exchange. They do it in the pharmacy.

SENATOR WATSON: What's their growth pattern in terms of AIDS?

DOCTOR CAVANAUGH: They have stopped AIDS. They have stopped it cold. They stopped it dead in its tracks. The same thing in England. Now in Edinborough they had an outbreak, but in the balance of Great Britain they were able to halt this geometric increase.

You see, what happens, and it was eluded to earlier, the increase goes five percent, ten percent, fifteen percent and somewhere between fifteen and twenty percent, when fifteen to twenty percent of the intravenous drug users have the virus, right around there, a geometric curve cuts in and it skyrockets. Now they were able to prevent that increase in England. They were able to prevent it in Denmark, in Australia and in other areas where they implemented, not just needle exchange, but comprehensive efforts that included needle exchange programs. We're at that point here, so the research has been done throughout the world. Many, many papers have been published. No increase in drug abuse and most importantly, in every study that I read there was an increased number of individuals referred to drug abuse treatment.

Now, if you're anti-drug and you want people to stop using drugs, how can one not support something that gets more people the help that they need? On that basis, the Board reconsidered. We held our own hearings this

year. Those hearings included many of the same witnesses that you heard and many others. We reviewed many of the scientific papers and on a unanimous motion, the State Board of Pharmacy agreed to support a pilot needle exchange effort as part of an overall AIDS education and drug treatment program.

The reason we put those caveats on it is we don't want to go willy nilly saying, "Let's just hand out syringes to people"; we want to do this in a responsible way.

That's basically my presentation. Glenn, do you want to add something?

MR. YOKOHAMA: No, I wasn't going to add anything other than some of the speakers had mentioned, I guess, the Board of Pharmacy is looking for, I guess there's a couple of avenues of going, apparently. One of those avenues is the legislature telling the Board of Pharmacy or the Department of Health Services that you are the ones that will be charged for evaluating pilot programs, for example, and I guess the other one is just through the legislative process where you get legislation to --

SENATOR WATSON: Okay, let me just ask --I thought I heard you, Mr. Cavanaugh, say that the Department of Health Services was in support of the needle

exchange program?

MR. CAVANAUGH: Yes, I read an interim report that was presented to Ken Kizer wherein they stated clearly that they were in support of a pilot program. You see, there are public and private positions that are being taken.

SENATOR WATSON: Was it just a needle exchange or the AIDS Leadership Plan that they were in support of?

MR. CAVANAUGH: Needle exchange was part of the report.

SENATOR WATSON: They were in support of that overall comprehensive --

MR. CAVANAUGH: Yes, and in private conversations with folks, they do support it. What they're basically saying, to let the cat out of the bag, is how do we do this in a way so that we don't get creamed politically? And I believe that the way to do it is by starting to tell the truth. I'm a conservative, and I can support a needle exchange program that is done with the proper safeguards, and I think other conservatives -- I mean, after all, what's a conservative if you can't conserve life? And we have to support any effort that will help prevent these newborns from getting this virus.

SENATOR WATSON: Are you clear whether the

Department supports the provisions of this plan or do they just support the report from the Advisory Committee?

MR. CAVANAUGH: They supported the report from the Advisory Committee.

SENATOR WATSON: Okay, so we would have to then find out if they support -- I had heard that they were opposed to a needle exchange program, but maybe with this kind of comprehensive approach?

MR. CAVANAUGH: I think what's happening, what we're seeing here today, there is a consensus building in the professional community. When you have California Medical Association, California Board of Pharmacy, responsible, basically conservative organizations, saying please grant us the authority to oversee such programs in a responsible way, then that has to have some effect.

SENATOR WATSON: I don't even know what conservative means when you are addressing this issue, when you say you're a conservative. That has no meaning. You've got to break it down for me. I think you're on the right road.

MR. CAVANAUGH: It means that I care about people,and it means that this is a public health issue to me, not a political issue.

SENATOR WATSON: Well, throw away the use of conservative because I don't think it describes anything.

MR. CAVANAUGH: Yes, but the opposition to this plan is going to be a dogmatic one in my mind, and it must be overcome.

SENATOR WATSON: And, they will present the moral arguments, and they have a place somewhere over here while we address what's actually happening today with human beings. We can argue this morally, but we have to argue it based on what we see is occurring among people within the society, and what is our responsibility to address from the health stand point.

MR. CAVANAUGH: Yes, and Senator, one point that hasn't been made. Addiction, I'm a molecular biologist, and from everything we know, an addiction really is a disease, and the intravenous drug user has, over the course of time, diminished ability to exercise sound judgment. Education in these cases, as Doctor Flynn points out, will not necessarily work. We cannot prevent these people from continuing their use. Now if they were the sole victims, morally you might say they made that initial choice; they're entitled to it. But their sexual partners, their children, and the members of the community, we're condemning those people to getting the virus, and there is no moral standing to do that.

SENATOR WATSON: I think that your Board could do a lot for society by promoting and saying just

what you said here. I think you have credibility. I think from the appointing power, you're there because they felt that you could present the case in a rational, reasonable, logical way; so do it. The more you speak out and the more you show the results of your research and your study and input from your advisory committee the easier it is going to be.

You see, on the other side of a conservative is a liberal, and that's me. The easier it's going to be for me to propose such a program. If we get it blocked up at the top, and I think you're going to understand what I'm talking about, then we've just had an afternoon exchanging ideas. I want this to turn into something real and certainly your Board can help.

MR. CAVANAUGH: Oh, it must.

