



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**



127988

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

127988

**U.S. Department of Justice
National Institute of Justice**

This document has been reproduced exactly as received from the person or organization originating it. Points of view or opinions stated in this document are those of the authors and do not necessarily represent the official position or policies of the National Institute of Justice.

Permission to reproduce this copyrighted material has been granted by

California Legislature

(Joint Publications)

to the National Criminal Justice Reference Service (NCJRS).

Further reproduction outside of the NCJRS system requires permission of the copyright owner.

Additional copies of this publication may be purchased for \$6.80 per copy from:

Joint Publications
State Capitol, Box 942849
Sacramento, CA 94249-0001

Please add California sales tax. Make checks payable to STATE OF 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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

I N D E X

<u>Speaker</u>	<u>Page</u>
George Clark	3
Michael Smith, M.D.	27
Mark Madsen	30
David Werdegarr, M.D.	39
Patricia Evans	47
Neil Flynn, M.D.	54
Jay Cavanaugh	60
Gil Gerald	70
Sherry Conroy	78
Thomas Horowitz, M.D.	82
Captain Bruce Mitchell	86
Commander Larry L. Anderson	94
John Brown	104

AFTERNOON SESSION

(1:35 p.m.)

1
2
3 SENATOR WATSON: Good afternoon and I'd like
4 to welcome all of you to this special hearing of the
5 Senate Health and Human Service Committee. We have
6 convened this afternoon to explore one question, "Are
7 needle exchange programs effective in combating AIDS?"

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

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

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

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

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

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

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

3 MR. CLARK: Yes.

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

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

10 SENATOR WATSON: Okay.

11 STATEMENT BY GEORGE CLARK

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

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

1 lives of hundreds of individuals. It's important that we
2 present these individuals into the process. This can only
3 remain an academic, moralistic and intellectual debate in
4 the absence of the injection drug users. The effects of
5 our needle exchange can be heard in the words of Nancy, a
6 32-year-old heroin user who has been using for 10 years.
7 She said this in a recent interview: "You know, a lot of
8 people here are using clean needles now, whereas before
9 they weren't. Everybody was sharing needles before. You
10 know, I've got to have my own because I'm positive, and
11 you know, if I didn't have them here they'd use mine; I
12 know it. But now it's not like that anymore." So, if you
13 listen to the information you get today from the different
14 presenters, present Nancy in your mind and the effect of
15 what having access to sterile injection equipment does to
16 her.

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

1 hundreds of thousands of syringes, and there is no evidence
2 that it promotes drug use. The number of drug users in
3 Amsterdam remains stable from the period of 1983 through
4 1988. The average age of an injection drug user has risen
5 from 26.8 in 1983 to 30.8 in 1988. That happened while
6 the percentage of young drug users, those are drug users
7 under the age of 25, diminished from 14.4 percent of the
8 injection drug-using community to 3.4 percent in '88.
9 This contradicts the argument that access to sterile
10 injection equipment will promote needle use among users.
11 The fact is that 38 percent of the people who participated
12 in Amsterdam's needle exchange have reduced their drug
13 use.

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

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

25 Prevention Point is a coalition of community-

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

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

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

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

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

10 Let's see, does this work?

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

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

17 SENATOR WATSON: Are they taking them?

18 MR. CLARK: Yes.

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

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

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

1 don't try to melt the metal.

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

8 SENATOR WATSON: Right, okay.

9 MR. CLARK: On November 2nd we began our
10 intervention. On that day we exchanged 13 needles. On
11 November 16th, 1989, so that's a year later, in a single
12 two hour period, we exchanged over 2100 syringes with more
13 than 360 individuals. That is in three locations in the
14 streets of San Francisco. In total, since we started in
15 1988, we have exchanged 31,448 syringes and have made
16 7,352 client contacts. These total client contacts, some
17 of them are duplicated, we can't tell how many are --

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

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

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

8 This is the take from that night where we did
9 2100 syringes so you can see.

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

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

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

23 The next slide please.

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

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

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

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

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

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

25 MR. CLARK: We have been hassled on two

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

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

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

14 MR. CLARK: This is the needle exchange.

15 SENATOR WATSON: Is that your vehicle?

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

24 You can go to the next picture.

25 SENATOR WATSON: So let me just ask you about

1 it. You have three people out there?

