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NEEDLE EXCHANGE, LEGALIZATION, AND THE FAILURE OF THE SWISS HEROIN EXPERIMENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY, INTERNATIONAL AFFAIRS, AND CRIMINAL JUSTICE

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

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NEEDLE EXCHANGE, LEGALIZATION, AND THE FAILURE OF THE SWISS HEROIN EXPERIMENTS

THURSDAY, SEPTEMBER 18, 1997

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON NATIONAL SECURITY,
INTERNATIONAL AFFAIRS, AND CRIMINAL JUSTICE,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 5 p.m., in room 2247, Rayburn House Office Building, Hon. J. Dennis Hastert (chairman of the subcommittee) presiding.

Present: Representatives Hastert, Souder, Barr, Barrett, and Cummings.

Also present: Representative Pelosi.

Staff present: Robert Charles, staff director and chief counsel; Ianthe Saylor and Sean Littlefield, professional staff members; Amy Davenport, clerk; Michael Yeager, minority counsel; and Ellen Rayner, minority chief clerk.

Mr. HASTERT. The Subcommittee on National Security, International Affairs, and Criminal Justice will now come to order.

Today, after holding nearly 40 hearings on drug policy over the last 2½ years, this subcommittee turns its attention to a new topic, needle exchange, legalization and the failure of the Swiss needle exchange and heroin experience. In this country, as in Switzerland, we have a host of serious social problems. Often these problems are linked, and that is incontrivably the case when discussing the spread of heroin addiction and the transmission of the HIV virus. I do not think that there is anyone in this room who would disagree with that assessment.

Unfortunately, it's not just the problems that are linked. Proposed solutions to heroin addiction and efforts to slow the speed of HIV are also linked. In the United States, as in Switzerland, those who care about having both the spread of heroin addiction and the spread of HIV and AIDS have been seeking compatible solutions. Unfortunately, as much as many would like to hope that needle exchanges or legalization of heroin is one such solution, I believe that the record is now clear that neither of these are moral compromises in a sense, and they are both ineffective in halting AIDS and heroin addiction. In fact, an overwhelming body of credible evidence now strongly suggests just the opposite.

In Switzerland, the needle exchanges placed the government in an awkward position of arresting people for heroin use and sale,

but not for shooting this illegal drug in the prescribed location. In fact, the government gave the addicts the needles they needed to shoot up the illegal heroin, often contributing directly to their premature deaths.

After a period of reflection, not unlike the period in Sweden between 1965 and 1967, the Swiss Government took the next obvious step. To avoid being a party to overdose deaths from bad, unregulated, and dangerous heroin, they decided to give away controlled pure heroin with their free needles. They continued to do this three times a day for addicts who want to shootup during the day in a safe place with clean needles. Those experiments, which have caused only 83 people in one location to exit the program out of 1,035 over the past 3 years, and some of those by dying, are hardly a success. Indeed, they are no more a success than the 14,000 methadone maintenance clinics now spread across Switzerland.

Now, the sad part of all this is that the Swiss people are, like the American people, proud, decent, compassionate, and moral people. The Swiss have resisted past national security threats, including Germany during World War II and cold war communism. This, too, is a threat to Switzerland's national security. They do not want to encourage growth in heroin addiction or methadone addiction, or as is now the case, mainline injection of cocaine, but they slipped down the slippery slope following whatever many told them was a justifiable moral compromise and one that would slow the spread of AIDS and drug abuse. They are now learning that such a compromise was ill advised. One hundred forty thousand Swiss patriots, many of them young people, have organized a referendum against the legalization of drugs for later this month. This is known as the Youth Against Drug referendum. I certainly commend the Swiss people for their courage and their convictions.

Let me make just two other short points: First, leading studies, including the Vancouver and the Montreal studies, featured in the British medical journal Lancet, show that needle exchanges, even without clean heroin giveaways, do not reduce the transmission of AIDS or HIV. In fact, as we will hear today, the incidence of transmission in these cities actually rose with the onset of needle giveaways.

Second, like many other issues we discuss in these Chambers, I think this is an issue that has enormous potential impact on a range of other issues. What we decide on needle exchange and heroin legalization will affect our social and moral fabric, as well as our national and community security.

There is a growing public push by well-financed drug legalization organizers to get America and Canada to follow Switzerland. That effort produced results in California and Arizona just last year. It will be capped next month by a conference in Colombia, one of the largest heroin-producing countries in the world. The conference, which is pushing for international legalization is openly financed by a prominent American and will reportedly be attended by Swiss Government officials advocating heroin legalization.

The point that we must not forget, and this is my chief message today, is that the road to tradition is paved with good intentions. Nobody in their right mind wants to see dangerous drugs legalized, a cure for HIV delayed, or more young people addicted to heroin.

Giving away free needles or doctor-injected heroin is simply, in my opinion, not a solution, not in Switzerland and not here. It is a fast track to moral corruption and the first step toward genuine disintegration of public security.

I would now like to recognize my colleague from Wisconsin, the ranking member, Mr. Barrett, for his opening statement.

Mr. BARRETT. Thank you, Chairman Hastert. It is a pleasure to be here tonight.

This is, no doubt, a very serious issue. It is a complicated issue. It is an issue that deserves our thoughtful attention. For some people, it is a case of pick your poison; for other people, it is an issue of personal responsibility; and for other people, the question is: What are we doing to save a life? I believe that this issue should be deliberated in a thoughtful manner.

Ironically, we had a vote on this issue last week. And now a week after the vote we are having a hearing on the same issue that we addressed on the House floor just a week ago.

I'm concerned with this hearing and the procedure of this hearing because I do not think that it meets the professional standards that we should expect from this committee and from all committees in this House. When this hearing was first scheduled, there was no attempt made at all to present a balanced view of this very serious issue. Minority members were not given adequate legal notice that this hearing was to be held, and we had frankly to scurry around at the beginning of this week to find a witness, fortunately a very good witness, to testify that there might be more than one way to look at this problem.

Monday we tried to reach the National Institutes of Health because we were given less than 4 business days' notice, 4 days' notice, to procure a witness for this hearing. I think, if we are interested, or if this committee were truly interested in having a balanced hearing, there would have been more of an attempt made to do this long before 4 days before the hearing.

I'm also hesitant, Mr. Chairman, but I feel compelled to bring up another issue. As I understand it, today one of our witnesses—and I welcome our witnesses from Switzerland—is here to testify before this committee. It's my understanding that there were several Members—I don't know who they were representing, if they were representing this committee, if they were representing themselves; they were Members of Congress who traveled to Switzerland last week, apparently at private expense, to meet with perhaps the group that is represented here today. I do not say that there was anything legally wrong in doing that, but I would ask that the record reflect what exactly happened there.

I do not think that this committee or any other committee should be used as any sort of instrument, and I want to make sure that there is no quid pro quo for a trip to Switzerland in exchange for appearing before this committee. Again, I'm not alleging that that is happening, but I think that there is a question that is raised here today.

I also want to thank my seat mate, Mr. Cummings, for obtaining the testimony we're going to hear today from Dr. Beilenson. It is my understanding that Dr. Beilenson runs a very good program in Baltimore, and I'm looking forward to hearing his testimony.

Finally, Mr. Chairman, I would ask unanimous consent that a report prepared by the Secretary of Health and Human Services be included as part of the record. This report, which was submitted to a Senate appropriations subcommittee, reviews existing research on the efficacy of needle exchange programs in reducing HIV infection and their impact on the illegal drug use.

And very finally, Mr. Chairman, having said that, I thank you for allowing Ms. Pelosi to join us at the dais today, and despite our bumpy road to this committee hearing, I'm hopeful that it will be a fruitful one for all of us.

Mr. HASTERT. I thank the gentleman from Wisconsin.

Mr. SOUDER. Reserving the right to object on the unanimous consent, I would then ask other members be allowed to submit other information too, because I think that would be the normal procedure.

Mr. HASTERT. Without objection, they may have 3 business days to enter information into the record.

I would also like to welcome the gentlelady from California, who is not a member of this committee, but certainly has an interest in this issue and certainly held the issues in very good debate form last week; and I can attest to that personally.

I would like just to comment, Mr. Barrett—and I'm sorry that there was some misinformation or miscommunication on this, but I went to Switzerland a year—or several months ago, last spring, also at the invitation of the office of the ONDCP, the drug czar, and the U.S. Department of State——

Mr. BARRETT. I'm aware of that.

Mr. HASTERT [continuing]. And this conference was a followup conference to that conference this spring. So if—if it would help you, we would be happy to put a—review or a program of that into the record.

Mr. BARRETT. I think that would be appropriate.

Mr. HASTERT. Fine.

[The information referred to follows:]

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II. Internationales Symposium gegen Drogen in der Schweiz

Samstag
Saturday

10.00 **Begrüssung**
Welcoming Address

Dr. med. Armin Oberle
Co-Präsident Schweizer Ärzte gegen Drogen

Dr. med. Giorgio Morniroli
Co-Präsident Schweizer Ärzte gegen Drogen

Dr. med. Giovanni Fantacci
Präsident AIDS-Aufklärung Schweiz
Einführung und Standortbestimmung

10.30 **Eröffnungsvortrag**
Opening Lecture

Professor Dr. Jeanne Hersch
Drogenlegalisierung –
ein Widerspruch zu den Menschenrechten
Drug Legalization – Incompatible with Human Rights

11.10 **Pause**
Break

11.20 **Vorträge: Aula**
Oral Presentations

Rauschgifte – Wirkungen und Folgen
Narcotic Drugs: Effects and Consequences

Prof. Dr. med. Gabriel G. Nahas
Drogen und der Niedergang des Westens –
Wie soll er gestoppt werden?
Drugs and the Decline of the West – How to stop the drift?

Dr. med. Karel F. Gunning
Erfahrungen eines Arztes in Marokko
Doctor in the Atlas Mountains

Prof. Dr. med. Ulf Rydberg
Schwedische Studien zu Cannabis und Schizophrenie
Studies on Cannabis and Schizophrenia in Sweden

Dr. med. Florian Ricklin
Persönlichkeitsveränderungen durch Drogen
Changes in Personality caused by Drugs

Dr. med. Dr. iur. Lothar Schreiber
Heroin – eine Gefährdung der Allgemeinheit
Heroin – Dangers for the General Population

Dr. med. Hansjörg Meier
Intoxikation durch hanfhaltige Lebensmittel
Intoxication by Food containing Cannabis

Prof. Dr. Renand Trouvé
Schädigende Wirkungen von Ecstasy
Damaging Effects of Ecstasy

11.20 **Podium: Saal**
Panel Discussion

Heroinabgabe und Suchtverlängerung
Heroin Distribution and Prolonged Addiction

Nationalrat Hans Fehr, AnnBritt Grünewald,
Prof. Dr. Jeanne Hersch, Dr. med. Hans Köppel,
Daniel Lüchinger, Prof. Dr. med. Alessandro Meluzzi,
Dr. med. Giorgio Morniroli, Olivier Panier,
Torgny Peterson, Prof. Dr. med. Richard Schwartz,
Prof. Dr. Dr. med. Peter G. Waser

11.20 **Workshop: Halle**

Drogenepidemie
und die Verantwortung der Medien
Drug Epidemics
and the Responsibility of the Media

Jean-Paul Vuilleumier
Einstieg in die Drogensucht und psychosoziale Ansteckung
Onset of Drug Abuse and Addiction and Psychosocial Contagion

Jonas Hartelius
Die sozialen Auswirkungen des Drogenmissbrauchs
Social Impacts of Drug Abuse

James L. Dandridge
Lateinamerikanische Städte gegen Drogen
Latin American Cities against Drugs

Jean-Philippe Chanaux
Drogenpolitik und Medien:
Requiem für eine Gegenmacht
Politique de la Drogue et Media: Requiem pour un contre-pouvoir
Drug Policy and Media: Requiem for a Counterforce

Anne de Vaureix
Die Bedeutung der Medien im Kampf gegen die Drogen
The Significance of the Media in Fighting Drugs

Claudio Sorrentino

N. N.

N. N.

12.45 **Mittag**
Lunch

14.45 **Vorträge: Aula**
Oral Presentations

Kritische Aspekte
zu Suchtverlängerung und Heroinabgabe
Critical Aspects on Prolonged Addiction and Distribution of Heroin

Dr. med. Ernst Aeschbach
Zur Wissenschaftlichkeit der Begleitforschung
der Heroinabgabe - eine Kritik
On the Scientific Value of the Research Studies Accompanying
Heroin Distribution - A Critique

Dr. med. Hans Köppel
Das politische Konzept der Überlebenshilfe
Harm Reduction as a Political Concept

Pfarrer Christoph Meister
ACL Schweiz – Gassenarbeit als Zeugendienst der
Freiheit in abstinenzfeindlichem Umfeld
ACL Switzerland and its Streetwork as Witnesses of Freedom in an
Environment Hostile to Abstinence

Professor Dr. med. Juan C. Negrete
Die Harm Reduction Bewegung – Bedenken eines Arztes
The Harm Reduction Movement – Concerns of a Health Professional

Sue Rusche
Legalisierungsbewegungen in den USA
Harm Reduction Movement in the USA

Dr. med. Francis Thévoz
Langfristiger intravenöser Heroinkonsum –
Schwächung der körpereigenen Abwehr
Injections répétées d'opiacés - action immunodépressive
Long-term IV-Heroin Use – Undermining the Immune System

AnnBritt Grünewald
Gefängnisse sind im Kampf gegen Drogen von
strategischer Bedeutung – Erfahrungen aus Schweden
Prisons are Strategic in the Fight against Drugs –
The Swedish Experience

Irving G. Tragen
Drugs and Society
Drogen und Gesellschaft

Saturday

14.45 **Podium: Saal**
Panel Discussion

Die schweizerische Drogenpolitik vor der Entscheidung: Internationale Erfahrungen

Swiss Drug Policy at a Crossroads: International Experiences

Nationalrat Toni Bortoluzzi, a.Ständerat Markus Kündig, Charlotte Cederschiöld MEP, Ernest Chénière, James L. Dandridge, Carl Cederschiöld, Jonas Hartelius, J. Dennis Hastert, Peter P. Rigby, Dr. med. Giorgio Salvadé, Nationalrat Jürg Scherrer, Nationalrat Alexander Baumann, N. N.

14.45 **Workshop: Halle**

Erfolge abstinenzorientierter Drogentherapien
Success of Abstinence-Oriented Drug Therapies

Robert J. Polito, Andrea Muccioli, Dr. med. F. Ricklin, Dr. med. Josef Nick, Dr. med. Bruno Frick

16.10 **Pause, Besuch der Ausstellung**
Break, Visit to the Exhibition

Samstag

16.40 **Vorträge, Saal**
Keynote Lecture

J. Dennis Hastert

Drogen – eine Bedrohung der nationalen Sicherheit
Drugs – Threat to National Security

Nationalrat Toni Bortoluzzi

Gesellschaftspolitische Veränderungen durch die Drogenpolitik
Changes in Society by Drug Policy

18.00 Führung durch die Altstadt von Zofingen oder Besuch der Ausstellung

Guided Tour through the Historic Centre of Zofingen or Visit to the Exhibition

19.00 Apero

19.30 **Gesellschaftlicher Anlass mit Abendessen**
(Tenue ungezwungen)

Evening Event with Dinner

Sonntag
Sunday

10.00 **Begrüssung**
Welcoming Address

10.10 **Vorträge, Saal**
Keynote Lecture

Franco Ballabio
Organisierte Kriminalität und Korruption
Organised Crime and Corruption

Daniel Schecter
Die Drogenpolitik der USA
und der Nationale Rauschgiftbekämpfungsplan
US Drug Policy and the National Drug Control Strategy

11.10 **Pause**
Break

Sonntag

11.20 **Podium: Aula**
Panel Discussion

Drogenprävention
Drug Prevention

Professor Dr. Hans-J. Bochnik
Freiheit von Sucht
oder Freiheit zur Sucht – ein Glaubenskampf?
Freedom From Addiction
or Freedom For Addiction – A Religious Battle?