MR. YOKOHAMA: By the way, I was going to say, Senator Watson, that the pharmacists, the CPAC as well as the California Society of Pharmacists, does have a task force that is trying to promote within the profession as well as in the community, some of the message that you spoke about.

SENATOR WATSON: I would like to invite all of you here, and particularly you two, I have a health advisory committee that's been ongoing for about 14 years now, and we've broken up into task forces. We have not

looked at needle exchange. We've looked at substance abuse as a whole, but I think, Jane, we should have one meeting dealing with just this issue because it's a cross section of all health providers and not only health providers, but third party payers, and all those who are interested in health delivery systems here in the state of California; and I feel that this is an area that is going to grow in terms of its visibility and our attention to it.

MR. CAVANAUGH: I believe, Senator, the Board would support a bill that empowered the State Department of Health or the Board of Pharmacy --

SENATOR WATSON: Would you write me a letter to that extent?

MR. CAVANAUGH: Sure, yes we will.

SENATOR WATSON: Thank you very much.

MR. YOKOHAMA: Thank you for the opportunity. Also, I'm not sure if it would be useful, but we do have the minutes of the last meeting.

SENATOR WATSON: Oh, we'd like to have that.

MR. YOKOHAMA: Thank you very much, appreciate it very much.

(Witnesses were excused.)

SENATOR WATSON: I'd like to call up now the Executive Director of the Minority AIDS Project in Los

Angeles, Gil Gerald.

STATEMENT BY GIL GERALD

MR. GERALD: Good afternoon.

SENATOR WATSON: Good afternoon.

MR. GERALD: Senator Watson and Honorable Members of the Senate Health and Human Services Committee, my name is Gilberto Gerald, and I am currently the Executive Director of the Minority AIDS Project.

I have been involved for more than six years in the response to AIDS and what is usually termed, in public health jargon, the minority community. Minorities, in fact, make up or are emerging as the majority in many urban centers. HIV transmission through needle sharing is a significant threat to our communities because drug use and abuse has surpassed epidemic proportions.

In California, as has been stated, there may still be an opportunity to prevent the higher incidence of HIV disease among IV drug users that has occurred in the northeastern cities of the United States. I thank you for this opportunity to present testimony offering support for needle exchange programs.

Needle exchange should be instituted as part of a comprehensive set of programs that are desperately needed to combat both the HIV and drug use epidemics. The views I offer on the question of needle exchange come

mainly from work on a report conducted under my direction while I was the Director of Minority Affairs for the National AIDS Network in Washington, D.C. The results of this report were published in the June and July 1989 issue of NAS Newsletter, multi-cultural notes on AIDS education and service.

The report looked at a number of needle exchange programs underway around the country and the public debate surrounding them. A recent check with the sources of this report reveal no significant new information. I'm submitting copies of this article as part of my testimony which I've provided to you.

Before speaking on the issues of the efficacy of needle exchange programs, I would like to offer the following commentary on one basic political issue posed by needle exchange proposals. A major problem with the public debate surrounding needle exchange programs is that these proposals are often presented or perceived as substitutes for a comprehensive set of programs that are desperately needed for the intravenous drug using population. This is a false construct which sets the stage for a lot of drama. If, in fact, there is no will by government to respond to the pent up demand, to apply the necessary resources to help the individual intravenous drug user and his or her family, then members of the

community, particularly the African-American community will be hard pressed to understand why there is now a will to fund a program that at this time can only partially answer the question of whether it will stop the spread of HIV.

In this sense, the needle exchange programs are pitted against a whole set of unmet needs and are seen as a bandaid solution to a much larger problem, the drug use epidemic and it's root causes.

Needle exchange programs need to be viewed in the context of the need for a comprehensive set of programs in which they are but one of a whole arsenal of strategies that need to be employed to deal with the HIV and drug use epidemic. This comprehensive set of programs should include programs including treatment on demand with a full range of options beyond methadone, as well as programs providing referral and full access to medical, mental health, housing, job training, job placement, child care and legal services.

In my experience it is this set of comprehensive set of programs that strikes a responsive chord in the African-American community. Having said that, I wish to offer a word of support for needle exchange as one strategy among many, all of which must be brought to bear on the problem of stopping the spread of HIV among

intravenous drug users. Behavior change is very difficult to bring about, but small changes in risk behavior mean a lot when it comes to HIV transmission, and time is of essence. Getting an intravenous drug user to stop sharing needles may not seem as great an accomplishment as getting him or her off to kick the habit altogether. However, with this one small step towards responsibility for oneself and others, this one step is a giant leap for an addict and a giant leap towards stopping the spread of HIV to their sexual partners and their unborn children.

Information from needle exchange programs in this country, including one in Tacoma, again, checking my resources for the report written earlier this year, indicate the following: (1) Drug use, as has been stated before, has not increased as a result of needle exchange programs. In Tacoma, of an estimated 300 to 350 regular users of the program, the median number of years the participants have been using drugs intravenously is 14 years. Further, there is no difference in the level of drug use pre-and post-participation in this program.

(2) Needle exchange sites have proven to be ideal sites for recruiting or referring individuals into treatment. Again, in Tacoma over 200 individuals were recruited into treatment, half of which remained in treatment. This is one important feature that needs to be

underscored. Needle exchange programs can be points of entry and access to a whole set of programs designed to support the IV drug user in his or her journey away from drug dependency. In this sense it is another kind of outreach program, as Doctor Evans has stated.

(3) From the standpoint of behavior change with respect to the sharing of needles, the Tacoma program reports that half of the individuals had already eliminated needle sharing before entering the needle exchange program, as a result of other prevention efforts. The needle exchange program was able to get another third to eliminate needle sharing as a behavior, and the use of bleach increased 50 percent.

