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Initiating Needle Exchange Programs

A Look at Two Communities

All across the country, communities are struggling to carry out effective HIV prevention programs. Relatively few strategies and interventions to reduce the spread of HIV, especially among injection drug users (IDUs), have been developed. Even fewer approaches have actually been found to reduce the spread of HIV. This is due in part to the difficulty of demonstrating the effectiveness of an intervention in promoting behavior change.

More than almost any other intervention to prevent or reduce the spread of HIV, needle exchange has been closely scrutinized to determine program effectiveness. Studies of needle exchange program clients demonstrate decreased rates of HIV drug risk behavior although evidence of decrease in HIV infection is ambiguous. Despite growing evidence of effectiveness, most communities cannot legally operate needle exchange programs due to existing State laws that ban the distribution of needles and syringes for use with illegal drugs (drug paraphernalia laws) or laws that require a prescription to obtain needles and syringes.

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Because of these barriers, fewer than fifty communities have established legal programs. Some have sought changes to existing State laws, some have declared a medical state of emergency to allow them to use whatever public health measures are necessary to address the HIV epidemic, and others have found loopholes in the law, such as exemptions for research, that allow programs to operate. The development of these programs has been hampered by an additional barrier, a ban on the use of federal funds to carry out needle exchange programs.

Because of restrictions, communities may not consider needle exchange to be a viable HIV prevention program for drug users. Some communities have avoided addressing the restriction by establishing underground (illegal) programs. These efforts have been carried out primarily by activists and not local government or community-based organizations. Even when these programs are welcomed by the community, they can still encounter challenges due to their illegal status and frequently cannot offer the same range of services (HIV counseling and testing, referral to drug treatment and other services, safe injection information) as legal programs. The advantage of operating underground programs is that services can be initiated sooner by avoiding the sometimes long process of changing or circumventing state law.

Needle exchange is extremely important because AIDS is the leading cause of death for young adults in our city and the sharing of dirty needles is a major contributing cause of AIDS.

— Mayor Kurt Schmoke, Baltimore

Injection drug users are experiencing a rapid increase in HIV infection as compared to other populations and if infected, can pass HIV on to their sexual partners and unborn children. Communities need to consider carefully every option to reduce the spread of HIV among IDUs since delays in establishing effective interventions may result in an increase in the spread of HIV. This issue of *AIDS Information Exchange* explores how two communities, Baltimore and Chicago, established needle exchange programs. ❑

In Baltimore Needle Exchange is Public Health

For more than seven years, Mayor Kurt Schmoke has raised the issues of drug policy reform and harm reduction. As Mayor of Baltimore, a city of 736,000 with an estimated 48,000 heroin and cocaine users (the majority inject), it would be difficult to ignore the devastation caused by drug use. While in office, Mayor Schmoke has looked at the problem of drug use primarily as a public health issue, especially when it comes to the relationship between injection drug use and the HIV epidemic. He has taken the leading role in responding to the needs created by the twin epidemics.

It was not hard to convince people that a problem exists. The ravages of AIDS can be witnessed in many areas of the city. Sixty-one percent of new AIDS cases in the city in 1993 were among injection drug users (an additional eight percent of AIDS cases were the sex partners of IDUs and three percent were babies born to drug users or the partners of drug users). One quarter of the IDUs in Baltimore are estimated to be infected with HIV. Four new HIV infections occur each day in the city.

Mayor Schmoke looked to other communities for approaches to address the problem. "I studied needle exchange programs in operation in cities in the United States and Europe and was impressed with their effectiveness," the Mayor has said. Despite the controversy sometimes associated with the initiation of needle exchange at the local level, Mayor Schmoke proposed the establishment of a program. "Needle exchange is extremely important," argued Mayor Schmoke, "because AIDS is the leading cause of death for young adults in our city and the sharing of dirty needles is a major contributing cause of AIDS."

Background

Over the course of the HIV epidemic, Baltimore has had an array of outreach programs targeting IDUs and has conducted several studies of the IDU population. More than three years ago, the Mayor and the City's Health Department began to explore the possibility of establishing a needle exchange program as a way to stem the spread of HIV among drug users. The most significant barrier to the establishment of a program was Maryland's drug paraphernalia law (needles and syringes were classified as paraphernalia in the mid 1980s). The law includes restrictions against possessing, distributing or selling needles and syringes if there is reason to believe that they will be used with controlled or dangerous substances. Under the law, anyone (including medical practitioners or pharmacists) who distributes clean needles to drug users could be charged with a felony if caught. In order to establish a needle exchange program, Baltimore needed to gain an exemption from the paraphernalia law.