J. Douglas Hall
Jugendliche, Eltern und Drogen in den USA
Teens, Parents, and Drugs in the United States

Dr. med. L. Merz
Drogenprävention aus psychologischer Sicht
Drug Prevention from a Psychological Viewpoint

J. Dennis Hastert

Dan Schecter

Nationalrat Toni Bortoluzzi

Professor Dr. Gonzales Miranda

Boris Piske

Mr. SOUDER. I ask—a parliamentary—it's not really parliamentary, just an inquiry.

This isn't likely to be our last hearing on needles ever either——

Mr. HASTERT. I certainly hope not.

Mr. SOUDER [continuing]. And wouldn't it also be true that whether or not legislation is passing on the floor, we're an oversight committee that looks into programs related to drug abuse at any time, and we'll continue to do that?

Mr. HASTERT. Let me just say for the record and just lay everything straight here, this committee has had a record of looking at drug issues, both prevention—we've had a very good record of passing legislation for drug prevention; we've looked at foreign source situations—and interdiction; we've been on the border. We've tried to do the things, hopefully, that save our kids. And we've had some very tough hearings with folks from Colombia and Peru and source countries.

And it will continue to be, as long as I'm the chairman of this subcommittee, the policy to have issues that deal with drugs, drug abuse, and drug prevention and to try to follow through, get as much information as possible, and move through it, that information, and recommend legislation as a result.

So without any further query or discussion, I'd like to recognize Congressman Barr for his opening statement.

Mr. BARR. Thank you, Mr. Chairman.

Just 3 days ago William Weld withdrew his name from consideration for United States Ambassador to Mexico. I supported that position, believing that he was the wrong man with the wrong message at the wrong time for the wrong job, messages that we do send our children such as, "Pot in certain amounts is cool," or "is a joking matter," a message that unfortunately our own President delivered in the past; or that pot is a, "medicine," that can heal rather than destroy are, in and of themselves, terribly dangerous and destructive messages.

In the wake of this ill-advised policy, we now have evidence that America's children are drinking, smoking, and using mind-altering drugs at the youngest ages ever. This was reported recently in "Substance Abuse and the American Adolescent," released by the National Center for Addiction and Substance Abuse at Columbia University. What's more, surveys found that 23.5 percent of 12-year-olds personally knew a drug user.

In 1996, just 1 short year ago, 10.6 percent of 12-year-olds personally knew a drug user. This represents an increase in 1 year alone of 122 percent. Also, drug overdoses and emergency room treatment of drug patients are increasing.

The war on drugs must be thought of in one way and one way only, as a war for the very lives of our children. I'm somewhat surprised frequently that some of our colleagues on the other side of the aisle, who rarely introduce legislation without claiming that it is, "for America's children," would support any legislation or initiatives that in any way, shape, or form would encourage or further drug abuse by children, particularly since similar initiatives have proved to be destructive in other nations that have thusly experimented with the lives of their children.

Mr. Chairman, we must never experiment with the lives of America's children.

Recently I did visit Switzerland where just such an experiment has taken place. My colleague, Mr. Barrett, may object to going over to where these things have taken place to get firsthand knowledge; I happen to think it is a good idea to do that. Apparently, he would not object to people traveling in this country or elsewhere to study needle exchange programs that may be heralded as the greatest things in the world, but he would have an objection to going to study groups that are fighting in this battle.

But I decided to go over to Switzerland and see firsthand. I saw failure. Drug use in Switzerland has not decreased; it has increased. America would rue the day when you would walk down a street in this city or any city in America and find, next to a soft drink machine, a machine that distributes needles or, more accurately, death in a box.

Mr. Chairman, this box that I hold here I bought with pocket change on a Zurich street from just such a death machine. I will ask unanimous consent that it be introduced into the record. It does not contain needles. It does contain the syringes without the needles; and what one gets for the equivalent of, I guess, about two U.S. dollars is three syringes, two or three needles, a condom, various instructions, and swabs and so forth. Then one takes this kit and goes to one of the government clinics where one can get, at government expense, heroin.

The proponents of the medicinal use of marijuana or needle exchange programs know that this is but the first step toward legalization of drugs in our Nation. For our children, this must never happen.

In Switzerland each year their needle distribution programs have given out more, not fewer, needles. It doesn't take a rocket scientist, Mr. Chairman, to conclude that more, not fewer, people are using drugs under the Swiss so-called experiment.

Of course, the initial logic behind these distribution programs was benign: Let's help combat the spread of HIV. In 1986, the Swiss started a needle exchange program in a park in Zurich which came to be known as Needle Park. In the beginning, they exchanged about 300 needles a day. By 1992 that number has swelled to 12,000. That bears repeating: The number of needles exchanged per day went from 300 to 12,000. Clearly more people, not fewer people, were using drugs.

But the failed Swiss experiment involved more than just needle exchanges. It also involved the distribution of death to its citizens. This grand experience made available certain illicit drugs through the government including heroin, morphine, and methadone. These drugs were made available at government-sponsored centers, still the case today.

Dr. Rachel Ehrenfeld, Mr. Chairman, who has studied the Swiss model, traveled to Switzerland to see firsthand what was happening. Mr. Barrett may object to that too, but what this lady found was very, very interesting, and what she found by her scientific observations and documentation convinced her that the Swiss model was not for America, or even Switzerland for that matter.

Mr. Chairman, I have here a photograph, labeled 1, which shows one of the vending machines found on the streets of Zurich where one—wherein one can, whatever their age, as long as they're tall enough to reach the button, can insert the money, pull a lever, and get a needle box.

Also I have here a photograph, which I've labeled on the back with No. 2, which shows the exterior of one of the government-run heroin distribution centers. Parked immediately outside of it is a baby carriage. There was a baby in that carriage. You have women going to these clinics to get shot up with heroin, leaving their babies parked outside in their carriages while they go in, at government expense and government encouragement, and get shot up with heroin.

Photograph No. 3—yes, sir.

Mr. HASTERT. If you would just finish up.

Mr. BARR. OK, I have various other photographs, Mr. Chairman, which I would ask unanimous consent be inserted in the record, of a methadone clinic, of one of the clinics where you actually inject the heroin under government supervision, a photograph that gives new meaning to the term "drug store," labeled "Drug Store," in which they sell marijuana plants, hash, various foodstuffs such as ice cream. Photograph No. 6 with marijuana and hash, candy bars, lollypops, you name it, they have it there.

Mr. Chairman, I just submit these for the record, and I would ask that my complete statement be made a part of the record to illustrate very, very graphically for all Americans who care enough about our children to study this issue to see what has happened in Switzerland. And we have before us in this first panel some learned gentlemen who have studied this and taken it upon themselves to try and do something about it. I think we ought to be encouraging them and encouraging the Swiss people on September 28, which is their national referendum, that will hopefully roll back this very ill-fated and poorly thought out drug distribution program.

Mr. HASTERT. Without objection, the gentleman's exhibits will be entered into the record.

[The prepared statement of Hon. Bob Barr and the photographs referred to follow:]

STATEMENT OF CONGRESSMAN BOB BARR (Ga-7)

Just three days ago William Weld withdrew his name from consideration for United States Ambassador to Mexico. I heralded that decision, supported by President Clinton, because William Weld was the wrong person, at the wrong time, for the wrong job. Senator Helms had the courage to stand firm for America's children. The messages we send our children, such as, pot in certain amounts is cool, or a joking matter, a message that our president has unfortunately delivered in the past, or that pot is a medicine that can heal rather than destruct, are terribly dangerous.

In the wake of this ill-advised policy we now have evidence that America's children are drinking, smoking and using drugs at the youngest ages ever.

This was reported recently in "Substance Abuse and The American Adolescent" released by The National Center for Addiction and Substance Abuse at Columbia University. What's more, surveys found that 23.5 percent of 12-year-old personally knew a drug user. In 1996, 10.6 percent of 12 year olds personally knew a drug user -- an increase of 122 percent! Drug overdoses and emergency room treatment of drug patients, are increasing

The war on drugs should only be thought of in one way. A war for the very lives of our children. I'm dismayed that my colleagues on the other side of the isle, that rarely introduce legislation without claiming that it's for America's children, would support any legislation or initiatives that in any way encourage drug abuse; particularly since similar initiatives have proved to be destructive in other nations that have thusly experimented with the lives of their children. Mr. Chairman, we must never experiment with the lives of children in America.

Recently I visited Switzerland where just such an experiment has taken place. It has failed. Drug use in Switzerland has not decreased -- it has increased. America will rue the day when you can walk down a city street and next to coke machine find a machine that distributes needles or more accurately death in a box, indiscriminately. Mr. Chairman, this box that I hold here I bought with pocket change on a Swiss street from just such a death machine.

The proponents of the medicinal use of marijuana or needle exchange programs know that this is the first step toward legalizing drugs in our nation. For our children this must never happen. In Switzerland each year, their needle distribution programs have given out more, not fewer needles. It doesn't take a rocket scientist to conclude that more not fewer people are using drugs under the Swiss experiment. Of course, the initial logic behind these distribution programs was benign: to help combat the spread of HIV.

In 1986, the Swiss started a needle exchange program in a park in Zurich. In the beginning they exchanged about 300 needles a day. By 1992, the number had swelled to 12,000; From 300 to 12,000. More people not fewer, using drugs.

But the failed Swiss experiment involved more than just needle exchanges, it also involved the distribution of death to its citizens. The grand experiment made available certain illicit drugs through the government; including heroin, morphine and methadone. These drugs are made

available at government-sponsored centers. Dr. Rachel Ehrenfeld, who has studied the Swiss model traveled to Switzerland to see firsthand what was happening. What she found convinced her that the Swiss model was not for America or even Switzerland for that matter. Among her findings:

Because of design there was no control group.

The project design was changed several times in order to "accommodate" reality.

The original design of the project called for supervision of the injection process to make sure the addicts don't save the drugs to sell them later on the streets, but no such supervision was found during site visits.

While original design called for support services -- especially psychiatric and medical treatment, job training and occupational therapy -- none were available at observed centers.

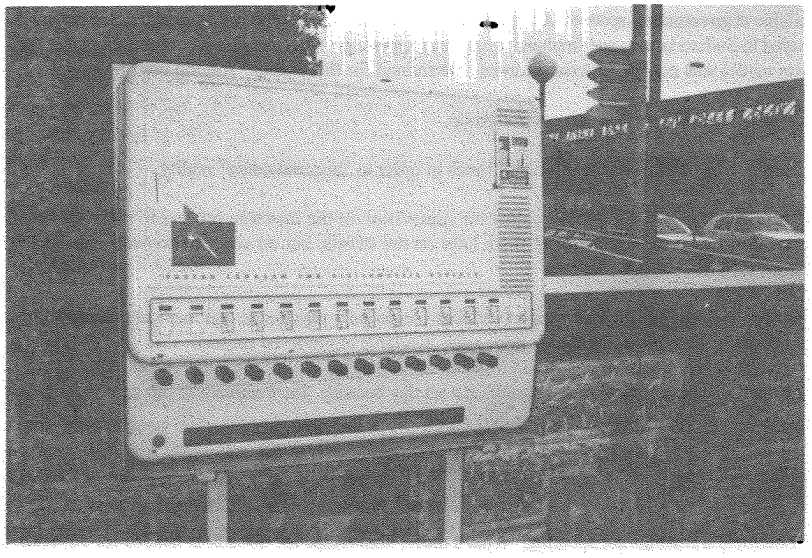
Urine analysis is conducted once a month on a set day because "the treatment in our center is based on trust" the director of one center proudly declared.

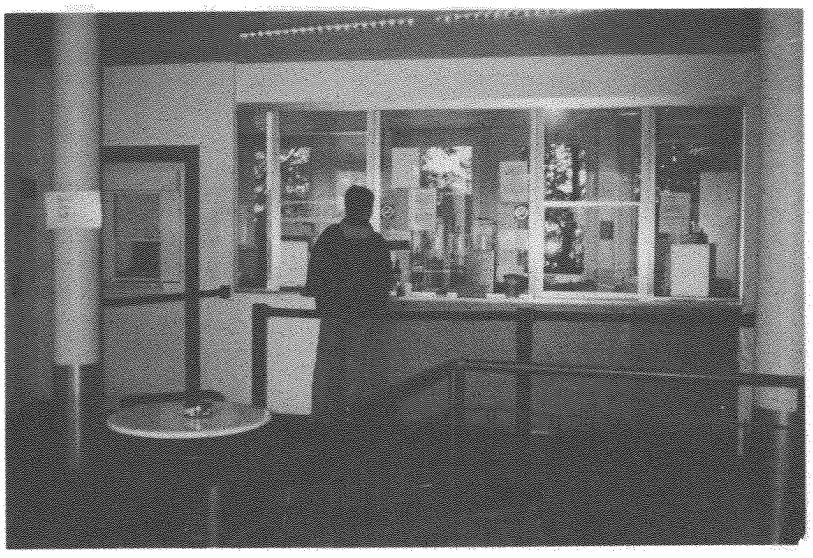
Heroin supplied by the government was also supposed to reduce the number of addicts. But so far, there is clear indication that the number of addicts is growing rapidly.

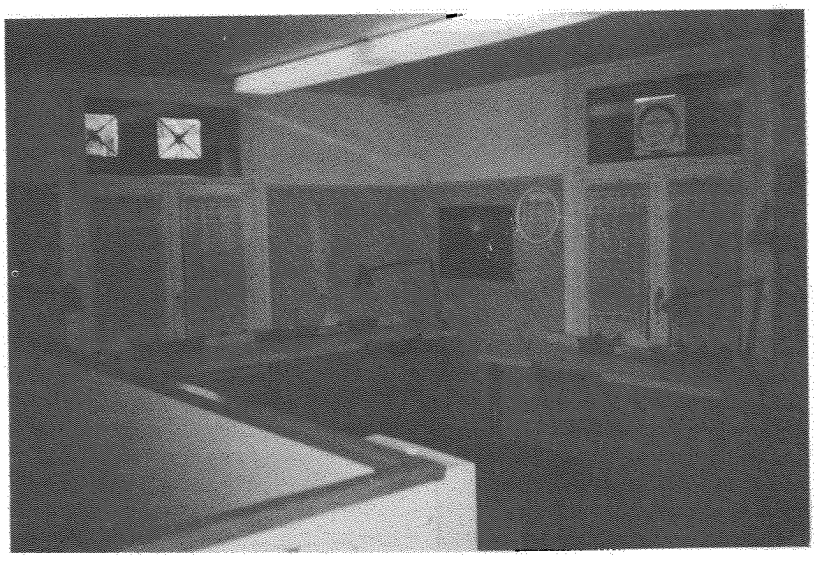
Dr. Ehrenfeld's findings are sobering. What's more, this recipe for disaster is headed for America if in Congress don't take a firm stance.