Clearly, needle exchange programs can fill gaps left by other approaches to reach intravenous drug-using populations and achieve behavior change. It is yet another demonstration that we need an eclectic approach to HIV prevention utilizing many strategies, not one.

Needle exchange is not a panacea. It is part of a set of strategies that must be employed, including treatment on demand, bleach and condom distribution and information about the proper cleaning of drug paraphernalia.

All needle exchange programs should be funded and supported in a way that provides for good evaluation

of the effectiveness of the program. Because most programs underway are new, it will take years and large samples of individuals to determine how effective they were in actually stopping the spread of HIV. This is a question for which there is no definite current answer. What is known is that certain needle sharing behaviors lead to HIV transmission and that needle exchange programs are documenting reductions in this behavior as a direct result of individual participation in needle exchange programs.

To wait indefinitely for absolute proof, and some members of the community demand that, that needle exchange programs, the spread of HIV before instituting a sanction program in California, a leading state in numbers of diagnosed AIDS cases, is unreasonable in light of the evidence that needle exchange programs do lead to reduction in the behaviors that provide for the transmission of HIV. What is reasonable is to require and fund evaluation over a long run to ultimately answer the question of efficacy.

In conclusion, I would urge members of the Committee on Health and Human Services to further examine the objective data that is available on needle exchange. The HIV crisis is closing in on its first decade. As the Executive Director of an agency established to the respond

to the crisis of AIDS in South Central Los Angeles, I am well aware how unpopular needle exchange is in the community here or elsewhere. However, much that the Minority AIDS Project and others have had to do to save lives and take care of one of those in need, could not wait for popular public outcry.

SENATOR WATSON: Okay, then how do we address the concerns that were just mentioned before, such as, those of Commissioner Gray, and the religious community?

MR. GERALD: I think that -- I've read the objections by Commissioner Gray and I would support the statements that have been made earlier about perhaps legislation that made it legal for an agency to take on this responsibility in the state of California. Beyond that we have to have quite a bit of community education around this issue and basically, presenting the facts. I also think that we need to position this issue in the context of a comprehensive program that the community is really demanding. They are demanding more than just an intervention around HIV. They really are concerned about the underlying issue of IV drug use. And yes, a speaker did speak about separating those issues. I think that's a lot to ask in the community. I think people do want to see more than just -- they would like to hear more about how this program does get people into treatment, how this

program does, is a point of access to people who are not currently accessed through existing programs.

SENATOR WATSON: I would like to share with you the letter from Commissioner Gray, and you might want to look at it in terms of how you would respond. Would you do that for us?

MR. GERALD: Yes, I would.

SENATOR WATSON: I'll have Mr. Stewart share it with you. Here it is.

MR. GERALD: I do have a copy of it.

SENATOR WATSON: Oh, you have a copy of it?

MR. GERALD: Yes, I have seen it.

SENATOR WATSON: I'd be interested in seeing your recommendations and your response to what she has sent us, if you would.

MR. GERALD: Certainly.

SENATOR WATSON: Okay, thank you so very much, and we appreciate what you've done and prepared for us.

MR. GERALD: Thank you, Senator Watson.

(Witness was excused.)

SENATOR WATSON: I'd like now to just skip and call up Sherry Conroy of the Department of Alcohol and Drug Programs because there are some questions that I'd like her to respond to.

In the meanwhile, if Doctor Horowitz would come

down in front, we'll take you right afterwards and continue on with the agenda.

STATEMENT BY SHERRY CONROY

MS. CONROY: Since you're running so far behind and you were kind enough to accommodate my flight schedule, I'll forego reading my testimony as submitted.

SENATOR WATSON: Thank you. Just submit it, and we'll all get a chance to read it.

MS. CONROY: Okay.

SENATOR WATSON: Can I have the sergeant come down and get a copy of her statement, please?

MS. CONROY: Just to briefly summarize, the first part of my testimony was to talk about the various activities the department's been engaged in either directly or through our 58 counties to prevent the spread of HIV and AIDS. We're very proud of those activities, so I would hope that you'll take a few minutes sometime later to get acquainted with our activities.

Those activities involve training, education and prevention HIV testing with pre-and post-counseling; and treatment on demand. We see those as the three primary strategies for my agency to be involved in. The bottom line of the testimony is, however, although the preliminary data from needle exchange projects both nationally and internationally, is promising, they do not

prove definitively that they do not encourage the use of drugs, and for that reason, our department does not support needle exchange programs.

SENATOR WATSON: Cut and dried, that's the end of it?

MS. CONROY: That's it.

SENATOR WATSON: I know that it's difficult when the word comes down from the top to take a position, but I'm not clear. You might want to reiterate for me why you are against, at this point, the needle exchange program -- because it does encourage the use of drugs, is that it?

MS. CONROY: Many of the needle exchange programs, first of all, are not stringently, scientifically designed to show that they do not encourage drug use.

SENATOR WATSON: Tell me this, on that point right there, what is the Department doing to advance and discourage the use of drugs? Advance your programs and discourage the use of drugs, what have you done successfully?

MS. CONROY: Well, I think we have a number of things --

SENATOR WATSON: And lowering the rate of growth for AIDS.

MS. CONROY: I think probably our best efforts are our prevention information, both efforts in our treatment programs and outreach efforts where we provide information on how not to attract the HIV virus or spread the virus. I think our HIV testing plus counseling program, in conjunction with the Office of AIDS within the Department of Health Services, is extremely effective in getting IV DU's to go into --

SENATOR WATSON: What evidence do you have that it is extremely effective?