Taking Needle Exchange to the State Legislature

The Baltimore Health Department took the lead in lobbying the State legislature and building support for needle exchange in the community. In 1992, a bill was introduced in the Health Committee of the House of Delegates (the lower house). The bill was widely criticized, with much of the opposition based on the fear that needle exchange would appear to condone drug use. There was no vote on the bill. According to Dr. Peter Beilenson, Commissioner of Baltimore's Health Department, "People really didn't seem to understand the intent of the program."

The following year, the bill was brought up in the House Judiciary Committee (because it dealt with changing an existing law). Although there appeared to be a greater degree of understanding of needle exchange as an HIV prevention measure, the bill was defeated by four votes. Up to this point, Governor William Donald Schaefer had not supported needle exchange.

In 1992 and 1993, there was already a certain level of

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HIV-related knowledge among the legislators. Each year a briefing on AIDS is held for legislators in order to increase their knowledge about the issue. But needle exchange was missing from these briefings and legislators lacked information about needle exchange as an HIV prevention measure and how it would fit into the City's overall HIV prevention efforts.

To compensate for this obvious lack, information about needle exchange was integrated into subsequent briefings on HIV/AIDS. As time went on more and more legislators became aware of the devastating impact of HIV in Baltimore and among them there developed a greater understanding of needle exchange as an HIV prevention measure.

Convincing the Legislature

In 1994, Mayor Schmoke made the establishment of a needle exchange program in Baltimore his top legislative priority. "This was his number one issue, even above education, funding issues and crime. He made this very clear," says Commissioner Beilenson. Unlike the previous two attempts, the Health Department took the lead role in lobbying the Legislature. The Health Department stressed that needle exchange is an HIV prevention measure and a public health necessity, emphasizing the devastating impact of HIV in Baltimore and the savings in medical costs that could result from preventing the spread of HIV.

Health Department representatives made individual visits to almost all the 180 Legislators and worked closely with the chairpersons of both the House and the Senate Health Committees. The Health Department used data from a CDC-funded study that was released in September 1993 and Commissioner Beilenson credits the information as instrumental in persuading legislators of the efficacy of needle exchange. The report, "The Public Health Impact of Needle Exchange Programs in the United States and Abroad," prepared by the University of California, Berkeley, School of Public Health and the Institute for Health Policy Studies at the University of California, San Francisco, was instrumental in answering some of the Legislators' questions about the impact and the efficacy of needle exchange. The report states that needle exchange programs are cost effective, do not increase drug use, serve as a bridge to other services (including drug treatment) and most likely decrease the spread of HIV among drug users.

Other important factors in the lobbying effort were the specific components of the proposed program and the funding source for these activities. The City of Baltimore pledged to provide all the funds for the program and establish up to 200 new drug treatment slots for program participants who wished to be referred to treatment. According to Commissioner Beilenson, "Big cities are frequently characterized as asking States for financial help. This time we were able to say 'We'll take care of the program. All we are asking you to do is to change the law so that we can legally carry it out.'" By establishing the treatment slots, Baltimore was able to counter arguments that resources could be better spent on drug treatment or that the exchange program was propagating drug use and promoting genocide (common arguments in debates about needle exchange).

The Health Department also consulted with needle exchange programs (New Haven, Philadelphia and others) in other communities for answers to some of the questions Legislators raised. One concern was that the program would act as a magnet and draw drug users from other communities. Other programs reported that they drew from approximately an eighteen square block area around the site, and since the two largest cities near Baltimore, Philadelphia and Wash-

The Importance of the Mayor's Leadership

Mayor Schmoke's determination to establish a needle exchange program was vital to the lobbying process and to building support for needle exchange at the local level. According to Commissioner Beilenson, "The Mayor has really made substance abuse a centerpiece of his Administration and his feelings have translated over the last couple years to people looking at drugs as more of a public health problem than a crime problem. When you look at it as a public health problem it leads toward a more humane attitude toward people. People look at it as a problem that needs to be treated."

Not only does the Mayor intend for the program to meet Baltimore's needs, he also hopes that the effort will further demonstrate the effectiveness of needle exchange as an HIV prevention measure. "We intend to show that needle exchange programs are effective in reducing the incidence of AIDS without encouraging greater use of illegal drugs," says the Mayor.

ington, D.C., both have programs, the Baltimore program would not be drawing IDUs from other urban areas where injection drug use is more prevalent than in the suburbs and in rural areas.