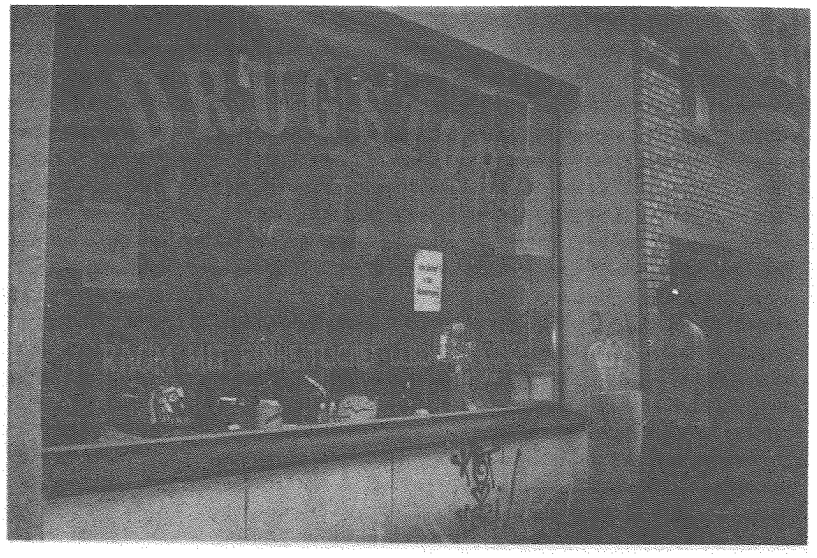
Mr. Chairman we must stand firm in opposition to any attempt to enable our children, the future of our great nation, to become drug addicts rather than scholars, to end up in the morgue rather than the hall of fame. We must make a stand here and now.

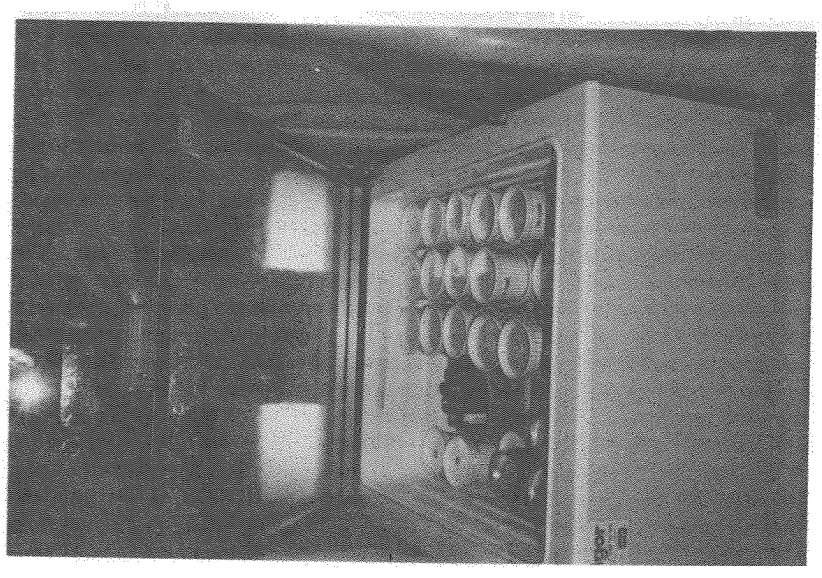
[show picture]











Mr. HASTERT. At this time I'd like to call on the distinguished gentleman from Baltimore, Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

I don't have to go to Switzerland. I can go 50, 55 minutes away from this place where I live and see a program that is working and saving lives. I pray to God; I pray that nobody on this subcommittee's family members ever gets AIDS. I pray that you never have to watch them die a slow death. I pray.

We have a program in Baltimore that is working. We don't have to go to Switzerland. That's a long ways away. I invite you to come to Baltimore.

I don't live in the suburbs, I live in the inner city where people are dying. They're dying. It's not—I can put a face on all of this, and they're dying slow, painful deaths, slow, painful deaths. And it's easy to sit here and say these things—you know, I'm going to sit here and listen to this testimony out of respect, but I want you to come to Baltimore where it is working.

Now, I don't think anybody applauds or jumps up and down and is happy about needle exchange, but there comes a time and a point in time where you have to make some certain decisions. Are you going to watch people die, or are you going to try to do something about it?

We so happen to have the No. 1 medical institution in the world—we don't have to go to Switzerland—Johns Hopkins University, 55 minutes away from here, no plane flights, just a short drive.

Study the situation in Baltimore. Baltimore has a major drug problem. This Congressman has never—at 47 years old, has never touched an illegal drug in his life. But the fact is—and I have a major problem with drugs, but the facts still remain that there is a program that is working 55 minutes away from here.

I don't know the laws of Switzerland, don't have a clue. I don't know the culture of Switzerland, don't have a clue. But one thing I do know is that people are slowly dying.

I agree with my ranking member, and I want to thank you, Mr. Hastert, for holding the hearing because I think a lot will come out of this. We have Dr. Beilenson with us, our health commissioner from Baltimore. He will tell you that the program is working, he will tell you that we're reducing our AIDS cases and deaths, he will tell you that this stuff about introducing drugs to young people is not the situation in Baltimore, that there's not one person, I think—Dr. Beilenson, you can tell them—not over the age of, I think it is 19, involved in this process. He will tell you that we're saving lives. But he not only will tell you, but it is backed up by the No. 1 medical institution in the world.

So I'm kind of confused. I am really confused. Perhaps if we want—if we were just dealing with something that just doesn't matter, like saving—like something that's just real simple, it doesn't make any difference, that's one thing. But when we're dealing with people saving lives, it would seem—I would agree with Mr. Barrett that we would want to have some kind of balance here to make sure that both sides are given—and especially, this is the greatest country in the world; I don't care what anybody says. And if we cannot look at our own country, 55 minutes away, and bring

witnesses in here to testify on what is working, what is saving lives, what is saving pain, what is saving death, then I have a concern.

And so when Mr. Barrett contacted my office and said we needed a witness, we were happy to make a phone call. It probably cost $1. We were happy to ask Dr. Beilenson to come in from 55 minutes away. We were happy to have him come and talk about the study that Johns Hopkins has done in monitoring our program. We were happy to consult the State Legislature of Maryland, that a few years ago barely passed needle exchange, but overwhelmingly passed it this past session because they saw it was saving lives—both Republicans and Democrats, because they realized that it was bigger than all of that, it was bigger, and it was about saving peoples' lives.

So I welcome this opportunity. I welcome this opportunity because I don't sit in the suburbs, I don't sit somewhere looking. I live in it, I see it every day. I see the needles on the ground, I see it, I see people in stupors. So, it's not about the business—has nothing to do with being for drug use. That's the last thing I want. And when Dr. Beilenson testifies, I think he will tell the other side of the story—as they say, the rest of the story.

So I hope, Mr. Chairman, that our hearing will yield—shed some light on both sides, both sides of the issues because there are two sides. Again, I'm talking about from 55 minutes away, not Switzerland, no disrespect; 55 minutes, greatest health institution in the world. It seems like we will rely on them as opposed to others.

Mr. HASTERT. I thank the gentleman from Baltimore.

The gentleman from Indiana, Mr. Souder.

Mr. SOUDER. I very much respect the intensity and the commitment of the gentleman from Maryland. I think he spoke completely from the heart and his concerns of what he sees in his community. But people can disagree strongly on this issue.

I quoted on the floor in the debate the other week Dr. James L. Curtis, director of psychiatry and addiction services for Harlem Hospital Center, who is on the National Black Commission on AIDS, looking at—particularly the HIV problem with African-Americans, and spoke in New York—both hearings here in Washington and in letters. This is what his words were:

> Not only do these programs promote a breakdown of law and order, they are also poor medicine and poor public health practice. In fact these programs constitute a reckless experiment with human beings totally unregulated by research guidelines ordinarily applied to protect human subjects from potentially dangerous research. They are among the reasons that those of us in the African-American community should be outraged by these proposals which do us great harm under the guise of compassionate concern.

There can be honest disagreement, even among the people who live in those neighborhoods; and there is disagreement in this country about needle programs. I don't appreciate the implication that somehow this is a trade-off or some kind of insensitivity to the people who are dying of AIDS, whom we should try to address. But that is not helped, in my opinion, by perpetuating a drug habit which actually, as Dr. Curtis also pointed out, often gets to the point where they can't even, when they treat the people in the hospitals, find a place to treat them for other diseases or related diseases.

One other thing I want to clarify is, this isn't a 50–50 debating forum in Congress. As a former minority staff director of a committee, we were lucky if we got a third of the witnesses or one witness. We have every right as the majority to have a majority of the witnesses, and we are looking into why we believe needle programs have been counterproductive around the world and in the United States.

If the minority members choose to defend the needle programs, they have a right under House rules to do so, and that's what we're going to do in this hearing. I wish we could have had a longer period of time to plan that, as sometimes these things go. I'm one of the people who's responsible for saying, how about Thursday rather than Friday. But this isn't a 50–50 debating forum, never has been, never will be; and we don't intend, if we get into legalization of marijuana, to have a 50–50 debate.

We believe, in the majority, that needle programs have been counterproductive, and we're looking at that. If the minority will help us have a debate, we'll have some debate, but we want to look at what our Government and other governments have done, which we believe has been counterproductive, and see if we can get our drug efforts on the right path.

And with that I yield back.

Mr. HASTERT. I thank the gentleman.

Let me, and then I will yield to you—let me just say that I had hoped that—it seems the debate is going back and forth at this dais. I hope that eventually we can get to our panelists and try to get back to the basics of what works and what doesn't work. I certainly entertain everybody being able to come up and say their piece on this, so that we do have truth in fact that we can start to wade through.

I'm going to introduce the gentlelady from California, not a member of this subcommittee or the committee. I was very honored to have her here and also then to introduce her.

I yield to Mr. Barrett.

Mr. BARRETT. Thank you, Mr. Chairman, and very briefly, because I agree with the gentleman from Indiana: You are in the majority, you control the hearing process, you can choose which witness you want to have; and we in the minority do have the right under rule XI to ask for a separate day of hearing.

My concern that I raised initially was, this hearing was going to be totally dominated, 100 percent, by the people who were opposed to these types of programs. I think that this is the greatest democratic institution in the world, and I think if it is going to remain the greatest democratic institution in the world, fundamental to that is that we have a fair debate. And frankly there is a lot of pressure on Dr. Beilenson today; there are five people who are speaking against the program and only one person who has seen some benefits to it.

So let's not mistake the comments that I have made earlier to say that I'm arguing for 50–50. I'm not so naive to think that you're going to do that. But I do think that the people who are interested in this issue want an honest debate, and I honestly felt that there was no intention, when this hearing was set up, to have a free exchange of ideas.

Mr. HASTERT. Let me just say for the record, Mr. Barrett, and I think you and I have worked on this in a very amiable way over the months. I think that you certainly have the right before—after notice, in requesting witnesses; and I don't think we've ever denied witness to your side, and that will continue to be the practice of this subcommittee.

Mr. BARRETT. Thank you, Mr. Chairman.

Mr. HASTERT. Now, at this time, I'd like to recognize the gentlelady from California.

Ms. PELOSI. I thank the chairman for his invitation to be here today and for his hospitality to join the members of the subcommittee. As a former member of the Government Operations Committee, as it was known in those days.

Mr. HASTERT. You date both yourself and myself.

Ms. PELOSI. And I thank the ranking member, Mr. Barrett, for his hospitality as well. I am pleased to be here sitting next to Representative Cummings and pleased to join him and follow his leadership as a cosponsor of the legislation regarding needle exchange, which I think is appropriate, wise and science based.

Heeding the chairman's wish to hear from our witnesses, I will try to be brief. I come here as a member of the Labor-HHS-Education Appropriations Subcommittee. It is our legislation that was on the floor where the issue of needle exchange came forward.

I, too, Mr. Chairman, want to stipulate to certain things in this hearing. I, too, reject the Swiss experiment. That's not what we're talking about in the United States at all. It is not about legalization, it's not about distribution of drugs; it is about needle exchange, it is about saving lives. It's clear that we can reduce HIV infection by 30 percent with appropriate needle exchange programs, and needle exchange programs do not increase the use of illegal drugs. Needle exchange programs can be an effective link to drug treatment and other medical services for people who have traditionally been outside the loop.

Mr. Barrett referenced the report that he put in the record and that we spent many, many, many days of hearings on with the National Institutes of Health. In February the NIH sponsored a consensus development conference on interventions to prevent HIV risk behaviors. The group of external prevention experts recommended lifting the current restriction on the use of Federal funds for needle exchange programs. Key findings, as I said before, were a 30 percent or greater reduction in HIV and other disease transmission; and a preponderance of evidence showing no change or decreased drug use.

During the NIH budget hearings before Labor-HHS Appropriations, Dr. Harold Varmus, the NIH Director, testified that in his opinion the ban on the use of Federal funds should be lifted and that science supported the necessary findings for the Secretary to make a finding that such programs were in the interest of public health. The same perspective was offered by Dr. Alan Leshner, Director of the National Institute on Drug Abuse, and Dr. Steven Hyman, Director of the National Institute of Mental Health.

Scientists are leading the fight to lift restrictions on funding these important public health programs. The effort also has been endorsed by the American Medical Association, the American Pub-

lic Health Association, the American Academy of Pediatrics, and other leading public health associations.

In closing, I want to make a few observations about what needle exchange is and is not. First, needle exchange is not needle distribution. It is an exchange; it is a one-for-one exchange. This thereby reduces the number of contaminated needles in circulation and, of course, has the added benefit of drawing young people into the loop in terms of prevention and other health services.

It is also an important cost saving to taxpayers. One hypodermic needle costs 10 cents as opposed to $110,000 of medical costs per person with HIV and AIDS, and that is not counting income support and revenue loss through loss of productive years.

So while I'm putting my full statement in the record, in trying to go faster here, I'm going to pass some of this important information up.

Mr. Chairman, our work on this issue has to be science based. That is what we waited for in our committee, for the science to come in. I'm fond of saying in my committee, the plural of anecdote is not data. You can talk about places in the world where some experiments do not work, or somebody knows somebody who went to needle exchange programs didn't have to give a needle in order to get a needle back; but the successful needle exchange programs—only those which have a needle exchange are the ones that we should support—do have benefits and should be considered seriously.

I came to listen, and I respect Mr. Hastert. I believe he came to listen as well. So I hope that we will all bring open minds to the table on this but the voice that speaks louder than any other is the voice of science.

I'm pleased to join bipartisanship with Dr. Ganske, Representative Ganske, our colleague, when he said on the floor, I urge my colleagues to think about the thousands of children who get AIDS because a parent got HIV from a dirty needle. He said that in support of lifting the ban on funding for needle exchange programs.

So in that bipartisan spirit, Mr. Chairman, I thank you for your invitation. I thank you for your goodwill in terms of this issue that I anticipate as the science—scientific information becomes more apparent, and once again reiterate, the Swiss program is not what we are talking about in the United States. It has no relevance to this debate, and I say that in spirit of friendship which you have extended to me to participate.

[The prepared statement of Hon. Nancy Pelosi follows:]

Statement of
The Honorable Nancy Pelosi
On Needle Exchange Programs
September 18, 1997

Mr. Chairman, as you know, I serve on the Labor-HHS Appropriations Subcommittee where the issue of federal funding for needle exchange programs has surfaced as a controversy. Our subcommittee has a history of attempting to let science, not politics, determine public health policy. Last year's Senate Labor-HHS bill included report language requesting a summary of the scientific findings on needle exchange programs. Secretary Shalala issued such a report in February of this year.

Mr. Chairman, I request that the Secretary's report be included in the hearing record.