MS. CONROY: We're in the early phases of it, Senator Watson, so I am remiss in saying that it is extremely effective. I believe that it will be extremely effective.

SENATOR WATSON: Okay, you pass this word on that I want to see the evidence that what you're doing is indeed paying off in terms of curtailing the spread of AIDS in terms of reducing the number of those who use IV's. I'm not so sure I agree with you and I'm giving you this word to pass on up and I really think that the Director might be more in agreement with this report than you're able to say right now. But I really think we have an epidemic on our hands, and I just haven't seen the evidence coming out of the Department that what is being done, and it's early I understand, is really recognizing

what level of emergency we are at at the current time.

So just pass that word on that we're going to be asking for documented evidence that the efforts through the Department are really paying off.

MS. CONROY: I really hear you, Senator Watson. I'd like to say a couple of things. One is a little bit off track, but I think if you looked at the National Household Survey on drug use we are seeing a drop in more recreational drug use. We still have hard core drug users, people that are addicts --

SENATOR WATSON: For California, for the city of Los Angeles, San Francisco, Richmond, Oakland?

MS. CONROY: For California as a whole.

SENATOR WATSON: I would be very impressed if I could see that data on Los Angeles, San Diego, Richmond, you know, the areas where the drug use is high. When we see the national surveys they look at Podunk, Iowa, you know, sure you had five people on drugs,and now you have two. That doesn't really compare well with what we have here in California,and let's try to focus in on California, particularly the urban centers and see what we're doing in that regard.

MS. CONROY: Okay. The other thing that I wanted to say is the prior testimony that I skipped over was the millions of dollars that we've committed for

treatment and prevention for HIV testing, pre and post-counseling --

SENATOR WATSON: And I do log the work we've done to get that out to the Departments. It was a big fight and there were people who challenged us all the way, but the majority prevailed, and you now have the funds to at least get started. Now, I want you to track it very carefully because we will like to see the data and to see if the money we're investing is really paying off or have we invested enough.

These are messages to be taken back. Thank you so very much and we appreciate you waiting this long.

MS. CONROY: Thank you.

(Witness was excused.)

SENATOR WATSON: Doctor Horowitz, it is good to see you.

DOCTOR HOROWITZ: It's good to be seen.

SENATOR WATSON: Pull that mike right up.

STATEMENT BY DOCTOR THOMAS HOROWITZ, M.D.

DOCTOR HOROWITZ: It's good because of the time that 90 percent of what I wanted to say was said and I see no reason to go over it.

The two things we need to stress is that there are numerous myths out there. There is the myth that anything to help a drug user encourages their use, and this

has never been proven. There is the myth that drug users are incorrigible, and tests only at our Commission has shown that we can have good inroads into the heroin-using community. It's more difficult to hit cocaine use because of the nature of the drugs; and lastly, that anything we do will interfere with law enforcement. Obviously, we're getting into delicate areas here. Obviously, any plan has to be done in such a way that is rational, both from a public health viewpoint and a law enforcement viewpoint, but we've negotiated with law enforcement in many other areas, and there's no reason why we can't be on the same side, much as our outreach workers are seen as anti-drug people on the streets.

It is a very, very strong anti-drug message when you have community people, who are accepted in the community, saying we're not going to give you any morality; we're not going to give you any law; all we're going to tell you is that this stuff is bad; it can kill you. And, if you're going to use, protect yourself and more important, protect anyone you love. That's the message we have to get out onto the streets.

We're getting it there with our outreach workers, but we have 30 of them and that's, you know, not a significant number. We need to increase that; therefore, we have to look at needle exchange as a tool. Clean

needles are a tool in this war, but it still is not going to build a house. It has to be put in the framework. There has to be treatment on demand. There has to be health educators who are accepted in the community. We find the outreach workers are the most useful. There then have to be social service agencies that can work with the outreach workers because these are street people, frequently, people who aren't going to present to the facilities, who don't have easy access to telephones to make the appointments and don't have easy transportation to the facilities.

Additionally, there are the tools of education, teaching them how to clean syringes if they continue to use. When they're ready to go into treatment, how to get into treatment, and of course, it's pathetic but in L.A.; the best we can do is a three-week wait,and for a person with drug use disease,they are impulsive,and you've got to work with that impulse. When they have the impulse to use, they'll use. When they have the impulse to go into treatment, they'll go into treatment.

L.A. is a divided community and as such, as we look at this issue,we find there are different solutions in different communities,and you have to look at each community separately. It takes a different type of outreach worker with a different message with different

equipment, and the sad commentary is our hands are tied.

In Los Angeles we have not come to a conclusion that a needle exchange program would be a major tool. It definitely wouldn't hurt,but I'm not sure it would be a major advantage,and I'm still learning about it,and I'm still studying it in each of the communities. What is sad is that in communities which are convinced, such as San Francisco, to have their hands tied is pathetic. That is really what I feel today is all about. If we're going to have a state policy,it has to be a state policy that gives a path of least resistance to treatment programs and to all the tools they need, and if we're going to have just a local issue, the state policy has to allow it to be a local issue without the hands being tied.

With the support of the Pharmacy Board, with the support of the medical community, I believe that a credible plan can be developed which will have limitations so that it would not become a tool for the drug user but stay what it needs to be, a tool for drug treatment. A person who uses drugs is going to afford those drugs through criminal activity frequently or through prostitution or through other acts that spread the virus, and that is what it's important. If we can clean the streets of the AIDS virus,it's safer for all of us, including law enforcement, including our paramedics,

including our emergency room personnel.