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

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

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

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

22 SENATOR WATSON: Are you camouflaging it,
23 disguising it?

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

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

5 SENATOR WATSON: That's unusual, for sure.

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

10 SENATOR WATSON: Oh, I see.

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

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

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

1 MR. CLARK: Yes.

2 SENATOR WATSON: And that's through the
3 donations?

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

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

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

19 SENATOR WATSON: Of course not.

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

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

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

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

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

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

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

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

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

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

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

12 SENATOR WATSON: Addictive personality?

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

19 SENATOR WATSON: What were you ingesting?

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

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

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

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

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

10 SENATOR WATSON: I do know.

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

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

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

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

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

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

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

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

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

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

8 SENATOR WATSON: Are you through with the
9 slides?

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

13 SENATOR WATSON: Okay, we'll let you.

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

18 SENATOR WATSON: Could we have the lights up
19 please?

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

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

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

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

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

25 SENATOR WATSON: How old is she?

1 MR. CLARK: 32.

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

4 MR. CLARK: Not as a heroin addict.

5 SENATOR WATSON: Does she have other
6 problems?

7 MR. CLARK: I'm not a clinician.

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

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

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

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

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

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

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

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

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

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

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

7 MR. CLARK: Exactly.

8 SENATOR WATSON: Okay.

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

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

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

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

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

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

23 MR. CLARK: Okay, right.

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

1 coming.

2 MR. CLARK: Okay, thank you.

3 (Witness was excused.)

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

10 STATEMENT BY MICHAEL SMITH, M.D.

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

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

25 You and legislature know somewhat about our

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

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

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

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

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

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

8 SENATOR WATSON: Very good.

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

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

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

18 STATEMENT BY MARK MADSEN

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

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

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

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

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

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

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

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

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

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

25 Most importantly, I think, the people who are

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

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

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

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

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

6 Doctor Smith you might like to comment.

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

22 SENATOR WATSON: It's like the alcoholic
23 anonymous mode.

24 DOCTOR SMITH: Absolutely the same thing.

25 SENATOR WATSON: Okay, let me ask you

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

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

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

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

20 SENATOR WATSON: I just threw that out.

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

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

4 SENATOR WATSON: Illegal use?

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

8 SENATOR WATSON: These are all potential
9 persons with AIDS?

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

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

16 MR. MADSEN: No.

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

18 SENATOR WATSON: Yes, 128,000.

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

23 SENATOR WATSON: This is high-risk behavior.

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

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

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

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

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

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

24 SENATOR WATSON: You got your point over.

25 DOCTOR SMITH: Thank you.

1 and AIDS expert.

2 SENATOR WATSON: Doctor Evans, welcome.

3 DOCTOR EVANS: Thank you.

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

7 SENATOR WATSON: Do we have a copy of that?

8 DOCTOR WERDEGAR: I have them here.

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

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

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

25 SENATOR WATSON: Have they ever considered

1 recycling?

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

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

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

9 SENATOR WATSON: What do they do with the
10 waste?

11 DOCTOR WERDEGAR: They are reduced to ashes
12 eventually.

13 SENATOR WATSON: What do they do with the
14 ashes?

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

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

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

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

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

1 about the epidemic.

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

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

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

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

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

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

1 testimony from the San Francisco Health Commission.

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

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

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

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

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

1 post-testing. How would you set that up?

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

4 SENATOR WATSON: Okay, very good.

5 STATEMENT BY DOCTOR PATRICIA EVANS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 I, as a practicing physician, really received no

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

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

12 SENATOR WATSON: Okay.

13 DOCTOR EVANS: So thank you very much.

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

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

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

8 DOCTOR EVANS: Thank you.

9 (Witness was excused.)

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

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

15 STATEMENT BY DOCTOR NEIL FLYNN

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

18 SENATOR WATSON: Can you summarize this?

19 DOCTOR FLYNN: I certainly can.

20 SENATOR WATSON: That would be very helpful.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 DOCTOR FLYNN: And I think it can be done.

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

24 DOCTOR FLYNN: Yes.

25 SENATOR WATSON: Thank you so much and we

1 appreciate the paperwork you've given us.

2 (Witness was excused.)

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

5 STATEMENT BY JAY CAVANAUGH

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

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

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

25 One of the things we saw was that we tracked the

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

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

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

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

1 fundamental ethical question.