The HIV epidemic remains an urgent public health problem. Unsafe drug injection is the second most frequent reported risk behavior for HIV infection, accounting for a growing proportion of new HIV infections among users, their sexual partners and their children. In order to respond to the challenge of preventing new HIV infections, we must have a sound public health approach to address the twin epidemics of HIV and drug abuse.

Our public policy on HIV prevention should be based on science, not politics. That is why needle exchange programs throughout the United States have been the subject of numerous scientific studies. The science speaks for itself:

First, needle exchange programs save lives by decreasing HIV transmission by more than 30%.

Three major reports have summarized the published studies and ongoing research on needle exchange. One was sponsored by the Centers for Disease Control and Prevention (CDC) in 1993, a second by the General Accounting Office (GAO) in 1993, and a third by the Institute of Medicine (IOM) in 1995.

The GAO study found the forecasting model developed by Yale University to be credible. The New Haven program reduced the sharing of needles by drug abusers from 71% to 15% of people who shared. The Yale evaluation found a 33 percent reduction in new HIV infections among New Haven needle exchange program participants over one year.

Second, scientific findings indicate that needle exchange programs do not increase the use of illegal drugs.

Although quantitative data are difficult to obtain, those available provide no evidence that needle exchange programs increase the amount of drug use by program clients or change the overall community level of drug use. In the New Haven study, 350 people each year were helped to get off drugs and get their lives turned around. The New Haven Police Department found no increase in drug-related problems during the time the program was in effect.

Third, findings suggest that needle exchange programs can be an effective link to drug treatment and other medical services.

Successful needle exchange programs share some common characteristics. The best programs are conducted in the context of comprehensive HIV prevention programs. The best programs also make referrals to drug abuse treatment and other public health and social services. These programs are most effective when they are part of the existing public health system. The programs are important because they can provide important

services to hard-to-reach populations.

In February, the National Institutes of Health (NIH) sponsored a consensus development conference on interventions to prevent HIV risk behaviors. The group of external prevention experts recommended lifting the current restriction on the use of federal funds for needle exchange programs. Key findings were a 30% or greater reduction in HIV and other disease transmission; and a preponderance of evidence showing no change or decreased drug use.

During the NIH budget hearings before the Labor-HHS Appropriations Subcommittee in March, Dr. Harold Varmus, the NIH Director, testified that in his opinion the ban on the use of federal funds should be lifted and that science supported the necessary findings for the Secretary to make a finding that such programs were in the interest of public health. This same perspective was offered by Dr. Alan Leshner, Director of the National Institute on Drug Abuse (NIDA) and Dr. Steven

Hyman, Director of the National Institute of Mental Health (NIMH).

Scientists are leading the fight to lift restrictions on funding these important public health programs. This effort has also been endorsed by the American Medical Association, the American Public Health Association, the American Academy of Pediatrics and other leading public health associations.

Now, let me address some political considerations.

First, needle exchange is not needle distribution. Also, it is not drug legalization. Clearly, the United States is not Switzerland and no American city is like Zurich. No one is arguing for openly allowing the use of hard drugs. No one is arguing for a needle distribution program. No one is arguing that U.S. cities should follow the example of Zurich. In fact, the opposite is the case.

We must look at the studies of U.S. cities like New Haven and San Francisco, not Swiss or Canadian cities. As of September, 1993, at least 37 active needle exchange programs have been identified in the United States. All but six of these programs require one-for-one exchanges and rules governing the exchange of syringes have been found to be well enforced.

Second, we must send a message that respects human life. If we have the opportunity to save lives, we have a responsibility to do so. Needle exchange programs save lives.

I am aware that many people fear that needle exchange programs sent the wrong message. But, this is not necessarily true. Comprehensive HIV prevention plans incorporate drug abuse prevention messages. Drug abuse prevention and referral to drug treatment should be the first line of attack. However, if

these approaches do not succeed, it is important that sterile needles replace used needles to prevent the further spread of HIV and other diseases.

According to the CDC study, between 4,400 and 9,700 new HIV infections could have been prevented between 1987 and 1995 in the U.S. had needle exchange programs been widely available. The study also found that an additional 11,300 cases of AIDS among drug users, their sexual partners and children could be prevented by access to needle exchange programs through the year 2000.

I am concerned about a message that these 11,000 lives are expendable. If we follow science, not politics, these lives can be saved.

Third, we must be concerned about the cost to taxpayers.

Needle exchange programs are cost effective. A sterile needle

costs 10 cents; the lifetime medical cost of treating a person with HIV infection is $119,000. When one considers disability benefits, loss of tax revenue, etc. the costs are much higher. The median cost of a needle exchange program in the U.S. is $169,000 per year.

Mr. Chairman, we are also likely to hear anecdotes about abuses of the system, but the plural of anecdote is not data. Science should determine public health policy, not politics. If we have the responsibility to protect our citizens from harm, to ease suffering and pain, and to ensure that the public health is safeguarded then federal support of needle exchange programs is an appropriate response to a danger that the science says we can contain.

Mr. HASTERT. Well, let me just say, listen, we shall. But first, everybody has been very patient.

We have a vote on the floor. I think we'll recess for 10 minutes, make the vote, and be back here in order to start the testimony as quickly as possible. We will recess for 10 minutes.

[Recess.]

Mr. HASTERT. At this time, I'd like to introduce our first panel. We have two very distinguished witnesses before us, Dr. Ernst Aeschbach—Dr. Ernst Aeschbach is a member of the board of Youth Without Drugs. We also have Mr. Erne Matthias. Mr. Matthias is one of the foremost experts on drug policy in Switzerland.

I thank you both for being here today, and in accordance with House rules, we must swear you in. Please stand and raise your right hands.

[Witnesses sworn.]

Mr. HASTERT. Let the record show that the witnesses answered in the affirmative.

Dr. Aeschbach, please proceed with your statement.

STATEMENTS OF ERNST AESCHBACH, M.D., SPECIALIST FOR PSYCHIATRY & PSYCHOTHERAPY FMH; VICE PRESIDENT, VPM; MEMBER OF THE BOARD, "YOUTH WITHOUT DRUGS"; AND ERNE MATTHIAS, EXPERT ON SWITZERLAND'S DRUG POLICY

Dr. AESCHBACH. Mr. Chairman, distinguished members of the subcommittee, first of all I would like to express my appreciation for being invited for this hearing. I want to talk to you about the serious problem we face in Switzerland, and that is an increasing number of drug addicts, and an increase in drug trafficking as well, related to devastating consequences for our youth, parents and finally to the whole society. We love our country. Therefore our problems need international attention.

The Association for the Advancement of Psychological Understanding of Human Nature is, among many other issues, actively engaged in all aspects of the drug problem, namely prevention at work and treatment. For the past 8 to 10 years, we have been witnessing a highly questionable change of drug policy in German-speaking Switzerland—open drug scene, toleration of rise in crime rates, and pursuit of survival and aid measures that facilitate addictive behavior instead of those which favor the abandonment of drug use and positive perspectives of life.

I would like to present a brief introduction about the most significant steps of Swiss drug policy. In 1985, the upcoming HIV problem served as a justification to claim for so-called harm reduction measures like needle distribution programs. In the beginning of 1989, about 300 syringes per day were distributed in the open drug scene. By September 1994, the number had increased to an average of 15,000 syringes and 10,000 additional needles a day. Also, there was never scientific evidence provided which would have clearly demonstrated that needle distribution is likely to reduce HIV transmission.

In 1987, there were 300 methadone recipients in the Canton of Zurich. By arguing that low-threshold drug facilities would contrib-

ute to a reduced HIV transmission rate, methadone was provided to addicts nearly without any prerequisites. Methadone, in such programs, is provided over the counter and accompanying treatment is not an integral part of the program. Subsequently, the number of participants in methadone programs has risen sharply, to about 3,000 in 1994. At the moment, there are about 15,000 addicts in a methadone program, which is about 50 percent out of the estimated 30,000 opiate addicts in Switzerland.

In 1989, the first big open drug scene, known as Needle Park, was installed in the middle of Zurich. At the same time, a massive pro-drug campaign was launched in the media all over the German-speaking part of Switzerland. Cannabis was claimed to be harmless. Within just a few months, the attitude of young people toward drugs changed.

The failure of Swiss drug policy is obvious. Nevertheless, models are being proposed which advocate the more or less free availability of drugs. One of these models called for the distribution of heroin. There is no scientific interest or reason for this heroin experiment because the hazards of heroin use have long been proven. Indeed, for the heroin experiment, the term "scientific study" has been used as a subterfuge. The real objective of Swiss heroin experiment is to introduce a definitive program to distribute heroin to addicts as soon as possible.

After presenting the final report on the occasion of a press conference in July 1997, the message of these allegedly successful projects has been communicated throughout the world. Immediately projects have been demanded for 8,000 to 9,000 addicts eligible for heroin prescription. However, there is evidence that the heroin distribution projects in Switzerland failed. The target group of severely addicted could not be reached, and the goal of abstinence was only achieved in a few cases.

If you wish, I would like to provide you more comprehensive data on this topic later on.

With the help of my organization and other organizations, a people's referendum for Youth Without Drugs has been initiated to stop these trends. The initiative calls for a restrictive drug policy aimed at abstinence, more effective prevention measures especially for young people, more therapeutic and rehabilitation facilities, and the prohibition of so-called state-controlled distribution of heroin.

Therefore, we reach the decisive point in Switzerland. All the more we need international attention and cooperation in order to strengthen our mutual fight against drugs.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Aeschbach follows:]

Aeschbach

ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGICAL UNDERSTANDING OF HUMAN NATURE, VPM

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Hearing of the Subcommittee on National Security - Introductory Statement

Ernst Aeschbach, M.D., specialist for Psychiatry & Psychotherapy FMH
Vice-president VPM, Member of the Board "Youth without Drugs"

Mr. Chairman, distinguished Members of the Subcommittee

First of all I'd like to express my appreciation to be invited to this hearing. I want to talk to you about a serious problem we face in Switzerland and that is an increasing number of drug addicts and an increase in drug trafficking as well, related to devastating consequences for our youth, parents and finally the whole society. We love our country, but at this very time the so-called "Swiss Model" is being exported in the whole world, therefore our problems need international attention. The Association for the Advancement of Psychological Understanding of Human Nature is – among many other issues - actively engaged in all aspects of the drug problem, namely prevention work and treatment.

For the past eight to ten years we have been witnessing a highly questionable change of drug policy in German speaking Switzerland: Open drug scenes, toleration of rising crime rates and pursuit of "survival aid measures" which facilitate addictive behavior instead of those which favor the abandonment of drug use and positive perspectives on life.

I'd like to present a brief introduction about the most significant steps of Swiss drug policy.

1985 the upcoming HIV problem served as a justification to claim for so-called harm reduction measures like needle distribution programs. In the beginning of 1989 about 300 syringes per day were distributed. By September 1994 the number had increased to an average of 15'000 syringes a day, although there was never scientific evidence provided which would have clearly demonstrated that needle distribution is likely to reduce HIV transmission.

1987 there were 300 methadone recipients in the canton of Zurich. By arguing that low-threshold drug facilities would contribute to a reduced HIV transmission rate, methadone was provided to addicts nearly without any prerequisites. Methadone, in such programs, is provided over a counter and accompanying treatment is not a integral part of the program. Subsequently the number of participants in methadone programs has raised severely to about 3'000 in 1994. At the moment there are about 15'000 addicts in a methadone program, which is about 50% out of the estimated 30'000 opiate addicts in Switzerland.

1989 the first big open drug scene, known as "Needle park" was installed in the middle of the city of Zurich. At the same time a massive pro-drug campaign was launched in the media all over German speaking part of Switzerland. Hashish was claimed to be harmless. Within just a few months the attitude of young people towards drugs changed.

Heroin Projects

The failure of the Swiss drug policy is obvious. Nevertheless, models are being proposed which advocate the more or less free availability of all drugs. One of these models calls for the distribution of heroin. There is no scientific interest or reason for this heroin experiment because the hazards of heroin use have long been proven. Indeed, for the heroin experiment, the term "scientific study" is being used as a subterfuge. The real objective of the Swiss heroin experiment is to introduce a definitive program to distribute heroin to addicts as soon as possible. The planned revision of the narcotics law and the introduction of a new pharmaceutical law will provide the necessary legal framework for achieving this objective.

The call for broad distribution of opiates to drug addicts, the continuous opposition against the purportedly exaggerated conditions of the Experimentation Plan which has been based on drug-policy, not scientific reasoning, and the exceptionally premature "success reports" given by project managers as well as evaluators, are clear proof of the protagonists' prejudiced opinion. Those who make such unequivocal drug policy claims and then first try to substantiate them scientifically are in danger of only seeing what they want to see. Such procedure is a crass breach of internationally approved scientific standards.

After presenting a final report on the occasion of a press conference in July 1997, the message of these allegedly successful projects has been communicated throughout the world. Immediately projects have been announced for 8'000 to 9'000 addicts eligible for heroin prescription.

However, there is evidence that the Heroin Distribution Projects in Switzerland failed. The target group of "severely addicted" could not be reached and the goal of abstinence was only achieved in a few cases. If you wish so, I'd like to provide you more comprehensive data on this topic later on.

Legalization network

The city of Zurich has been for some years the center of legalization strategies and part of a legalization network connecting all of Europe. In 1990 the "European Cities on Drug Policy (ECDP) was founded in Frankfurt/Main (Germany) by the cities of Zurich, Frankfurt, Hamburg and Amsterdam. The first conference adopted the so-called Frankfurt Resolution in which the cities pleaded for a widespread heroin distribution to drug addicts, for decriminalization and legalization of cannabis and for the introduction of shooting galleries (rooms where drug addicts are allowed to inject drugs). They also intend to alter the 19961 United Nations Single Convention on Narcotic Drugs.

The ECDP is therefore in close cooperation with other organizations for the purpose of drug legalization, to name a few: International Antiprohibitionist League (IAL), the Drug Policy Foundation (DPF) in Washington D.C., the Italian CORA and the Italian Partito Radicale.

Youth Without Drugs

With the help of VPM and other organizations a people's referendum for a "Youth without Drugs" has been initiated to stop this destructive trends. Within 6 months we were able to collect more than 140'000 signatures.

The initiative calls for a restrictive drug policy aimed at abstinence, more effective prevention measures, especially for young people, more therapeutic an rehabilitation facilities, and the prohibition of so-called state-controlled distribution of heroin, but also cocaine, LSD, cannabis, smokable opium, hallucinogens and analogous substances (Designer drugs). Moreover, it demands that young people and families are protected from drugs.

If the referendum "Youth without Drugs" doesn't pass the upcoming vote on September 26, legalization is an easy step. An expert group of the Federal Council of Switzerland made a proposition which allows possession of small amounts of drugs and to deal with preparatory acts.

One of the reasons for launching the Swiss referendum "Youth Without Drugs" in December 1992 was the initiators' concern that the Swiss heroin experiment could be misused to promote the liberalization/legalization of drugs. If the referendum is enacted, heroin projects would be forbidden and at the same time, appropriate and necessary measures would be implemented to aid drug addicts.

Therefore, we reached a decisive point in Switzerland, all the more we need international attention and cooperation in order to strengthen our mutual fight against drugs.

Thank you Mr. Chairman

Swiss Drug Policy 1985 - 1997

1985 HIV Problem arising – Needle Distribution Programs

The upcoming HIV problem served as a justification to claim for so-called harm reduction measures like needle distribution programs. In the beginning the Health Authorities withstood the pressure made by media and refused to approve needle exchange programs. But very sharp attacks against the surgeon general of the canton of Zurich - he was called a fascist and a murderer – caused him to yield.