We have to look at this issue rationally rather than emotionally. Unfortunately, it's emotionally charged. I cannot tell you what the Commission's stance will be as time goes on. As it is now, we feel we get more "bang per buck" from our outreach workers, but as I said, there are communities where this may be a tool that can help them. I don't know that, but it's sad if we make this decision, our hands would still be tied.

SENATOR WATSON: Doctor Horowitz, I wonder if you'll stay seated, and I'd like to hear from the next two presenters, and maybe we can have an exchange as to how we'd work with them.

The next two are Doctor Bruce Mitchell, Commanding Officer of the Narcotics Division, Los Angeles Police Department, and Commander Larry L. Anderson, Chairman of the Los Angeles County Sheriff's Task Force.

Is Commander Anderson here?

MR. ANDERSON: Yes.

SENATOR WATSON: Would you come and join us please, and we'll take you as a panel here.

All right, Captain Mitchell.

STATEMENT BY CAPTAIN BRUCE MITCHELL

MR. MITCHELL: Thank you very much for inviting me to speak in front of the Senate Health and Human

Services Committee.

Since I was invited here to speak I'm going to speak as a law enforcement professional, and address the IV drug abuse problem from that perspective. That includes what I believe the effect on the crime rate is, the laws, the victims and property loss.

The bottom line is the Los Angeles Police Department does not support any form of a needle exchange program, and I'll explain a little bit why we have that position.

As you know, it's currently against the law. There are a number of Health and Safety Code Sections that prohibit the possession of hypodermic needles and many other "paraphernalia", but to support any kind of a program like this is, in effect, giving tacit approval to drug addicts and users and indirectly supporting the sellers of those illicit drugs. As law enforcement officers, we cannot condone breaking the law by supporting drug abuse in order to solve a health problem.

The City's crime rate under this program, as it is right now, would just continue to remain unacceptably high. Citizens would still be vulnerable as victims and the property loss due to all types of theft crimes would continue. IV drug usage has a direct correlation to the crime rates of the crimes of robbery, burglary, theft,

receiving stolen property, prostitution and shop lifting.

Because of the addictive nature of the heroin addict, who is your typical IV drug user, they commit many more crimes then the typical non-drug user. The typical heroin user has a habit of approximately $100 to $150 a day to support his habit, and to support that habit, he has to steal anywhere from $300 to $400 worth of property that belongs to the citizens of the country, the city, or our community to support that habit. They're stealing from the good citizens of this city to support their illegal drug habit.

I think the link between drug use and crime has been firmly established throughout the years, and one cannot be at the exclusion of the other. Localities expressing high rates of illegal drug use also experience high rates of criminal activity.

Some of the estimates that I've read on the number of IV drug users in the City of Los Angeles, vary from 60,000 to 100,000. I heard some testimony today about studies, and they indicate that there's no evidence that a needle exchange program would cause the crime rates to go up or IV drug users to increase in the number. How can they be so certain when the estimates are so wide, from 60,000 up to 100,000.

SENATOR WATSON: Let me ask you this. If

they already have a needle, and that's what I understand the exchange program is, they already have a needle and they're just replacing that needle, one for one.

MR. MITCHELL: And the way we see that, that's not going to stop your IV drug user from exchanging that needle with their other users. The way they typically use it—they'll purchase their heroin, that's usually right downtown here in Los Angeles, and they'll take five and six and seven people together; they'll go over in some corner where they are secreted from the public, and they will heat up that heroin; and they will inject it right there, and all six of those people will exchange that same needle. So whether they have that one needle that is left over from the previous shooting, or they have that needle that they're using for the first time, they're still going to share that needle.

I think it's unrealistic to expect each and every IV drug user to have a single needle that they use one time and only for themselves.

SENATOR WATSON: No, what I understand is that you don't get a new one unless you have one to turn in. So, if twenty people use it it's still the same needle, you know, they only get one needle.

MR. MITCHELL: That's correct.

SENATOR WATSON: You're not increasing the

number of needles in circulation. You're increasing the number of needles that are clean.

MR. MITCHELL: Or what are believed to be clean and they would only be clean at the time the first person uses the needle.

SENATOR WATSON: Correct.

MR. MITCHELL: Apparently there would not be more needles on the streets, from the program.

SENATOR WATSON: Right, that's what I understand from the program.

MR. MITCHELL: I don't contradict or argue that point.

With a needle exchange program, what is of concern to me as a law enforcement professional with 25 years in law enforcement is that our heroin use today is increasing. It's gradually increasing and has been increasing for the last few years.

SENATOR WATSON: Now, let me ask you. Do you think that's the result of a needle exchange program in San Francisco?

MR. MITCHELL: No. But it's a part of the problem in that heroin use is increasing, and at the same time, our IV cocaine use is increasing. They differ a little in that the typical heroin user will shoot up and then they'll nod off for sometimes as short as an hour,

sometimes as long as six and eight hours, something like that. It depends on that person's tolerance. Then they'll shoot up again, and they'll shoot up again. But what's of concern to me is the cocaine user now who's also using an IV, and by doing that, they have to shoot up much more frequently. Sometimes they'll have to shoot up as frequent as every 30 minutes to sustain that high. A needle exchange program is not going to help this type of a law enforcement problem.

SENATOR WATSON: But when you look at it it's not only a law enforcement problem, it's a public health problem too. That's what we're trying to solve. I understand that awesome problem law enforcement has to do. I understand also the epidemic nature of the problem in terms of AIDS and the spread of AIDS.