Baltimore's prospects were further improved when the Governor indicated that he would consider approving legislation allowing needle exchange in Baltimore in early 1994. The State Secretary of Public Safety (responsible for the state police and correction system) and the State Secretary of Health along with several other members of the Governor's Cabinet also expressed their support for needle exchange.

Changing the Law

In March 1994, the bill (Senate Bill 402) passed the House by 84-51 (with all but two of Baltimore's 27 member delegation endorsing it) and in the Senate by one vote. The law allows Baltimore to establish a pilot needle exchange program.

Three delegates gave impassioned pleas during the floor debate. Elijah E. Cummings spoke about the impact of HIV on his district, which leads the State in AIDS deaths. Offering another perspective was Clarence Davis, who acknowledged that the bill was not a comprehensive answer to the drug problem but that it would allow his community to keep the streets and parks free of needles. Perhaps the most persuasive statement came from Ruth M. Kirk, who had never spoken on the floor in over a decade as a delegate. She stated that she believed two of her brothers had died of AIDS.

Governor Schaefer signed the bill into law in May. He said, "It is so easy to say no, stay the same, don't take chances, not be progressive." Effective June 1, 1994, the law exempts needle exchange program participants and staff from prosecution under drug paraphernalia and controlled paraphernalia restrictions against possession of hypodermic needles and syringes within the City of Baltimore. Under the law, needles and syringes obtained from the program cannot be redistributed by participants to individuals not taking part in the program. This is to encourage drug users to come to the exchange so that they can access the array of services offered.

Needle Exchange is Cost-Effective

- The total lifetime cost of treating a single adult AIDS patient is $102,000.
- The cost in the first year of life of treating a single child born with AIDS is $210,000.
- Baltimore's pilot needle exchange program will serve approximately 1,000 addicts at a total cost of $160,000 (all from City general funds). Therefore, if only two adult cases of AIDS are prevented, **the pilot program will save the State money** (since the vast majority of AIDS care ends up being covered by Medical Assistance or is passed on as uncompensated care).
- In New Haven, a needle exchange program has been operating since 1990 and has resulted in a 35% decrease in the risk of HIV transmission among participants. With a 4% seroconversion rate per year among injection drug users in Baltimore, such a result with Baltimore's proposed initial pilot **would result in savings of approximately $1 million per year.**
- If just a third of Baltimore's uninfected injection drug users are eventually enrolled in a needle exchange program (far lower than the 60% of injection drug users enrolled in New Haven), **approximately 125-150 new HIV infections would be averted per year, saving approximately $12.5 to $15 million in public health care expenditures.**
- The money saved by this program would be put to good use in providing **additional substance abuse treatment slots to help more addicts become drug free.**

Taken from Baltimore City AIDS Prevention Needle Exchange Pilot Program Fact Sheet

Looking Back on the Lobbying Effort

Other cities have taken different routes to circumvent State laws that prohibit the distribution of needles and syringes. Perhaps the most well known is San Francisco where Mayor Frank Jordan declared a public health state of emergency in order to operate a needle exchange legally within the city and provide the program with public funds. Other communities have considered suing the State, arguing that needle exchange is necessary to stop the spread of AIDS. While changing the law takes time, it will hopefully ensure that there will be no further legal entanglements once the program is established and that the program will be insulated from changes in the political climate in the future. For other communities contemplating changing State laws, Commissioner Beilenson has the following advice:

Do a lot of the ground work first and don't just go to health organizations and institutions but go to other community groups like religious groups and business groups. Explain the rationale behind the program and be prepared to address questions about needle exchange condoning drug use. Stress that needle exchange is an AIDS prevention program that will be tied to drug treatment if at all possible. Also, stress the economics of needle exchange and the possible cost savings. Emphasize that needle exchange is a health issue and not a criminal justice issue.

Starting the Program

After the three-year lobbying effort, the Health Department was eager to get the program in place (services were initiated in mid-July). The legislation called for an advisory committee appointed by Mayor Schmoke to recommend a protocol to the Commissioner of Health. The law stipulated that the protocol include:

- Program operating procedures for the furnishing and one-for-one exchange of hypodermic needles and syringes to injection drug users;
- A community outreach and education program; and
- A protocol for providing a linkage for program participants to substance abuse treatment and rehabilitation.