"We have broken his neck", a leading proponent of needle distribution programs said.

At the time of the open drug scene at needle park, about 300 needles were distributed a day, but this number was increased to a maximum of about 15'000 syringes plus 10'000 additional needles a day.

Today needles are distributed in all low-threshold drug-facilities or through vending machines. Dirty needle on children's playground are a serious threat. Used needles were even used as weapons to threat people.

1987 "Liberalization" of Methadone Programs

Easy access to methadone programs was another important step towards legalization. Until 1987 we have had well structured methadone programs. Prerequisite to enter the program was an age of 20 years, several unsuccessful attempts in treatment, urine tests to control additional consumption of other drugs, counseling on a regular basis, a workplace and a residence. There were 300 addicts in such methadone programs in the canton of Zurich before 1987. Since 1987 addicts can subscribe very easily to methadone programs, almost without any prerequisites.

At the moment there are about 50% of the estimated number of drug addicts in the whole of Switzerland in a methadone program, namely 15'000 persons.

1989 Media Campaign

Since 1989 Switzerland has suffered from a massive pro-drug campaign. The liberalization movement has gained ground much faster than everybody would ever have imagined. We have noticed an increasing number of publications questioning that drugs are harmful. More and more so-called experts turned up and advocated a more liberal way to deal with drugs, and even legalization of all drugs was discussed as an option.

These messages have been communicated by all means available. For instance, dozens of articles have been published daily, radio sessions, television shows promoting drug consumption and presenting a guidance to cultivate cannabis, street

parties where addict's utensils were sold, workshops teaching how drugs can be consumed properly, to mention only a few examples.

1989 Establishing of Open Drug Scenes in Switzerland

1989 the first big open drug scene (known as the Needle park") was full established in the middle of the city of Zurich, a district where 50'000 pupils and students attend school. It was relevant, that Police was not allowed to enforce the law in area on Zurich Needle Park. Also in other major towns in Switzerland similar but smaller drug scenes emerged.

12/90 Vote in Zurich against Shooting Galleries

A majority (63%) of the inhabitants of Zurich rejected a city government proposition to establish so-called shooting galleries. A short time after this rejection it was revealed that the city council of Zurich already ran different shooting galleries secretly.

2/91 Position Statement of Swiss Government

Forced by the resulting absolute chaos, the Federal Council took an official position for the first time 1991:

- The number of drug addicts has to be stabilized and later reduced by 20%.
- Prevention efforts have to be improved.
- Distribution of heroin is not to be discussed.

5/92 Federal Council - Pilot Project for Distribution of Heroin

In May 1992 The Federal Council of Switzerland voted under massive political pressure to allow a temporary project to distribute heroin to addicts.

10/92 Federal Council - Decree for a scientific Evaluation

In October 1992 he issued the decree for the scientific evaluation. According to this decree, the projects should be limited to only 250 recipients for heroin. He stated clearly, that abstinence must be the ultimate goal of all measures undertaken.

12/92 Referendum "Youth Without Drugs" launched

In December 1992 we launched the people's referendum called "Youth Without Drugs". From then on this referendum was the focus of public attention and the target for a lot of misinformation and heavy attacks.

This people's referendum calls for a restrictive abstinence oriented drug policy, prevention measures have to be expanded and therapeutic facilities have to be made available. In order to prevent any legal uncertainty the substances forbidden in any case are mentioned namely.

Another referendum, called Droleg (which is a short for "drug legalization") was launched shortly after "Youth Without Drugs". It represents an opposite position in Switzerland, namely to make drugs legally available.

1/93 Needle Park closed

"Needle Park" was closed simply by installing fences at the entrance of the drug scene, which was located on a peninsula in Zurich's river. No further measures have been undertaken to prevent a new emergence of a drug scene.

6/93 New open Drug Scene at Letten Railway Station emerged

As expected, a few months after closing down the Needle Park a new open drug scene emerged in the same district of Zurich.

7/93 "Youth Without Drugs" submitted

The committee Youth Without Drugs successfully collected 140'000 signatures in a record time of only 6 months.

10/93 Federal Office of Public Health admits Heroin Projects

Swiss Health authorities published the "General Experimentation Plan". According to this plan, abstinence is the ultimate goal and therefore the criteria to evaluate a possible success of the heroin Distribution Projects.

12/93 Heroin Projects Started

Heroin projects were started with 250 addicts eligible for heroin prescription. Nevertheless the legalization lobby called for a broader distribution of opiates to drug addicts. The continuous opposition against purportedly exaggerated conditions of the Experimentation Plan.

3/94 Attempt to set up a Common Platform: FDP, CVP, SP four Pillars including Harm Reduction

In March 1994 three major parties (CVP, FDP, SP) set up a common platform for a so-called "Third Way". The content is actually the same as that of "Youth Without Drugs". It differs only in allowing harm reduction measures like distribution of heroin. In April 1994 Federal Council decision

4/94 Federal Council decided

- Counter-proposition against "Youth Without Drugs"
- UN Convention 1988 not be ratified
- Commission set up for a revision of the narcotic law

10/94 Heroin Projects expanded to 500 Recipients

First expansion of Heroin Projects to 500 addicts eligible for heroin prescription.

2/95 Open drug scene at Letten Railway Station closed

Closing the big open drug scene Letten Station has been used as a means of political pressure by the city of Zurich and most mass media on the Federal Government. The argument of the Zurich's social department was: "Where shall all these addicts now get their drugs, when not through the State?"

Zurich's Government only agreed to close down the scene (which means enforcing the law) if in reaction to it, the villages around Zurich agreed to take care for their own addicts. It has to be understood, that most oft this small villages do not have any facilities, personal or knowledge to deal with such a complicated problem as drug addiction is.

3/95 UN Conventions 1971, 1972 ratified

Contrary to a recent announcement, the ratification of the Convention on Psychotropic Substances 1988 has been postponed. The convention claims for a commitment to punish consumption of illegal drugs. Ratifying this convention would avoid further liberal steps on drug policy in Switzerland.

5/95 Heroin Projects expanded to 800 Recipients

Heroin addicts eligible for heroin has been raised to 800. 3 further research question has been included:

- Heroin Distribution in prisons
- Heroin Distribution to addicts with mental diseases
- Heroin Distribution in existing methadone program facilities

6/95 Federal Council – Official Statement against "Youth Without Drugs"

The Federal Council recommended to reject the Referendum "Youth Without Drugs". His own drug policy however gives way to a legalization of drugs. His so-called 4th pillar provides help for drug addicts. There is no need for this additional 4th pillar, because even now physicians are committed to provide medical care and authorities have to help on social issues.

2/96 Expert Commission: Revision of Narcotic Law

Expert Commission of Federal Council is in favor of legalization. They made a corresponding proposition to the Federal Council of Switzerland: Consumption of all drugs and possession and dealing for own purposes should be legal.

Subcommission on Narcotic drugs, a permanent commission of the Department of Internal Affairs, agrees with the proposition made by the expert commission mentioned before.

"According to the new, revised narcotic law, drugs should not be more easily available", the president Mr. van der Linde said. Furthermore he said: "Nobody deludes oneself that drugs can be easily obtained today ".

2/97 INCB Report (Switzerland)

INCB Report 1996
"The Board notes with concern statements of some government officials in Switzerland and also in other countries about preliminary results of the Swiss project on the prescription of heroin to drug addicts and its evaluation by WHO. Those statements are based on some sentences, taken out of context, taken from an unpublished interim report that will be studied by WHO experts. (...) The Board regrets the attempts of political pressure groups to exploit the project as part of their campaign to achieve a wider distribution of heroin. The Board will cooperate fully with the Government of Switzerland within the terms of the international drug control treaties, but that does not mean that the board endorses the project."

The INCB furthermore stated that the declared goal of abstinence has not been achieved, although addicts have been participating for 3 years. On no account this can be considered as a success.

"It is the Board's opinion that no Government should accept the proliferation of such trials. Otherwise the world would, under the cover of science and medicine, move along a path to legalization of the non-medical use of drugs."

"In reality, the search for quick fixes is the result of political neglect in the past. (...) there was too long a very tolerant attitude and a delay in activating necessary financial and human resources for efforts in demand reduction, particularly in primary prevention and law enforcement."

"The unusual and extensive media coverage afforded to such trials, including the unequivocal statement of some politicians who described the trials as being a first step toward legalization, may have already a negative impact on preventive programs, by the way of contributing to an increasing social acceptance of heroin."

3/97 Commission on Narcotic Drugs, CND

CND, Vienna, March 1997
This year heroin projects have been discussed under a special item. No single country supported the Swiss heroin projects. The summary given in the plenary stands for itself:

Statement of World Health Organization, WHO at CND, Vienna, March 1997
"According to WHO, the advocacy for the non-medical use of heroin and the controlled supply of heroin, without medical supervision, was not founded on any

scientific or practical experiments and was likely to be harmful to any country in which such a practice might be initiated. At present, there was no scientific evidence to support the view that controlled supply of heroin to addicts was, or might be, a safe and effective form of treatment. (...) Several delegates expressed the view that the legal prescription of heroin raised a serious question to the international drug control system and that any proposal advocating its use should be firmly opposed."

4/97 Crime statistics of the Canton of Zurich published

Since the beginning of the Heroin Projects it was alleged, that criminal behavior among drug addicts has changed. However the statistics show that burglaries and drug offences increased. Rural areas suffer especially from armed robbery.

"The increase of burglaries by 8% lies within the statistically expected deviation", was said. However, the increase of drug related crime is more difficult to explain. It was told that increased efforts of the police is a possible reason. This interpretation may be a part of the truth, but anyway if there is a true change of behavior among addicts, it should have at least a distinct impact on drug related crime.

4/97 "Youth Without Drugs" put to the Vote on September 1997

We have reached a decisive point in Switzerland. Winning the Referendum "Youth Without Drugs" will stop all further attempts to legalize drugs in Switzerland. The Referendum presents also an excellent basis and a commitment for an abstinence oriented drug policy, primary prevention and treatment for addicts.

Demographic Data Regarding Illegal Drugs in Switzerland

In the middle of the 60s – no considerable drug scene

Drug Deaths in Zurich

1971-79	107

Criminal Procedures

1969	237
1978	1521

Heroin Addicts (estimated)

1979	2'000
1989	30'000

Lifetime Prevalence of illegal Drugs: 19 years old Males in Zurich

1971/74	24.5%

Lifetime Prevalence in Zurich: Age Distribution (n=555)

15-16	17-18	19-20
10%	21%	21%

Lifetime Prevalence in rural Regions (n=310)

17
1%

Criminal Prosecution 1976: Age Distribution (n=535)

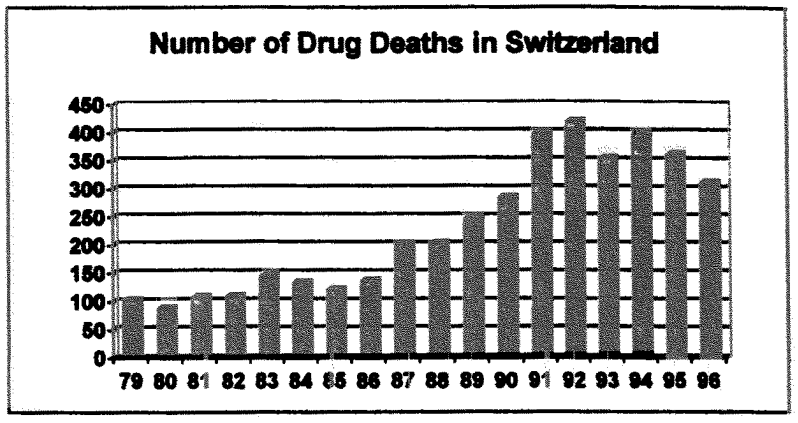
<16	16	17	18	19	20	21	22	>22
1%	3%	7%	8%	11%	14.5%	10.5%	9.5%	35.5%

Criminal Prosecution 1979: According Police Reports

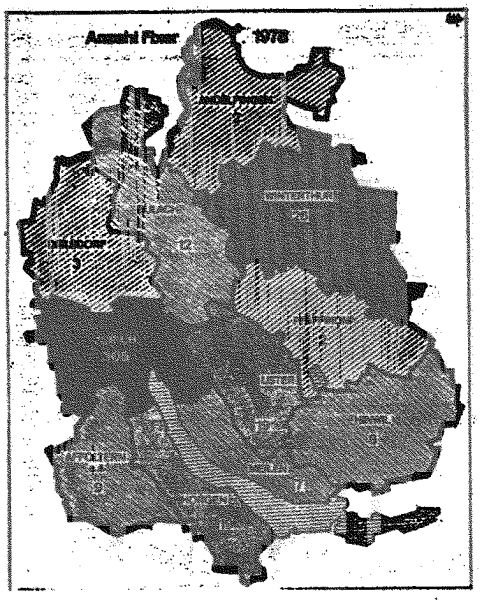
<16
2.5%

Police Report

- Increasing activities of drug dealing organizations in Zurich.
- They are conducting market researches.
- Cocaine use in Bohemian circles only.
- Almost no LSD after raiding a drug producing gang in the UK.
- Almost no Amphetamines, because of well working control of this medicine available on prescription only.



Number of Drug Addicts in the Canton of Zurich1978
(1 Million Inhabitants)



Lifetime Prevalence of illegal Drugs: 15 to 39 years old

	Women		Men		Total	
	%	Number	%	Number	%	Number
Any Drug	11.5	149'400	22.0	278'000	16.7	427'400
Cannabis	11.1	144'100	21.5	271'300	16.3	415'300
Heroin	0.7	8'900	1.9	23'600	1.3	32'500
Cocaine	1.8	23'500	3.5	44'600	2.7	68'100
Methadone	0.3	3'700	0.5	6'900	0.4	10'600
Crack	0.1	1'200	0.0	400	0.1	1'600
Amphetamine	0.6	7'800	1.5	19'500	1.1	27'300
Hallucinogen	1.2	15'000	3.0	37'900	2.1	53'000
Others	0.3	3'800	0.7	9'300	0.5	13'100

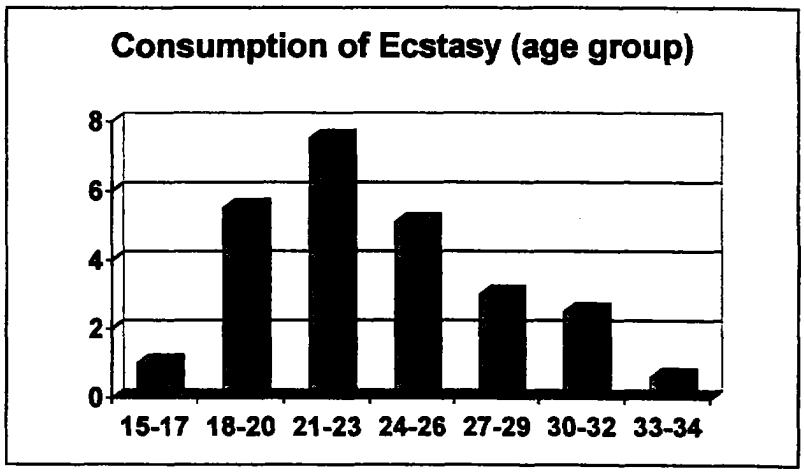
Consumption of illegal Drugs: 15 to 39 years old 1992/93 (at least once weekly)