The reason why the Health Committee and not the Judiciary Committee is holding this hearing is because we are looking at it from a health standpoint.

MR. MITCHELL: I understand that.

In fact, that was the next point I was going to make.

SENATOR WATSON: Go ahead.

MR. MITCHELL: The department agrees that the AIDS epidemic is a major health problem affecting the entire U.S., and we feel that we have to have a strategy

that has a permanent solution; and the way to do that is through public education and some of the treatment programs that a number of your experts have already mentioned. The Los Angeles Police Department supports those programs. We're not opposed to any of the programs. We're simply opposed to the needle exchange portion of any of these outreach programs.

We have one program that we use in law enforcement. In the Los Angeles Police Department, we call it the DARE program.

SENATOR WATSON: I'm very much aware of that.

MR. MITCHELL: My colleague also has a program that is very much effective, and it is called the SANE program. They both are designed to reach elementary school children. What we tell those children is how to say "no". That's the message. We truly tell them how to say "no", and studies that have been conducted have shown that programs like that do work. Children who have been exposed to the DARE program are less apt to use narcotics than those who have not been exposed to it.

How do we tell a student at that age to say "no" and absolutely never use narcotics, but by the way, if you decide to use it, use a clean needle. I think as a professional we're losing all credibility with our children. We have to tell them don't use it. We can't

say don't use it, except if you do and add the needle program. It doesn't work that way. If we want to convince our children that narcotics use is bad, we have to tell them it's bad, and there are no exceptions. Then we have to have some treatment programs.

How law enforcement can help there is by when a person is identified as an IV drug user, we can see that they're directed from the criminal justice system, and they get that appropriate, permanent education, some long-term programs. And that's how we can help is in the identifying abusers.

SENATOR WATSON: I want to commend law enforcement for its DARE program. I have a lot of respect for that program, and it does pay off with young people. We are concerned about those adults now that can father or bear children, and what is happening to them, and how we address this challenge. It's bigger than all of us. Even with the use of crack cocaine, I'm listening and tuning in to what we did during the suffrage period and what we did with alcohol. I don't know how to win this war and I think in partnership, we can at least debate it, and that's what this is all about.

So, I want to thank you and Doctor Horowitz. When we finish with the next witness I would like you to comment.

Let me ask now for Commander Anderson to continue.

STATEMENT BY COMMANDER LARRY ANDERSON

MR. ANDERSON: Thank you, Senator. I'm Commander Larry Anderson from the Los Angeles County Sheriff's Department and for my statement I want to take about five minutes, Senator, if you'll bear me out.

The Los Angeles County Sheriff's Department opposes any amendment to existing law that would permit health authorities to have the discretion of providing a needle exchange or distribution to intravenous drug abusers. Of course, as you know, the current law in California does prohibit the distribution or possession of drug paraphernalia.

The underlying issue that we're dealing with today is really identifying and implementing programs that might be effective in reducing the spread of HIV among drug abusers. Needle exchange is only one alternative that is being experimented with in several communities in the United States. The first government-sponsored needle exchange program was initiated in New York City in 1988, and that report on results to date is not due until the end of this year. It's apparent, however, that the number of IV drug abusers in the program represent only a minuscule percentage of the number of IV drug users in New

York and we're not aware of any data that would indicate that needle exchange programs have been successful in reducing seropositive rates among addicts. To engage in further experimentation without valid information from existing programs, we don't feel would be prudent.

Needle exchange programs and needle exchange does not prevent the sharing of needles, as Captain Mitchell has mentioned previously. It's the sharing that spreads the virus. Sharing a new needle is just as dangerous a practice as sharing an old one. It's the sharing behavior that must be modified. Providing a new syringe is a method to allow a drug abuser to continue to use unlawful substances.

Let's consider the message the government would be sending out, especially to our young people after our pronouncement of a national strategy to wage an all-out war on drugs. Our people and our young people in society already receive too many mixed messages. We can't afford to compromise on this issue, and the message against drug abuse must be clear. It must be recognized that our drug problem is user-generated.

Lawful alternatives to expanding the availability of drug treatment programs must be thoroughly considered. The California Department of Health Services has reported that 92,000 to 95,000 persons are being

admitted into drug treatment programs yearly, with about 35,000 of those persons in publicly funded Los Angeles County Programs. Additionally, in a survey conducted statewide by the state health officials, in a representative sample 96 percent of the intravenous drug users recognized IV drug use as very related to getting AIDS. Ninety-seven percent perceived sharing dirty needles as being very related to getting AIDS. However, the practice of their high-risk behavior didn't seem to reflect that awareness. Again, supplying a clean needle when the drug abuser is sharing it with another is not going to solve the problem.

The drug problem is one of demand. The user is the basic problem in creating a market for illicit drugs and every action must be considered in preventing drug abuse and identifying those persons who need the treatment. Existing law prohibiting the distribution and possession of drug paraphernalia provides us a means to identify drug abusers so that judicial action can be taken. Perhaps mandatory drug treatment should be considered for those identified abusers who have not sought out voluntary treatment and assistance.

SENATOR WATSON: If I might just interrupt you. That's the kind of thing that I propose but they tell me that it's too costly. I wanted mandatory

treatment, but the state government or county government would have to then fund that treatment and supply that treatment. But I think that's one of the solutions to it also. And you heard the other witnesses say it's just not accessible.

MR. ANDERSON: That's the problem. Effective drug treatment programs need to be readily available to anyone requesting help and at little or no expense to that individual.

A significant legal question must also be addressed concerning any legal exchange program. Consider this question. If a government entity furnishes a device with the knowledge that it would be used to inject an unlawful and dangerous substance into the human body, that government entity may be liable for the resulting consequences including the death of an individual that could reasonably be expected from such activity.