The advisory committee includes representatives of the State Secretary of Health, the State Secretary of Public Safety, local representatives from the health department and the police department and current and former IDUs. From the very beginning of discussions about needle exchange the Health Department sought a wide range of input including current and former IDUs, State and local police, the State's Attorney, public health representatives, researchers, and Health Department representatives.

The Health Department had already developed a protocol and presented it to the advisory committee. Although there was some discussion about it, the committee was receptive to the Health Department's program. One concern was the number of needles that participants can exchange. While the program's aim is to make as many sterile needles as necessary available in the community, there was concern about the possibility of abuse if no cap was established on the number of needles clients could exchange. Without a cap, needles could be sold on the black market or participants

Program Philosophy

While the NEP does not condone drug use, it also does not condemn its IDU clients, and that is important. The program seeks, through both formal protocol and the less tangible actions of staff, volunteers and advisors, to create an atmosphere that encourages compassion, self-respect and positive action within the IDU community. The NEP is designed to encourage participants to examine and take responsibility for their lifestyle choices, and create options for those who decide to make positive changes.

Program Goals

- To slow the spread of HIV infection within the IDU population and their contacts by providing relatively easy access to sterile needles and by teaching risk reduction methods.
- To evaluate the effectiveness of needle exchange in reducing the incidence of new infections among participants with minimal intrusions into the rapid and anonymous needle exchange process.
- Establish links between IDUs and drug rehabilitation and primary medical care.

might exchange for others who would then not have access to the additional services offered by the NEP. The advisory committee recommended that the program start out with no cap on the number of needles and then reassess the feasibility of unlimited exchange after the program has been in operation for a time.

The Final Product

During the first year of the pilot project, the Health Department anticipates serving 700 to 1,000 participants. The program can be expanded to meet demand if resources are available. The Health Department originally planned to run the program from a fixed site, possibly a renovated row house. After studying programs in other cities, it opted for a recreational vehicle (RV) with regularly scheduled stops. Not only is the RV less expensive (a one-time cost vs. monthly rent), but it also provides more flexibility in selecting sites, allows the program to serve more than one area, and avoids locating the program directly next to another building that may house a business or residence.

The following factors were considered in determining the RV stops: central location in area of high prevalence of injection drug use; convenience to other providers of social services (e.g., substance abuse treatment, HIV, TB, STD care and additional social services); and local community response to the program. Services are currently provided at two sites. The Health Department hopes to add additional locations in other parts of the city.

The program provides the following materials and services to participants:

Materials Dispensed

- needles and syringes
- safe disposal containers
- safe needle use pamphlets
- AIDS prevention program fliers
- condoms
- HIV/AIDS resource booklet
- carrying case (for syringes)

Services

- HIV counseling and testing
- TB skin testing and referral to chest clinic
- Syphilis serology
- referral to STD clinic
- drug treatment intake documents
- drug treatment referral
- case management

The program staff conducts the initial screenings (for HIV, TB, STDs) and then makes referrals to other providers in the city for additional services as needed. Extensive counseling and services are not provided in the RV.

Evaluation

The Baltimore program will be evaluated on two levels. Basic demographic data are collected on all partici-

Partial List of Organizations Supporting Needle Exchange in Baltimore

Medical and Chirurgical Faculty of Maryland
Baltimore City Medical Society
Maryland Chapter of American College of Emergency Physicians
Maryland Alliance for Healthcare (comprised of Med Chi, Maryland Hospital Association, Medical Data Analysis Corporation, Blue Cross Blue Shield of Maryland, Maryland Nurses Association, Maryland Association of Health Maintenance Organizations)
Mid-Town Churches Community Association
Advocates for Children and Youth
Baltimore Jewish Council
National Black Women's Health Project/Maryland Public Policy Committee
Baltimore City Substance Abuse Directorate
University of Maryland School of Medicine Adult HIV Program
Johns Hopkins School of Hygiene and Public Health, Program of Infectious Disease
Mayors AIDS Coordinating Council
Liberty Medical Center
Mercy Medical Center
Bon Secours Hospital
Sinai Hospital of Baltimore
Francis Scott Key Medical Center
Mid-Atlantic Association of Community Health Centers
Baltimore Medical Systems, Inc.
AIDS Service Providers Network
Maryland Nurses Association

pants. Participants are given coded identification cards (the participants' names do not appear) that allow the program to track frequency of use.