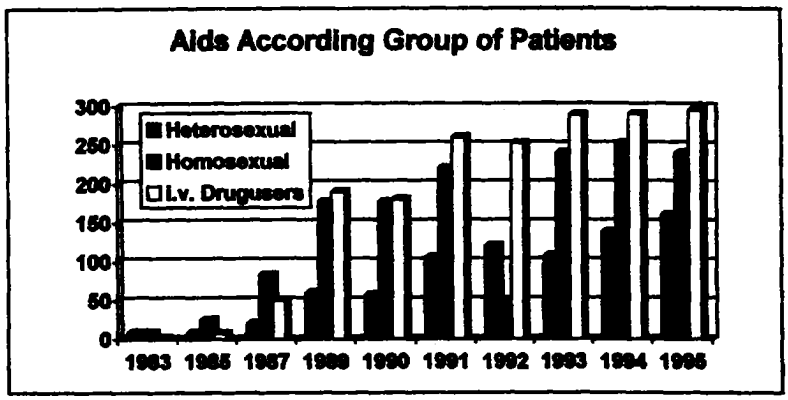
	Women		Men		Total	
	%	Number	%	Number	%	Number
Cannabis	0.9	11'200	2.9	36'700	1.9	47'900
Heroin	0.1	1'700	0.1	1'700	0.1	3'400
Cocaine	0.1	1'000	0.1	700	0.1	1'700
Methadone	0.1	1'800	0.1	1'100	0.1	2'900

Consumption of illegal Drugs: 14 to 16 years old

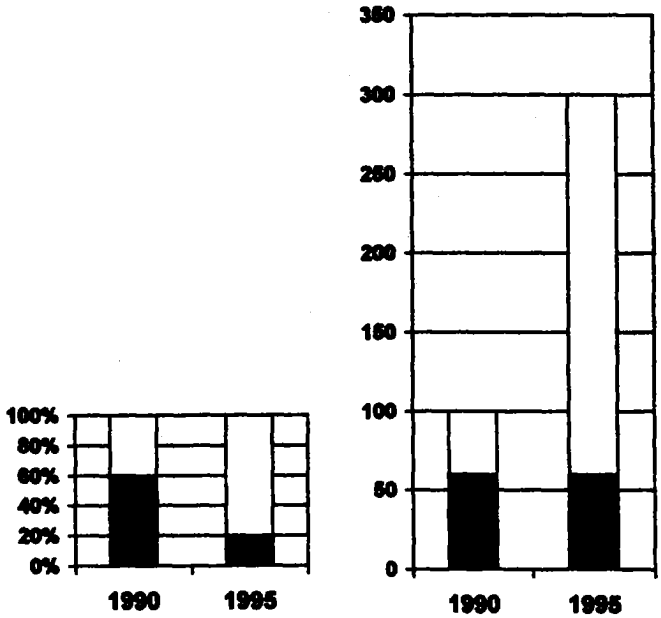
	Sex				Language Region							
	Girls		Boys		German		French		Italian		Total	
	1986	1994	1986	1994	1986	1994	1986	1994	1986	1994	1986	1994
Cannabis	11.1	16.9	11.0	22.9	11.7	18.8	10.2	21.9	4.6	22.0	11.0	19.9
LSD	1.7	*)	1.2	*)	1.5	*)	1.6	*)	0.8	*)	1.5	*)
Ecstasy	*)	1.5	*)	1.4	*)	1.1	*)	2.0	*)	1.5	*)	1.3
Ampheta.	4.1	6.2	2.0	10.7	3.5	11.1	2.6	4.5	2.7	1.9	3.2	8.6
Opiate	0.5	0.5	1.0	1.1	0.6	0.7	0.7	1.1	2.3	0.9	0.7	0.8
Cocaine	1.1	0.8	1.5	1.2	1.3	0.9	1.3	1.1	2.3	1.6	1.3	1.0

*) no data





HIV-Prevalence among intravenous Drug Abusers



Mr. HASTERT. Mr. Matthias.

Mr. MATTHIAS. Mr. Chairman, members of the subcommittee, please take these sheets that are attached to my testimony.

I'm honored to testify before your subcommittee, and I would like to thank you very much for your invitation. I'm proud of being a Swiss citizen, and therefore I feel ashamed of the drug policy of my country. In my testimony, I'm going to focus on the effect the Swiss drug policy has in Europe and maybe in the United States.

The analysis I'm going to present is the result of an 8-year monitoring of Swiss drug policy. If it is too concentrated, I'm pleased to answer your questions.

I would like to show you why Switzerland is an excellent label for selling a dangerous drug policy in humanitarian disguise. Please look at the first sheet. Switzerland is situated in the very center of Europe. It consists of three different areas, each with different language; that is, Swiss-German, French, and Italian. It is as small as Costa Rico, has 7 million inhabitants, but is nevertheless of huge financial and strategic importance.

Switzerland is independent and has a unique position. It is not a member of the United Nations, it is not a member of NATO, it is not a member of the European Union. Therefore it is difficult to influence Swiss policy from outside, for example, via these international treaties or alliances.

I've now pointed out what we are not. But now let's look at the positive aspects of our country. According to our reputation, the reality is somewhat different. Switzerland and its citizens have a long humanitarian tradition—a Swiss founded the Red Cross—has a well-developed and very extensive democratic system, is traditionally minded, conservative and anti-Communist, prosperous and has important banks.

In order to understand today's situation, we have to look back on 1988. Please look at the next sheet. 1988 was the year when the International Anti-Prohibitionist League in Italy was founded. The political aim was to prevent—to avoid a consensus against drugs in uniting Europe like the one you had at the same time in your country. Shortly afterwards in each European country, a branch of this Anti-Prohibitionist League or a cover organization was set up, sometimes supported by Soviet or East German Intelligence.

The most advanced narco-state in Europe is the Netherlands. They have had a liberal drug policy for many years, and there are many newspaper articles which show that the State has been penetrated by the drug Mafia up to a very high level. For years, the Netherlands have been the hot spot for legalization in Europe, but got a very bad reputation.

In contrast to Switzerland, the Netherlands is a member of the European Union, NATO, the Schengen Treaty, and the U.N. Due to this, last year France and Germany put severe political pressure on the Netherlands, tried to influence their drug policy and even discussed trade boycotts.

Please look at the third sheet. In spring 1989, a reliable source in the health department of the city of Amsterdam said that a strategic decision has been taken. The activities aiming at drug legalization should be shifted from the Netherlands to Switzerland. The first step using similar tactics would be to start needle exchange

programs, then methadone and then heroin distribution. The source said that Switzerland was an open, democratic society, to a great extent penetrated by the 1960's flower-power generation, but had a good name to use. Meanwhile, the Netherlands had time to improve their reputation and could later on reimport the so-called Swiss model.

Remember, in 1989, in Switzerland no one—no one was talking about these issues about heroin projects. But right now, in 1997, according to people who promote legalization, Switzerland is the second most advanced country concerning drug policy.

Please take the next sheet. The aim, intention, is to export the Swiss model to England, to Germany, to Australia, to the United States and South America by using Switzerland's good reputation. The intention is obvious: first, to install an independent so-called independent European drug policy; second, to break down the resistance of the United States against drugs; and third, to prepare the ground for an abolishment of the three international U.N. conventions against drugs.

In my opinion, what's going on in Switzerland is of strategic—is a strategic operation. Because of its democratic openness, the country is easy to penetrate. Because of its independence, it cannot easily be put under pressure like the Netherlands. Because of its good image and humanitarian tradition, it is a good camouflage for a horrible development and will therefore become a serious threat for all countries with restrictive drug policy.

Myself and my colleague would be grateful if you could help us to liberate ourselves from this junta which has taken over our drug policy, which acts in an undemocratic way and which does not represent the will of the parents and the population in Switzerland and which will ruin our society, as well as others.

Thank you.

[The prepared statement of Mr. Matthias follows:]

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Zürich, 16 September 1997

Subcommittee on National Security,
International Affairs and Criminal
Justice
The Honorable Chairman Denis Hastert
Congress of the United States
House of Representatives
Washington DC 20515

Testimony on the Swiss Drug Experiences before the Subcommittee

Dear Mr. Chairman, members of the subcommittee

I am honored to testify before your committee and I would like to thank you very much for your invitation. I am proud of being a Swiss citizen and therefore I feel ashamed of the drug policy of my country. In my testimony I am going to focus on the effect the Swiss drug policy has in Europe.

1. Switzerland's reputation

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Switzerland is independent and has a unique position.

- It is not a member of the UN
- It is not a member of NATO
- It is not a member of the European Union.

Therefore it is difficult to influence Swiss Policy from outside, for example via these international alliances.

I have now pointed out what we are not, now let's look at the positive aspects of Switzerland: According to our reputation (the reality is somewhat different), Switzerland and its citizens

- have a long humanitarian tradition (a Swiss founded the Red Cross)
- has a well developed and very extensive democratic and federal system
- is traditionally minded, conservative, anti-Communist, prosperous and has its important banks.

2. Europe and the Drug Legalizing Movements

In order to understand today's situation, we have to look back on 1988. This was the year when the International Anti-Prohibitionist League in Italy was founded. The political aim was to prevent a consensus against drugs in the united Europe, like the one you had at the same time in your country. Shortly afterwards in each European country a branch of this Anti Prohibitionist League or a cover organization (sometimes supported by the Soviet or East German Intelligence) was set up.

Please take a look at the next sheet. The most advanced Narco State in Europe are the Netherlands. They have had a liberal drug policy for many years and there are many newspaper articles which show that the state has been penetrated by the drug Mafia up to a very high level. For years the Netherlands have been the hot spot for legalization in Europe but got a very bad reputation.

In contrast to Switzerland the Netherlands are a member of the European Union, NATO, the Schengen treaty and the UN. Due to this in 1996 France and Germany put severe political pressure on the NL, tried to influence their drug policy and even discussed trade boycotts.

3. The Shift from the Netherlands to Switzerland

Please look at the next sheet. In spring 1989 a reliable source in the Health Department of the City of Amsterdam said that a strategic decision had been taken: The activities aiming at a drug legalization should be shifted from the Netherlands to Switzerland. The first step would be to start with heroin distribution. The source said that Switzerland was an open democratic society, to a great extent penetrated by the 'sixties flowerpower generation' but had a good name to be used. Meanwhile the Netherlands had time to improve their reputation and could later on re-import the Swiss Model.

Remember, in the same year, in 1989, no one in Switzerland was talking about heroin distribution. But right now according to people, who promotes legalization, we are the second most advanced country concerning its drug policy.

4. Aims

The intention is to export the Swiss Model to England, Germany, Australia, USA and South America, by using Switzerland's good reputation. The intention is obvious: break down the resistance of the US against drugs and prepare the ground for an abolishment of the three international UN conventions against drugs.

5. Schedule

On the next sheet you can see a chart showing the legalizing activities in Switzerland. In 1988, just after the foundation of the IAL we were flooded by the first powerful wave of cannabis legalization. Today cannabis fields are grown in many parts of our country.

A second wave from 1990 to 1992. By that time, we had several enormous open drug scenes, for example the needle park in Zurich. This problem was created by political will. The police were not allowed to interfere. The closing down of the open drug scene was a deal between the conservatives and the liberal and left wing parties in our government. On the one hand the police were now allowed to close down the drug scene but on the other hand there was a price to pay for this the extension of the heroin experiments.

There was also a strategic reason for this second wave. On the 6th of December, 1992 the Swiss population had to vote on the question whether Switzerland should join the European Economic Area EEA as a first step to become a member of the European Union.

For the promoters of legalization it was vital to change our narcotic laws before entering the European Union. The EU has a more or less strict drug policy and members cannot change their laws if the anticipated change contradicts the general consensus. But if a country with liberal laws enters the EU it is not forced to change these laws, at least not immediately. Thus Switzerland should have become the first country with liberal or even no narcotic laws at all. The Netherlands have a narcotic law but for legal reasons it is not enforced. The Swiss population rejected the EEA in 1992, and the next vote will not take place until the year 2000 so that the drug legalization groups have time to act.

In 10 days we will have the vote on the referendum Youth without Drugs. We want to implement an article in our constitution which makes a drug liberalization impossible.

If the vote fails the next steps will be

- first an extension of the heroin distribution from 1,000 participants to 15,000 participants.
- secondly a revision of the narcotic laws with far-reaching consequences.

The draft is top secret because it should not become public before the vote, as it contains the following points: Consumption and possession of small amounts of drugs is not pursued (approximately 30 grams cannabis and a few grams of heroin and cocaine). Together with the permission to grow cannabis extensively the law enforcement becomes nothing but a farce.

Abroad and in your country alike the Swiss Model will be presented as democratically legitimized and proven in a country which is well known for its respectability and its humanitarian and traditional thinking.

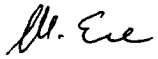
6. Summary

In my opinion what's going on in Switzerland is a strategic operation. Because of its democratic openness the country is easy to penetrate. Because of its independence it cannot easily be put under pressure like the Netherlands. Because of its good image and humanitarian tradition it is a good camouflage for a horrible and terrible development and will therefore become a serious threat for all countries with a restrictive drug policy.

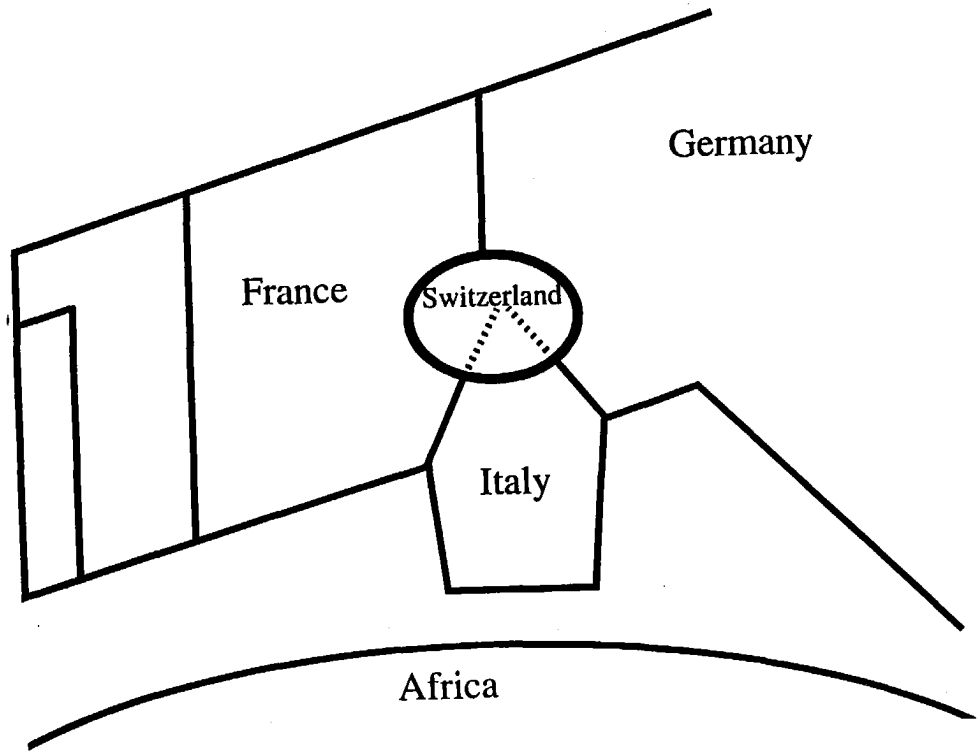
I and my colleagues and the politicians showing guts in Switzerland have tried everything we could but we could not stop this mess. We would be grateful if you could help us to liberate ourselves from this 'junta' which has taken over our country, which acts in an undemocratic way and which does not represent the will of the parents and the population in Switzerland. And the people would be aware of the dangers of drugs for society if they had not been brainwashed by the media for the last 9 years.