The solution to the drug abuse and health problems is not in furnishing needles so that abusers can continue their lifestyles. If we as concerned citizens are truly dedicated to winning the war against drugs and stemming the spread of disease, we will strengthen prevention programs along with drug treatment availability and without compromising our existing laws.

SENATOR WATSON: I think you've raised some

points that we'll have to really consider. What we're going to do is pull together the laws in the other states where they do do legal exchange to see what the legal implications are when there are bad results. I think you hit on some legal questions that we have to look at.

MR. ANDERSON: May I address that just for a moment, Senator?

SENATOR WATSON: Sure.

MR. ANDERSON: Portland, Oregon has had a needle exchange program, and in the state of Oregon, there is no law against the possession of controlled, of needles, or it was very easy for them to implement a program. They had no law that prevented that position.

In Tacoma, Washington, I understand their program --

SENATOR WATSON: How does that exclude them from liability?

MR. ANDERSON: I don't know that it does. I don't know that it excludes anyone from liability.

SENATOR WATSON: Well we'll check with Oregon and see what their experience has been.

MR. ANDERSON: In Tacoma, for example, I know as was mentioned earlier by other speakers, I understand that that program was city-funded by the city of Tacoma for about $44,000; and the State's Attorney General has

recently ruled that the decision by the State Health Officer was improper, and it was unlawful; and he has ordered that that program be shut down as far as expense to the City of Tacoma. That issue is in the courts in the State of Washington right now.

Boulder, Colorado was also mentioned a little earlier. That activity as far as the distribution of needles is against the state law in Colorado,and the District Attorney in Boulder, Colorado, I understand, has given his permission for the health officials to engage in the program and indicated he would not prosecute those individuals for distributing needles to the IV drug abusers.

New York is another matter. There is all manner of law,and all of the programs that were mentioned in foreign countries, again, there's all manner of law, all manner of culture, of social practice, grown up through decades, and I think that it would be very imprudent for us to base our programs against the practices of some of those countries where their laws and social practices are quite different from ours.

SENATOR WATSON: I don't think that's our intent at all. Our intent is to find out what the other states are doing and their experience.

I want to thank you two, and if you'll stay

there, I'd like Doctor Horowitz, since you mentioned law enforcement in your presentation, a way of working with law enforcement to work out some of the problems, I thought you might like to comment on what you've heard. I think they've stated their positions rather well.

DOCTOR HOROWITZ: Of course, as I said, I'm not a proponent of needle exchange. I am a proponent of public health authorities having the ability to do what they deem is necessary. In looking at our Committee, we have not seen this as a step that is appropriate for L.A. county. The reason being, I go out on the streets; I've seen the shooting galleries off skid row, and I'm not convinced that the needle would be used by one person as their prized possession. Some would, but some wouldn't; and the "bang for buck" I'm not sure is there. I'm still a proponent that if we teach them what treatment's available, what social services are available, other ways they can be more careful, but understanding there is no safe sex, there's safer sex. There is no safe drug use, there's safer drug use. And, understanding it's a cost benefit and they're playing Russian roulette, and the only difference is do they want to do it with a revolver until they're ready to get into treatment or do they want to do it with an uzi?

The fact is, if you use drugs long enough and

are involved in the activities it takes to afford the drugs, people are going to get AIDS. All we can do is educate them and hope they learn before it's too late. And as I said, my feeling is the outreach worker is the most important tool. Therefore, we're looking at two issues and law enforcement, yes, something like the DARE program. There's not enough money to do it right. We need more. That's where we can influence kids. From the South Pacific, "You've got to be taught before it's too late, before your six, or seven or eight." We have to get to them young, but then they go home and find parents who are using. We have 3,000 to 5,000 adolescents living on the streets around Hollywood who are into survival sex, into drug use. The DARE program won't work for them. We've got to find ways to get to them. We've got to find innovative ways of keeping them from getting AIDS. We have to find better ways to educate the prostitutes and the jobs.

SENATOR WATSON: Any suggestions or recommendations that any of the panel here might have?

DOCTOR HOROWITZ: As I said, I think the important thing is to have a dialogue and to start looking for answers that don't cripple either of us.

SENATOR WATSON: That's what we have done here today is to bring people from all sides of the issue

to take a look at it and discuss in a public forum.

I do thank all three of you and if you'd like to make a closing remark --

MR. MITCHELL: Senator, if I may, just another remark. I mentioned during my presentation that information that we had from the state of California indicated that now, at this time, 92,000 to 95,000 people, IV drug abusers, are being attracted into drug treatment programs in the state of California. Something is attracting them into treatment. However, I think what has to be looked at is that's a small number compared to what we probably have in the state of California. It been estimated that we probably have 120,000 in the Los Angeles area alone, but the point is, I think, that we have to look carefully at what kind of successes we're already having. What kind of programs do we already have? How can we strengthen those programs that currently exist and give those people a hand who are trying to get the job done right now?

SENATOR WATSON: I think people will go and seek help if they know about it and if they have hit that point where they reach out. What we need is the support, the commitment, and the advocacy. Law enforcement could be very, very helpful in asking that we have more money go in and more expertise go into these programs so we can

generalize them to the entire state. There might be a good program in the Bay Area, a good program down in San Diego, but we have the problem statewide, and we do need to have the correct appropriations to see that these programs are more successful.

So, you may close.