A more detailed evaluation of the program is being carried out by Dr. David Vlahov of the Johns Hopkins School of Hygiene. Participants are tested for HIV and their needles are more closely analyzed to determine if needles have been shared. Participants are also followed in and out of treatment. User surveys are planned to determine if the program is user-friendly. Participants are paid to participate in the larger evaluation. Because there have been numerous studies carried out on the drug using population in Baltimore, the Health Department believes that participants will not be intimidated or deterred by the evaluation measures. An ongoing study by Dr. Vlahov of IDUs in Baltimore has over 2,000 participants.

Building the Support of the Community

There was never any organized opposition to needle exchange in Baltimore. According to Commissioner Beilenson: "Because the Mayor has been talking about drug policy reform and harm reduction for seven years now, I think people realize, and they see everyday, what problems substance abuse and AIDS are for Baltimore. So it was not hard to sell and we have received very few negative calls and letters in the last year."

During the last year of the lobbying effort, every time Commissioner Beilenson spoke to a community group he discussed needle exchange and asked the organization for a letter of endorsement. The Department of Health collected dozens of letters from community and religious organizations, business groups, community health centers and hospitals. Although most organizations were receptive to needle exchange, they still had questions about the program, such as the location of the sites and the drug treatment services. The overall attitude of community groups, according to Commissioner Beilenson, can be summed up as: "It is not going to hurt and it will probably help."

When it came time to implement the program, communities were eager to have the services located in their area. "We had the reverse of a NIMBY (not in my back yard) problem. We had communities asking for needle exchange programs to be located in their community," says Beilenson.

Even groups that in some cities have not been receptive to needle exchange programs have voiced their support for the program in Baltimore. The Health Department has had strong support from the Police Department. The Chief of Police was involved in the planning and the District Commanders attended briefings on the program and have expressed their support. The Department is making a video about the program to educate line officers and inform them of the Department's policy not to interfere with the services provided by the exchange or intimidate participants.

Drug treatment providers have also been very supportive. A coalition of drug treatment providers sent a letter of support to the Health Department. Commissioner Beilenson worked with the coalition to determine where the additional drug treatment slots to serve needle exchange participants should be placed. The additional slots were divided among two service providers. "There wasn't even a turf battle." says Beilenson. ❑

CRA Sees the Need and Acts

Most needle exchange programs in the country have been brought about in one of two ways, either through a long process of building community support and legislative action or through acts of civil disobedience designed to draw attention to the issue as much as deliver services. The Chicago Recovery Alliance (CRA), which now exchanges more than 20,000 syringes a week, did not follow either of these paths when initiating their efforts.

Chicago has an ongoing need for HIV prevention efforts targeting injection drug users (IDUs). There are an estimated 60,000 injectors in the city and as of March 24, 1994, 35% of the city's 8,393 cumulative AIDS cases were among injection drug users.

The ground work for CRA's efforts had been laid by an extensive research project initiated in 1986 at the University of Illinois Chicago, School of Public Health, and funded by the National Institute of Drug Abuse (NIDA). The research project consists of street outreach to injection drug users using an indigenous outreach model (outreach education is conducted by ex-addict peers). During the street encounters, outreach workers help IDUs to recognize risks in their own lives, discuss ways to alter behavior to minimize risk, and

discuss and demonstrate risk reduction measures such as the use of bleach to clean syringes. Each year the outreach workers have over 100,000 contacts with approximately 15,000 drug users.

The same researchers are also conducting a longitudinal study on HIV seroconversion in IDUs. Since 1988 they have followed 1,000 IDUs (350 were already infected with HIV) to determine if the interventions are successful in promoting behavior that reduces the spread of HIV, and in actually cutting the rate of new infections. Over those four years the IDUs studied went from 100 percent to only 14 percent engaging in risky injection practices, like needle sharing, and the seroconversion rate decreased from 10 percent per year to under two percent, a dramatic drop in the rate at which people are becoming infected with HIV. According to Mary Utne-O'Brien, Ph.D., who oversees the study, the researchers consider needle exchange to be a logical complement to their street education outreach work. But restrictions prohibiting the use of federal funds for needle exchange prevented the integration of needle exchange into the study's activities.