I thank you very much Mr. Chairman, members of the subcommittee also in the name of many people in Switzerland for this opportunity to testify before your committee.

Yours very truly



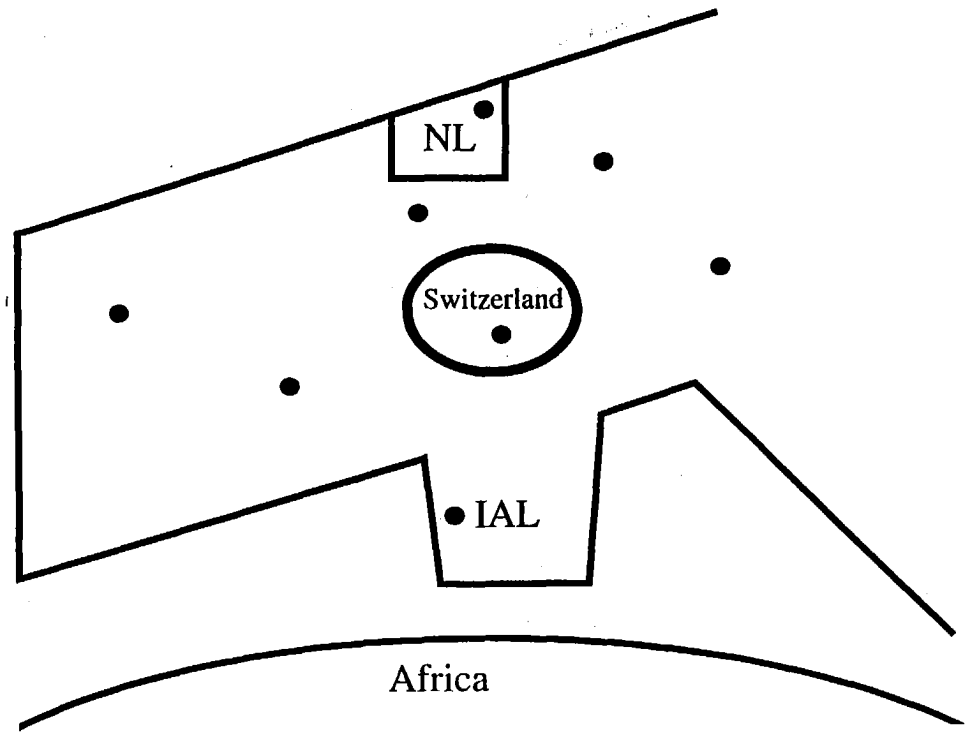
1) Switzerland's Reputation



- No UN Membership
- No Nato Membership
- No EU Membership

- humanitarian
- very democratic
- traditionally minded
- conservative
- prosperous

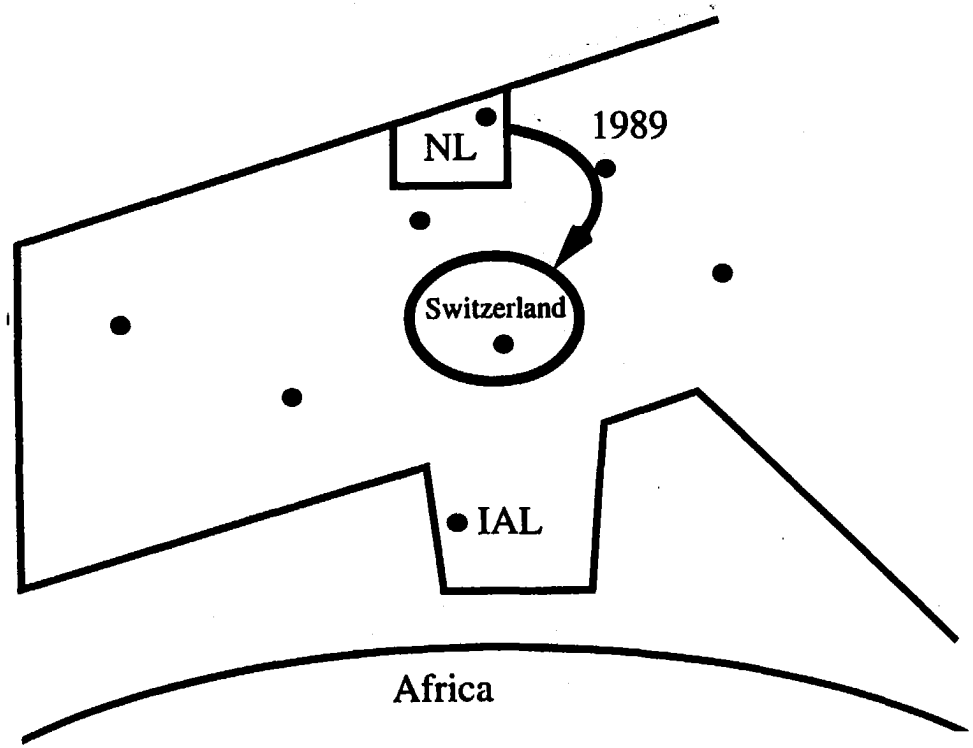
2) Europe and the Drug Legalizations Movements



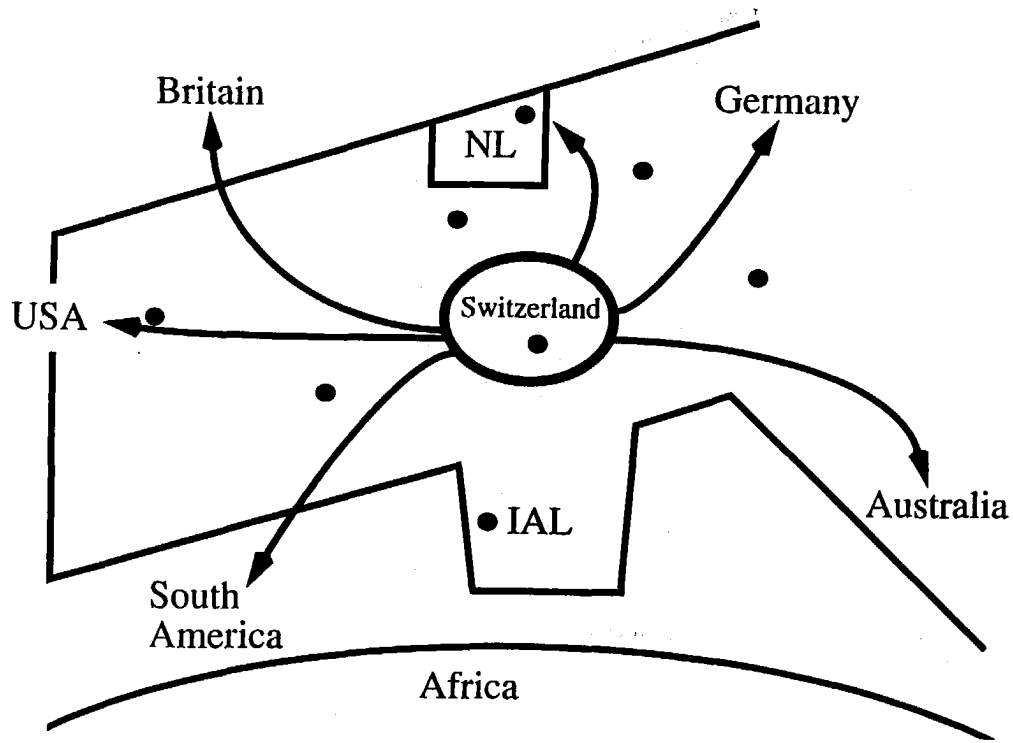
1988
International
Anti-Prohibitionist
League IAL

Netherlands bound by
- UN
- Nato
- EU
- Schengen

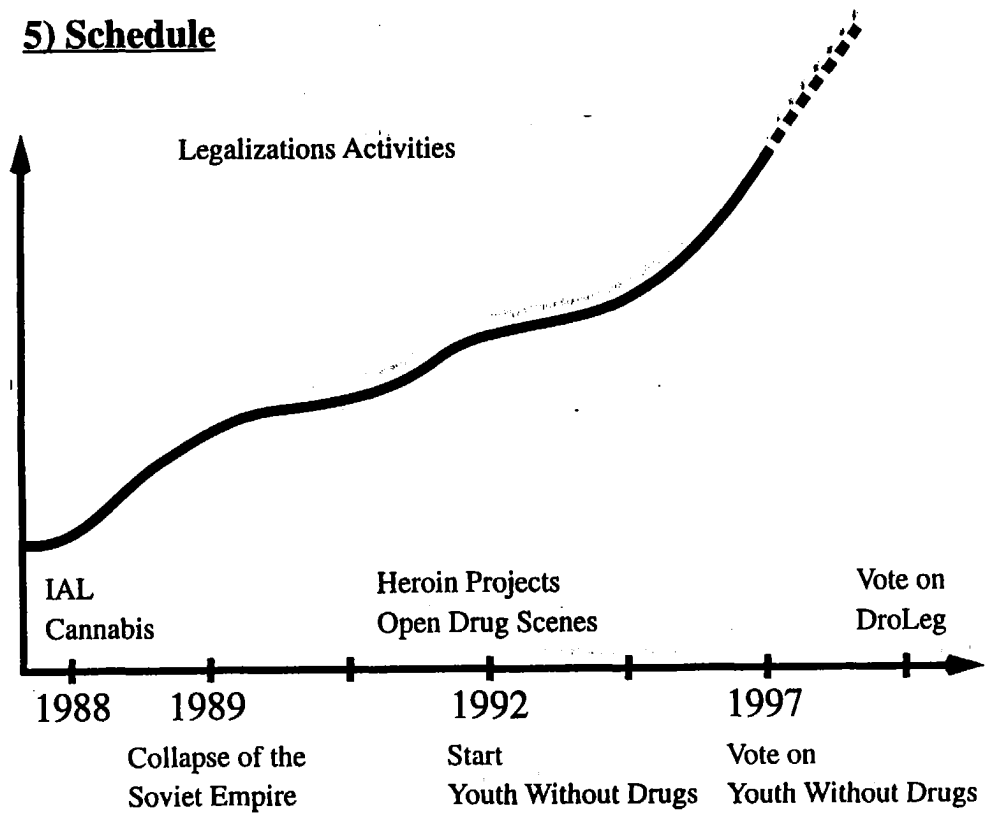
3) The Shift from the Netherlands to Switzerland



4) Aims


Britain
Germany
NL
USA
Switzerland
IAL
Australia
South
America
Africa

5) Schedule


Legalizations Activities
IAL
Cannabis
Heroin Projects
Open Drug Scenes
Vote on
DroLeg
1988
1989
1992
1997
Collapse of the
Soviet Empire
Start
Youth Without Drugs
Vote on
Youth Without Drugs

Mr. HASTERT. Thank you very much.

Let me ask you a couple questions. First of all, you made a statement that this is most prevalent in German-speaking areas of Switzerland. Why would that be, as opposed to the French-speaking or the Italian-speaking areas of Switzerland?

Dr. AESCHBACH. I think that there are different reasons for that. First of all, I think that medias in the German-speaking part have pushed that more in this part of the country. It also has to do with the different mentalities of the two parties in Switzerland. It was well known that in the French-speaking part there is no ground for legalization movement, so it has been decided to introduce it for the first time in the German-speaking part.

Mr. HASTERT. So the German-speaking part of Switzerland also includes some of the more commercial parts of Switzerland, is that correct, the center of your banking areas? Zurich and Bern?

Mr. MATTHIAS. This is correct. If I may add something, the legalizing—the legalizers are connected all over Europe, maybe all over the world. And the German-speaking area in Europe is very important for them. Zurich was the city where the so-called Frankfurt resolution was founded and that work of legalizing groups. This is also a reason why the German-speaking area in Switzerland is more in favor of drug legalization than the other parts.

Mr. HASTERT. You are also saying the German-speaking newspapers, that there tends to be, the editorials and the writing is pro-drug legalization; is that correct?

Dr. AESCHBACH. That is correct.

Mr. MATTHIAS. It is about 85 percent of all newspapers in the German-speaking area advocate legalization strong and do not give room for the other opinion.

Mr. HASTERT. Has there been any research or any looking into the situation of the directorates in newspapers also being interacting directorates of the banks?

Dr. AESCHBACH. To my knowledge, no. I don't know about that.

Mr. MATTHIAS. No.

Mr. HASTERT. Let me ask you another question. This heroin has to come from someplace. You say the Swiss Government buys the heroin; is that true?

Dr. AESCHBACH. Yes.

Mr. HASTERT. Where does it buy it from?

Dr. AESCHBACH. Switzerland has applied for permission with the INCB, the International Narcotics Control Board, in Vienna, which is part of the UNDCP, and they have approved the amount that is necessary for this first ever 250, then 500 and, at the latest, 800 participants. The amount of heroin is approved by the INCB.

Mr. HASTERT. Where is this purchased from, then?

Dr. AESCHBACH. First, it was not openly said where it comes from. But as far as we know it is a company, a pharmaceutical company in Scotland that is providing this heroin, legal heroin.

Mr. HASTERT. Where does that come from?

Dr. AESCHBACH. We don't know that. There is a legal market for a certain amount of opiates.

Mr. HASTERT. You don't know where the source of the heroin is, then?

Dr. AESCHBACH. No.

Mr. HASTERT. Then you distribute that in Switzerland, the heroin is actually distributed through the cantons, right?

Dr. AESCHBACH. That is right.

Mr. HASTERT. By truck or——

Dr. AESCHBACH. No, this is done by the police. Police is in charge of that, that it is safely distributed to the heroin sites.

Mr. HASTERT. One of the things—do you see any increase in the use of cocaine? One of the things that we have found or there is evidence that as heroin increases also mainlining of cocaine, also. Is that prevalent?

Dr. AESCHBACH. Yes, Mr. Chairman. It was in that time when the methadone programs has been so-called liberalized. Methadone was made more available. They have lowered the prerequisites to enter the program, and it was very easy to get methadone at this time. Methadone was also sold in the black market and this has led to the introduction of cocaine in the open drug scenes.

Mr. HASTERT. Is cocaine legal?

Dr. AESCHBACH. No, it is not legal, but drug addicts like the combination of methadone and cocaine.

Mr. HASTERT. Do they use these needles that you can buy in the machines, the needle exchanges, to use the illegal drugs, cocaine?

Dr. AESCHBACH. If there is a vending machine nearby, they use it but if no clear needles are available, they will inject the drugs immediately. So this is a major problem also that they are not able to look for these needles. They use the drugs immediately, if they bought it.

Mr. HASTERT. So in a sense you have a dual distribution of drugs in Zurich and other cities, other cantons, both the legal distribution through the government through the clinics, through the heroin, free heroin clinics; is that correct?

Dr. AESCHBACH. Yes.

Mr. HASTERT. And then you have distribution also of illegal drugs, including heroin and also cocaine, by drug pushers, just like we may have in this country?

Dr. AESCHBACH. That is right, yes.

Mr. HASTERT. Are there police-free zones where this happens?

Dr. AESCHBACH. Well, in the times when we have had these open drug scenes, we have had two open drug scenes, first is Needle Park, this was in 1993 and until February 1994, and we have had another, shortly after the closing down of this open drug scene another drug scene has emerged, very nearby. It is called the Railway Station. In these scenes, as far as we know that, the police was not allowed to patrol and to arrest people.

Mr. HASTERT. Thank you. The gentleman from Wisconsin.

Mr. BARRETT. Dr. Aeschbach, just to make sure that I understand correctly, in Switzerland the program includes the distribution of heroin; is that correct?