MR. MITCHELL: Excuse me, Senator Watson. With the President's new anti-drug program that is just published today, as I understand, hopefully there will be a lot more money for not only combat drug abuse, but for treatment programs also. I'm sure there is going to be some grant money available, and perhaps we could have some type of a program that could combine law enforcement and then track those people all the way through the treatment, and maybe that could be a pilot program.

SENATOR WATSON: Sure. Could you say that loud and long, please?

MR. MITCHELL: You bet I will.

SENATOR WATSON: Thank you. I appreciate all of you.

(Witnesses were excused.)

SENATOR WATSON: Finally, John Brown, the Director of a local Aids agency. Mr. Brown?

Mr. Brown will be our last speaker unless there is someone with just a burning desire to say something.

STATEMENT BY JOHN BROWN

MR. BROWN: Thank you, Senator Watson, for adding me to the agenda.

As the Executive Director of an agency that is involved in street outreach here in Los Angeles County and as part of a coalition of both county and state-contracted outreach programs here in Los Angeles County, one additional perspective I have as someone who has been involved in AIDS education and AIDS prevention since virtually beginning of the epidemic here in Los Angeles County, we really have adopted, and I have adopted, a pragmatic attitude toward these things. Of course, we support a needle distribution exchange type of program. I think what we see as a problem, or what our frustration is here in Los Angeles especially, in dealing with a very conservative Board of Supervisors that has authority over health policy, is that little things become very important, including terminology and the way things are being worded. I think a very good example of this is in the visualizations that come up when you talk about pro-abortion as opposed to pro-choice. Now here today you have heard no testimony at all that has talked specifically about needle distribution and its values alone as an intervention. It's all been in conjunction with a comprehensive program in which needle distribution

is certainly a part of. But condom distribution and bleach distribution is also an important part. There is no studies at all that have looked comparatively at the value of needle distribution as opposed to the value of condom and bleach distribution. It has all talked in terms of the impact that outreach, comprehensive outreach has had on affecting HIV infection in a given area.

Here in Los Angeles, we have, through necessity, have had to use a lot of very creative ways to do intervention. We're proud of the things that we've done even though we haven't -- talking about needle distribution is abstract -- we can't even distribute condoms and bleach in Los Angeles County. It may be, and we have experienced in the last round with the Board of Supervisors, that in fact, the inclusion of needle distribution and actually the focus of needle distribution on that outreach package, that comprehensive outreach package, in many ways led to a major kind of policy decision that prevented us from even using condoms and bleach. What our concern is, being out there daily is that we see very little possibility of anything happening the near future to really get needle distribution going as part of the comprehensive outreach that's happening in this state. But, at the same time, we're frustrated over the fact that we can't even get bleach and condoms out on

the street because it has been linked to this "package", much in the way, you know, early on abortion was linked to family planning. When the focus becomes, when you're talking about needle exchange, and what you're really talking about is comprehensive outreach, comprehensive AIDS outreach, because you're not talking about needle exchange alone, what you're doing is you're using terminology that incites a certain reaction. And, if, in fact, we can keep the perspective that certainly with all the best conditions, needle exchange would be a wonder thing to have as part of outreach, that really as Doctor Horowitz said, the most effective thing out there is the outreach worker. The person who is out there saying to these people, "we care", and anything we can give them, whether it's a needle exchange program or condoms and bleach, it's got to be looked at as what it really is. It's an AIDS outreach package, it's an AIDS outreach program.

The focus being on needle exchange programs as opposed to AIDS outreach programs might sound like a petty little point, but really it is our experience that we lost, and now we're talking about a year into this, that we lost the passage of condoms and bleach and the distribution of condoms and bleach over the needle exchange issue.

I would just like to say in closing, that we

appreciate you conducting these hearings and keeping this issue alive, and the leadership you have taken in regards to AIDS and substance abuse; and in the future if there could be more of an emphasis on the establishment of a definition of comprehensive AIDS outreach and the implementation of comprehensive AIDS outreach without necessarily always focusing on the fact that, or calling this a needle exchange program, even though needle exchange does need to be part of it.

SENATOR WATSON: I think we certainly get your point, and I think you're absolutely right. When we start breaking this program up in component parts and throwing up those red flags, we're in serious trouble with a moral outrage reaction. We do need to learn how best to describe what it is we want to do. And a comprehensive program certainly is what we would like to use as a goal.

As we conclude the hearing today, I just want to say that I think we are a little more enlightened. We certainly will take this information back to Sacramento. We'd like to call on you to assist us in thinking through what the program ought to be. I am not sure what kind of legislation will come out of today's hearing. I do know earlier this morning Senator Seymour's legislation was the focus of our hearing. This afternoon we talked about needle exchange, and we did talk about that because that is

a highly controversial program that is being casually or illegally operated on the streets, but one of great interest because it pretends to be,might be one of the facets of an overall program.

There will be continued debate. I thank you for spending the afternoon with us. I thank you for your testimony,and I will now adjourn this meeting.

(Whereupon, at 4:09 p.m., the above-entitled matter was concluded.)

CERTIFICATE OF REPORTER

I, DAVID ROSEN, an Electronic Reporter, to hereby certify:

That I am disinterested person herein, that the foregoing public hearing before the Senate Committee on Health and Human Services in the matter of the Evaluation of Needle Exchange Programs as a Way to Combat AIDS, was recorded by me and thereafter transcribed into typewriting.

I further certify that I am not of counsel or attorney for any of the parties to said hearing, nor in any way interested in the outcome of said hearing.

IN WITNESS WHEREOF, I have hereunto set my hand this 11th day of December, 1989.

David Rosen

DAVID ROSEN
Official Reporter