From Concept to Action

CRA was started in January 1991 by a group of sixteen individuals who saw a need for an organization to bring together the issues of HIV and recovery from drug problems since HIV organizations tended not to address issues of recovery and drug treatment programs often were not equipped to deal with HIV. Fifty to 75 percent of CRA's original members were living with HIV, half were in recovery and half were still using drugs. The organization draws some of its principles from the twelve-step philosophy, and administration is therefore minimal in order to keep the focus on the primary purpose of CRA and avoid getting caught up in organizational priorities.

CRA is committed to harm reduction (reducing the harm drug users do to themselves and their community through various measures) and defines recovery as "any positive change." Members identified needle exchange-centered harm reduction outreach as an important service that could protect the health of drug users and they were committed to making it available on a long term basis.

Exploring Legal Barriers

Illinois has both a prescription and a paraphernalia law. CRA worked with lawyers from the AIDS Legal Council of Chicago to determine if there were any way to carry out needle exchange legally. A provision in the law provides an exemption for research activities and carrying out needle exchange as a "research project" would be legal. Both participants and exchange program staff would not be subject to arrest based on their involvement in the program. CRA met with researchers from the University of Illinois at Chicago School of Public Health, who had been conducting extensive outreach on their own, developed a research protocol, and contacted existing needle exchange programs for advice on operating a program. According to Dan Bigg, CRA founder and current program administrator, "Based on this and a lot of fear we started."

Activities were initiated in January 1992. Three volunteers went to a site on the southside of Chicago and began exchanging syringes. The exchange was conducted from 1 p.m. to 3 p.m. on Saturdays. Prior to initiating the exchange, CRA volunteers had met with local police in order to explain the program and how to identify program syringes. With the exception of two donations from ACT-UP, the efforts were entirely supported financially by CRA members.

Because research had to be an integral part of its activities, CRA developed a protocol to collect information necessary to answer some basic questions about needle exchange. The researchers set out to determine if needle exchange was harmful, if it did any good, and if it was worth the resources required to carry it our. The researchers worked with CRA to set up procedures, design data collection forms, train volunteer staff and analyze and interpret data.

The exchange operated for five months without incident. In May, CRA received a grant from AmFAR which resulted in media attention. Up to this point most people were unaware that needle exchange was being carried out in the community. Once again the legality of the program became an issue and CRA met with the State's Attorney for further discus-

Reaching Women

CRA staff and volunteers are concerned about the small number of women accessing the exchange (twenty percent of exchangers in 1993 were women). They found that some men exchange for women who are reluctant to use the exchange themselves. CRA currently asks exchangers how many women they are exchanging for so that they can get an idea of the size of this hidden population.

ons. The determination was the same as before: needle exchange is legal as long as it is conducted in conjunction with research.

Health Department Role

When CRA was initiating these efforts, the Health Department maintained a neutral attitude toward needle exchange and remained uninvolved until Judith Johns became Assistant Commissioner of HIV/AIDS Public Policy and Programs for the Chicago Department of Health. Before coming to the Health Department, Johns had been a supporter of CRA's efforts. Shortly after she started, in November 1992, the local Health Department began providing funds to CRA to support its activities. The Health Department also provided CRA with condoms to distribute to exchangers.

Johns believes that one of the reasons there has been so little controversy surrounding needle exchange is that the Health Department has always been careful to present it as a public health issue and emphasize its role in HIV prevention efforts.

Developing a Responsive Program

CRA strives to make its services as responsive as possible to the needs of drug users. Not only is CRA's leadership mostly made up of drug users, people in recovery, and people living with HIV, but CRA relies heavily on Community Advisory Groups (CAGs) composed of exchangers. Meetings are held every three to four months and food is provided to encourage attendance. The CAGs provide invaluable input about the operation of the exchange and site selection.

As CRA expanded its efforts, some sites were less effective because they were established without the input of the advisory committee (when going into a new community CRA did not initially have access to potential exchangers who could provide the information necessary to select good sites). CRA found that exchangers were afraid to go to sites that were too close to areas controlled by gangs because they did not feel safe there. Clients also avoided a site located near an area where drugs were bought and sold because of the high level of police activity there. On the other hand, sites close to public transportation tended to be successful because clients can come from throughout the city, not just the immediate neighborhood. However, approximately 90 percent of the exchangers at the sites come from adjacent zip codes.

Interacting with the Community

Because of a conscious decision to begin exchanging without developing broad-based public support prior to initiating services, CRA began quickly and expanded rapidly. By the end of 1992, CRA was exchanging syringes at four sites in Chicago. Some organizations and community members supported CRA before it started to provide services, and as CRA expanded and more people became aware of the program, questions concerning the ethics or the efficacy of needle exchange never really arose.