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

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

14 SENATOR WATSON: Where was this research
15 done?

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

18 SENATOR WATSON: And where did it take place?

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

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

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

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

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

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

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

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

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

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

1 exchange program?

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

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

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

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

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

25 SENATOR WATSON: Are you clear whether the

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

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

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

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

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

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

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

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

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

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

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

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

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

15 MR. CAVANAUGH: Oh, it must.

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

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

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

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

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

15 MR. CAVANAUGH: Sure, yes we will.

16 SENATOR WATSON: Thank you very much.

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

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

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

23 (Witnesses were excused.)

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

1 Angeles, Gil Gerald.

2 STATEMENT BY GIL GERALD

3 MR. GERALD: Good afternoon.

4 SENATOR WATSON: Good afternoon.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 MR. GERALD: Yes, I would.

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

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

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

12 MR. GERALD: Yes, I have seen it.

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

16 MR. GERALD: Certainly.

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

19 MR. GERALD: Thank you, Senator Watson.

20 (Witness was excused.)

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

25 In the meanwhile, if Doctor Horowitz would come

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

3 STATEMENT BY SHERRY CONROY

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

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

9 MS. CONROY: Okay.

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

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

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

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

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

6 MS. CONROY: That's it.

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

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

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

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

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

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

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

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

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

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

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

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

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

13 MS. CONROY: For California as a whole.

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

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

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

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

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

13 MS. CONROY: Thank you.

14 (Witness was excused.)

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

17 DOCTOR HOROWITZ: It's good to be seen.

18 SENATOR WATSON: Pull that mike right up.

19 STATEMENT BY DOCTOR THOMAS HOROWITZ, M.D.

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

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

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

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

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

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

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

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

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

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

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

1 including our emergency room personnel.

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

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

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

18 Is Commander Anderson here?

19 MR. ANDERSON: Yes.

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

22 All right, Captain Mitchell.

23 STATEMENT BY CAPTAIN BRUCE MITCHELL

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

1 Services Committee.

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

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

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

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

1 receiving stolen property, prostitution and shop lifting.

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

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

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

25 SENATOR WATSON: Let me ask you this. If

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

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

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

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

24 MR. MITCHELL: That's correct.

25 SENATOR WATSON: You're not increasing the

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

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

6 SENATOR WATSON: Correct.

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

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

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

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

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

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

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

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

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

19 MR. MITCHELL: I understand that.

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

22 SENATOR WATSON: Go ahead.

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

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

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

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

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

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

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

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

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

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

1 Let me ask now for Commander Anderson to
2 continue.

3 STATEMENT BY COMMANDER LARRY ANDERSON

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

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

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

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

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

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

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

1 admitted into drug treatment programs yearly, with about
2 35,000 of those persons in publicly funded Los Angeles
3 County Programs. Additionally, in a survey conducted
4 statewide by the state health officials, in a
5 representative sample 96 percent of the intravenous drug
6 users recognized IV drug use as very related to getting
7 AIDS. Ninety-seven percent perceived sharing dirty
8 needles as being very related to getting AIDS. However,
9 the practice of their high-risk behavior didn't seem to
10 reflect that awareness. Again, supplying a clean needle
11 when the drug abuser is sharing it with another is not
12 going to solve the problem.

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

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

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

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

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

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

25 SENATOR WATSON: I think you've raised some

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

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

8 SENATOR WATSON: Sure.

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

14 In Tacoma, Washington, I understand their
15 program --

16 SENATOR WATSON: How does that exclude them
17 from liability?

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

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

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

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

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

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

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

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

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

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

25 The fact is, if you use drugs long enough and

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

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

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

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

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

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

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

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

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

6 So, you may close.

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

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

18 MR. MITCHELL: You bet I will.

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

21 (Witnesses were excused.)

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

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

STATEMENT BY JOHN BROWN

1
2 MR. BROWN: Thank you, Senator Watson, for
3 adding me to the agenda.

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

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

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

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

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

25 I would just like to say in closing, that we

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

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

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

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

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

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

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

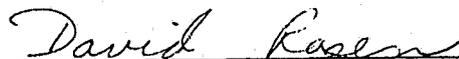
CERTIFICATE OF REPORTER

1
2
3 I, DAVID ROSEN, an Electronic Reporter, to
4 hereby certify:

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

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

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

16
17
18 
19 DAVID ROSEN
20 Official Reporter
21
22
23
24
25