CRA recognized the need to meet with community members such as churches, businesses and other service providers to educate them about their services even though there was no organized opposition to needle exchange. According to Bigg, "Almost everyone was receptive to the program once they understood what we were doing." CRA did not seek out controversy. "We were told on some occasions 'Don't

Who Supports Needle Exchange

Most needle exchange programs have encountered unexpected sources or support within their communities. While it is certainly true that there are people who have unlimited contempt for drug users, there are many who view drug addiction as an illness and feel compassion for those who are struggling with this problem. In working within communities, CRA was surprised by some of the supporters.

Many diabetics were supportive of CRA's efforts. Because of their access to sterile injection equipment, some diabetics who had been conducting their own informal "exchanges" were relieved that drug users would now have access to syringes through CRA.

Unexpected support also came from individuals operating shooting galleries. Many people were exchanging large numbers of syringes that they made available in their shooting galleries. To facilitate, and make safer, the collection of syringes, CRA began giving them sharps containers (special containers designed for the safe disposal of syringes). According to CRA staff, some of these individuals even brag that only safe injections take place in their shooting gallery.

meet with them. They will not support you.' and we did not meet with these people." states Bigg. If people had not voiced their opposition, CRA did not want to give them the opportunity to do so. The limited opposition to the program was mostly related to concerns about property values and the impact of a site in a neighborhood. CRA was very responsive to these concerns and worked with neighborhoods to come up with acceptable solutions. There was never organized opposition to CRA's efforts.

Interacting with Law Enforcement

Prior to initiating services, CRA met with police to inform them of the program and explain the nature of the planned research. This was an important step because the success of the program was dependent on police cooperation. Officers had to be educated about the program and the legal exemptions that apply to participants (officers cannot use participation in CRA's program or the possession of a program syringe as the sole basis for a stop, search or arrest). In August 1992, the Superintendent of Police issued a Departmental notice instructing officers not to use involvement with syringe exchange as the sole reason for a stop. CRA has kept the police department informed when procedures have been expanded or changed, so that line officers can be informed of the changes.

Ongoing communication with police has been essential. At one site participants reported incidents of police harassment. CRA went back to the police district in which the site was located and met with officers to provide them with more information about the program. After the meeting the incidents of harassment declined.

Supporting exchangers who do have problems with the police because of their involvement with the program is essential. To build the trust of the exchangers they must know that there are not risks involved in accessing CRA's services. "One hundred percent of the people that were arrested and charges made against them based on possession of program syringes got off, which inspired confidence among participants. However, we still have people who do not want to get involved in a visible program," states Bigg.

Reaction to Needle Exchange

Reactions varied from site to site. Clients were overwhelmingly supportive of CRA's efforts, though gaining the trust of exchangers took time. According to Bigg, there had been a history of service providers and researchers entering the community and providing services while they completed their research or for the duration of a grant and then leaving when their project was finished or the grant expired. "People didn't expect us to show up every Saturday like we did now for 32 months," states Bigg.

Other events, such as a major drug bust in the community where the exchange site was located during the first year, cast suspicion on the exchange (they were still considered outsiders). Some exchangers thought they might have been involved. CRA's ongoing dedication to providing syringes allayed fears.

While exchangers were supportive of CRA's efforts, other community members were not always receptive. Opposition was mostly related to concerns over the impact of the program on the community. Some people did not want the sites near their property, for example, fearing an impact on their own day-to-day living or that tenants or potential tenants would be driven away.

Expanding Research

CRA has expanded its research protocol in order to collect more information. Exchangers are now issued cards identifying them as participants in the program. Each exchanger has an individualized, anonymous code which allows CRA to collect more demographic information and to track usage. Before, CRA relied on marking syringes in order to prove program involvement. Because of the sheer volume of syringes that CRA is now exchanging, it is no longer practical to mark each syringe individually. Since February 1994, approximately 2,100 cards have been issued.

Because it was a serious departure from how the exchange had hitherto operated, the I.D. cards were pilot-tested. The researchers were concerned, based on their experience with the population, that many users who were not open with family and friends about their drug use would be reluctant to carry the I.D. card. Additionally, there was concern that the cards would be passed from user to user, which would prevent researchers from tracking specific individuals. After four weeks issuing more than 100 cards, CRA had encountered virtually no refusals nor problems relating to their use.

Clients have been receptive to the cards and collecting the additional information required has had no dis-

ernible impact on the provision of services. Police like them too because the I.D. makes it unnecessary for them to search participants and risk being stuck by a syringe.

Looking to the Future

Currently, CRA exchanges at seven sites and serves about 500 injectors directly and 1,000 indirectly a week. Program growth has been limited mainly by the lack of financial resources. Given the needs of exchangers and the demand for syringes throughout the city, CRA faces difficult decisions in terms of program growth. "If we were given additional funding," states Bigg, "it would be difficult to decide whether to expand services because our clients have needs in so many areas or to expand needle exchange efforts since we still are unable to meet demand."

After evaluating CRA's efforts for the past few years, Dr. Utne-O'Brien states, "I'd like to see CRA get more support and not have to work so hard to get funding." Increased funds would allow CRA to devote resources to train staff in providing more extensive education and referral at the needle exchange site. Utne-O'Brien stresses that because very few IDUs are in treatment, it is important to use other contacts with them, such as needle exchange, to deliver risk reduction messages and make linkages to the wide array of services this population needs. "This may be the only chance to reach them with a variety of public health messages," she states.

The Health Department's Judith Johns would also like to see CRA expand its efforts, with more sites and hours of operation and by increasing its interaction with exchangers in order to provide more risk reduction information and referral. Additionally, Johns would like to see more information about needle exchange directed to the general public. "CRA's activities are still seen as controversial by many, which makes it hard for them to raise the funds necessary to expand their efforts," says Johns.

The Wait for Drug Treatment

While CRA does not have the resources to provide services other than needle exchange-centered harm-reduction outreach, it makes informal referrals to other services. According to Bigg, "Since the exchange has opened it has gotten harder to get people into treatment. Even some private programs (where clients must pay) have started waiting lists. It is very hard to get into the types of programs people want, which is medical detox and methadone."

Access to drug treatment depends on who is seeking services and the kind of treatment requested. Pregnant women or people infected with HIV have an easier time getting into programs, and social-setting detoxification is more available than other types or treatment. "Very few people are interested in social-setting detox, or what some call 'cold turkey' detox. Treatment, like other services, must be attractive to the consumer," says Bigg.

"It is a horrendous experience getting into methadone treatment if you cannot pay for it. It takes about four to six weeks to get an appointment for intake, from then if everything works out the wait is six months or more but some people have withstood this. There is methadone treatment for pay. When we started the wait to get in was a day or two. Now it takes about two weeks," continues Bigg.

According to Bigg, each month between 30-40 people using the exchange express an interest in receiving treatment. At any given time about 100 people are at some stage in the process of getting into treatment programs and CRA assists between 5 and 15 exchangers access treatment each month.

The shortage of drug treatment and the desire of so many users of the exchange to access treatment is a sad but powerful testimonial to the need for needle exchange. There are people who want to change their behavior but cannot access the necessary services. Until they can, needle exchange can help them avoid becoming HIV infected.

Still A Lot to Learn About Preventing HIV Transmission

Needle exchange is often seen in shades of black and white. Not many people have mixed opinions about it. But even those who are strong supporters of needle exchange do not see it as a panacea for the HIV epidemic. According to Dr. Utne-O'Brien, "We need to know in the aggregate what is the impact of needle exchange."

CRA looked at reasons why some drug users did not access the needle exchange. Non-users often stated that proximity and convenience were crucial factors in their use of the exchange. Since eighty percent of those surveyed said that syringes could be obtained from other sources, some IDUs may not be motivated to go out of their way to obtain syringes from the exchange. There is also the possibility that the exchange may even promote sharing because users are more inclined to give away syringes when they can get more free. Utne-O'Brien emphasizes, "We need to see what people do with the needles after you give them to them."

Because needle exchange will never reach all IDUs, it is necessary to continue to provide information that will encourage and support the adoption of safer behaviors. Most supporters of syringe exchange agree that it needs to be part of a comprehensive approach that includes education, access to sterile injection equipment, and drug treatment on demand. ❑

Additional Publications on Needle Exchange from USCM

Needle Exchanges in New Haven, **AIDS Information Exchange** (March 1992)
Needle Exchange: Public Health and Politics, **HIV Capsule Report** (March 1992)
Needle Exchange: Evolving Issues, **HIV Capsule Report** (July 1994)
Needle Exchange: Moving Beyond the Controversy (September 1994)

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