Dr. AESCHBACH. To make this clear, it is on the one side heroin distribution project and on the other side it is a scientific evaluation of this project.

Mr. BARRETT. But you do have the distribution of heroin. I am trying to discern the differences between what is going on in Switzerland and what is going on in the United States. You are aware

of the fact that there is no distribution of heroin in the United States?

Dr. AESCHBACH. Yes.

Mr. BARRETT. I would assume that you would conclude that that is a pretty significant difference between the two programs?

Dr. AESCHBACH. That is right, but I would like to mention that when we have introduced the needle, you call them needle exchange programs, in Switzerland it is actually a needle distribution program, it was an exchange program in the very beginning but it has changed, people said, well, we cannot provide empty syringes. We have to give these people something to——

Mr. BARRETT. I understand. Again, I want to point to the differences. The first difference is that in Switzerland you have the distribution of heroin and in the United States you do not have the distribution of heroin in this program.

My second question: Mr. Barr showed a picture, I don't know if those were syringes or what. You are aware, are you not, that in the United States, we do not have distribution programs, we have exchange programs? You are aware that there is a——

Dr. AESCHBACH. I understand, yes.

Mr. BARRETT. Are you also aware that for the exchange programs that it is a one-for-one exchange program?

Dr. AESCHBACH. Yes, I am aware of that.

Mr. BARRETT. And do you think that is a significant difference?

Dr. AESCHBACH. Yes. I only want to mention that it was the same procedure in our country, but it has changed very quickly.

Mr. BARRETT. But in the United States, you are aware that it has not changed?

Dr. AESCHBACH. I hope so.

Mr. BARRETT. Again, I just wanted—so in Switzerland we have the distribution of heroin and we have the distribution rather than the exchange of needles.

Is there any attempt made in Switzerland to bring people into treatment programs during the distribution? Obviously, I would think if you are buying products from machines that there is no one standing next to the machine who is going to encourage someone to get into a treatment program; is that correct?

Dr. AESCHBACH. Actually, there is a lack to bring, to motivate people to go for treatment. Also, we have very good treatment centers in Switzerland, centers that work very well and very successful, also.

Mr. BARRETT. It strikes me that one of your criticisms of the Swiss program is that it does not have a scientific basis to it; is that correct?

Dr. AESCHBACH. This is exact. The scientific heroin project is, for my point of view, not scientifically based. There is a lack in the scientific design because the final goal of this project is to demonstrate whether this project can lead toward abstinence or not, and the success rate is very low. It is actually about 5 percent.

Mr. BARRETT. You are a medical doctor; is that correct?

Dr. AESCHBACH. That is right.

Mr. BARRETT. Have you studied any of the scientific analysis of the programs in the United States?

Dr. AESCHBACH. On the needle programs, yes, I did. Some of them I know.

Mr. BARRETT. Do you think that those lack scientific merit?

Dr. AESCHBACH. Well, studies I have in mind, for instance, the Montreal study and a couple of other——

Mr. BARRETT. Montreal is in Canada.

Dr. AESCHBACH. Yes, I know. What I have in mind about these studies is that some of the studies have demonstrated that addicts are not able to change their behavior. Also, they are very well-informed about the dangers of needle sharing, but they were not able to change their behavior because opiate addicts are—opiates are mind-altering substances. This may be the reason.

Mr. BARRETT. Are you familiar with the findings of the NIH consensus panel on AIDS prevention strategies?

Dr. AESCHBACH. I am sorry?

Mr. BARRETT. The NIH consensus panel on AIDS prevention strategies?

Dr. AESCHBACH. No.

Mr. BARRETT. Are you familiar with a 1993 GAO study on needle exchange programs?

Dr. AESCHBACH. No.

Mr. BARRETT. Are you familiar with a 1995 report of the National Academy of Sciences?

Dr. AESCHBACH. No. Sorry.

Mr. BARRETT. That is fine. I don't expect you to be, frankly. Perhaps at your leisure, it is a long flight back to Switzerland, these studies found that needle exchange programs reduced an important risk factor for HIV transmission and did not lead to increased drug use. So I would ask, in your free time, you might want to take a look at that.

Thank you both for coming to give your testimony. I have no further questions.

Mr. HASTERT. Thank you.

I want to, I think, clarify this. In Switzerland, when you provide needles, free needles, and there are heroin clinics there, is that correct, where if somebody declares himself as an addict, they do have the ability to then go on a Federal pension or State pension; is that correct?

Dr. AESCHBACH. I have to clarify that needles are provided in special facilities, health facilities, harm-reduction facilities. In the heroin clinics, only addicts who are approved, who are admitted to the projects, are allowed to use needles and drugs there.

Mr. HASTERT. So they are given needles for actually a legal drug at that time because the heroin is legal; is that right?

Dr. AESCHBACH. Pardon me? No, heroin is not legal in the project. But they are not allowed to take the needles out of these heroin clinics. This is not——

Mr. HASTERT. A little different from the situation here in the United States.

The gentleman from Indiana, Mr. Souder.

Mr. SOUDER. First, I wanted to read into the record a statement from a couple of different people but in particular Dr. Kleber, who worked in the drug czar's office, and is now a professor of psychiatry. He points out, it is a letter in the New York Times, that this

report from the Institute of Medicine report, "Preventing HIV Transmission," the role of sterile needles, that it says it can be effective in spreading the use of HIV. The line avoids the use of "does prevent" and "are effective." These are far too strong. He points out that even this is contradicted in some foreign studies. Then he goes on to say that as a doctor, part of the problem here is that 50 percent of the new HIV cases relate to injecting drug users and physicians don't want to see people die of AIDS.

On the other hand, physicians don't want to see people die of drug addiction, and these two worthwhile goals may at times conflict. The committee wrestled over many hours and heated discussions with the problem. The careful wording that the committee agreed upon should not be exaggerated by proponents of needles. They are not the panacea that the supporters hoped for.

So even the most pro-needle studies do not exactly show it. What they say is that they can be effective.

I want to thank—Mr. Barrett, who did a good job of drawing out some of the points that I was hoping to point out. As a conservative who often has these domino theory kinds of things, it is interesting to watch the dominos actually having fallen.

Let me ask this question again, what you are saying is, initially you didn't distribute heroin in Switzerland, and initially it started as a needle exchange program, not a distribution program?

Dr. AESCHBACH. Yes.

Mr. SOUDER. Initially, when you had the 300 methadone recipients, was the focus that it wasn't going to be a large program, was there any indication that it was going to be 3,000 and then 15,000 people? Was that even discussed or did most proponents of this say it will be a small program, it will only be a few people?

Dr. AESCHBACH. It was not discussed. It was to liberalize these programs to lower the threshold to enter into these programs, and the justification was the outcome, well, the increasing HIV problem.

Mr. SOUDER. Did that happen gradually or——

Dr. AESCHBACH. Yes.

Mr. SOUDER. For example, in the syringes, it is in the beginning in 1989, as you said in your testimony, that 300 syringes a day were distributed. By September 1994, it was 15,000.

Were there any articles at the time that suggested that it was going to be this scale, or did the proponents at that time say it is a limited type outreach, we will never have needle parks and all this kind of stuff? What kind of discussion occurred in your country?

Dr. AESCHBACH. The reason for this dramatic increase was an increase in the number of drug addicts in the open drug scene, though they have provided as many needles as they wanted. It was not a decision that we distribute 15,000 needles, but it was an increasing problem. It was a dramatic problem, especially in Zurich but also in other towns in Switzerland.

Mr. SOUDER. Did the churches speak out as this was a growing problem? What has been the activity of the churches in Switzerland?

Mr. MATTHIAS. The activities of the church is we have the Catholic Church and the protestant church who are the most important.

And the protestant church from the beginning took a very liberal attitude and said, we must help these people and it is our humanitarian duty to give them what they have to have.

The Catholic Church in the beginning was not decided, but right now the bishops gave out a decision that they are more or less in favor of legalization and against the uses of the drug movement. So even if the bishops take an opposition toward the position of the Pope in Switzerland, the bishops' conference took these positions and nobody could understand why.

Mr. SOUDER. I can't either.

Let me ask another question about the needle park and where law enforcement does not enforce the drug laws.

Did that happen at the beginning, or is that something that was just kind of an exception that they did not enforce it closely and then as it expanded it——

Mr. MATTHIAS. During both drug scenes, the first and the second, it was a political decision that the police should not interfere in these open drug scenes. Sometimes they were allowed to go, but in the end, they were not allowed to go. It was a political decision. In the end of the second open drug scene, the thing really went out of control, the dealers threatened the police that if they would interfere in the open drug scene, they would go on strike, selling drugs.

And then 2,000 or 3,000 addicts would go crazy, or the dealers went to the police headquarters and said, you arrested a colleague. Let him free or we will let a bomb explode in the house nearby. Then a few hours later the dealer was free. So it was really the result of this policy.

Mr. SOUDER. It is a scary thing to potentially see your future. That is what you have helped us understand. Thank you.

Mr. HASTERT. The gentleman from Maryland, Mr. Cummings.

Mr. CUMMINGS. Mr. Chairman, I have no questions. I think Mr. Barrett has asked the salient questions.

Mr. HASTERT. The gentleman from Georgia.

Mr. BARR. Mr. Chairman, I don't sit here as a judge. This isn't a legal proceeding. I don't have to pretend to look at both sides of the issue and weigh it very carefully and then make my decision. I have already made my decision. Drugs kill and I am not interested in programs that further drug usage.

It does not surprise me that when drugs are made available to drug addicts, they do drugs. When needles are made available to drug addicts, they use those needles to do drugs. When we make it easier for people to get drugs, they get drugs. That, I think, is really at the heart of what we are here about.

I appreciate the testimony of these witnesses. I know that neither of them is here to tell us what to do in our country. Neither of them would be that presumptuous. They are simply here tonight to tell us what has happened in their country that many foresaw several years ago but were not listened to. I think that we can learn from this.

It has nothing to do with whether any of us are from an inner city or a suburb or a rural area. It has to do with doing everything we can, as legislators, to learn from other areas, other peoples, other governments, other situations that have gone through the

process on which some in this country would have us embark and have seen what has happened, and it is not good. It has nothing to do with whether or not we feel compassion for people who are drug addicts or who are diseased. It has to do with trying to lessen the likelihood, not increase the likelihood, of doing drugs.

The gentleman from Wisconsin glossed over a study, the Montreal needle exchange study. It is not surprising that he glossed over that. All of us in this room know where Montreal is. We do not need his snide remarks to tell us that Montreal is in Canada.

The fact of the matter is that he glossed over the Montreal needle exchange program because its conclusions do not agree with his. In the respected medical journal, British medical journal, the Lancet, they stated quote, referring to the Montreal study, "the study of nearly 1,600 Montreal injection drug users found that those participating in the city's needle exchange programs had a 33 percent cumulative probability of HIV seroconversion compared with 13 percent for injection drug users who did not participate in the program." It says that, goes on to state that the increased risks of HIV infection were "substantial and consistent despite extensive adjustments for confounders."

I think this study is important simply to state that those here who think we ought to rush forward with a needle exchange program because it seems on the surface to be benign and compassionate, which it is, that there may be some dangers out there.

I think it is also very interesting to hear from these witnesses, Mr. Chairman, who make very clear that when their country embarked on a benign and compassionate sounding program, several years ago, the aim was not to provide heroin. The aim was not to provide needles. It was a very simple exchange program.

I think the lesson for us here, which they are not making, I am making, is that these programs, once they start, they do get out of hand, human nature being what it is. Gives people who do drugs, drugs. You give people needles who want to use those needles for drugs, they use those needles for drugs. I think that is a very important lesson.

I appreciate hearing the testimony of these witnesses, simply letting us know what the experience in their country has been. I think there are some things that ought to at least give us pause to reflect on that other countries have gone through and maybe we can learn from that.

I would like to ask our two witnesses here, back several years ago, when Switzerland, in the late 1980's, first embarked on this program, these programs, what were the arguments that were used to further the program? What were the arguments that you heard from those people who wanted these programs to move forward?

Dr. AESCHBACH. Congressman, do you mean the arguments for introducing needle exchange programs?

Mr. BARR. Yes, sir.

Dr. AESCHBACH. Well, the most heard argument was that HIV transmission could be lowered or prevented by these measures, but actually there was no scientific study presented, never in our country, which could prove that these programs work. Instead, these programs were, these studies, which were made in my country, are based on interviews with drug addicts or questionnaires. But they

are not based on mandatory blood tests, for instance. So these studies are very unreliable. I think that new treatment methods or health measures in the drug scene, like needle exchange programs, should first prove that they are working, that they are effective.

Mr. MATTHIAS. Congressman, in the late 1980's, when this problem came up, it was, as I tried to explain, one piece of the tactic and vocal debates that were going on. Also, press campaigns and pressure groups tried to make this, to open this door. In Switzerland, the distribution of needles was really the first step to the situation we are in now. I would be happy if the Swiss politicians never had opened this door.

Mr. BARR. Thank you, Mr. Chairman.

Mr. HASTERT. The gentlewoman from California.

Ms. PELOSI. Thank you, Mr. Chairman. I really do want to commend you on one score. And that is yesterday I asked in another hearing if a witness from China could testify and they said no, no foreign witnesses could participate. I appreciate your liberal attitude toward inviting witnesses with information wherever they are from.

Mr. HASTERT. As the gentlewoman knows, I am one of the most liberal persons in Congress.

Ms. PELOSI. Local papers, please copy.

I thank the gentlemen for their testimony. The more I hear them testify, the less relevance I think the Swiss experiment has with what is happening in the United States.

I think that it might make a difference to our witnesses if they knew that the head of the National Institutes of Health, the National Institute of Drug Abuse, and the National Institute of Mental Health, the American Medical Association, American Academy of Pediatrics, the list goes on and on, followed the science.

I agree with you, you would be more comfortable if you had a scientific basis for the proposition that needle exchange programs would reduce the spread of HIV. And indeed, we have not advanced this issue without the science and that, again, it should always be science based.

I wanted to call to your attention a specific part of the GAO report that our colleague, Mr. Barrett, recommended, because in that GAO report they found the forecasting model developed by Yale University to be credible. The New Haven program reduced the sharing of needles by drug abusers from 71 percent to 15 percent of people who shared needles. The Yale evaluation found a 33-percent reduction in new HIV infections among New Haven needle exchange program participants over 1 year. So while you mentioned that you had read some of the information, I wanted to particularly call that aspect of the GAO report to your attention.

May I just ask one quick question, because I know that the committee is eager to hear from the other witnesses. The Zurich experience, it has not spread to any other major cities in Switzerland?

Dr. AESCHBACH. Yes, it has.

Ms. PELOSI. Well, in your testimony you mentioned—what other cities?

Dr. AESCHBACH. It was first in Zurich but it has spread to other major cities in Switzerland.

Ms. PELOSI. Could you tell me what other cities?

Dr. AESCHBACH. Bern, Basel, St. Gallen, Lucerne, Geneva, Old Lucerne, Schaffhausen; all the bigger towns in Switzerland.

Ms. PELOSI. Have picked up the same approach, OK. I was interested in that because you were talking about other countries. I wondered within Switzerland.

Once again, Mr. Chairman, I know you are eager to hear the other witnesses as well. I thank the gentlemen for their testimony and the distance they have traveled, but once again reiterate that what they have described here further convinces me that it has no relevance to what we are doing in the United States, because it is completely different.

Mr. HASTERT. I thank the gentlewoman.

I guess everybody is convinced in different ways. But one of the things that the folks from Switzerland did say, that it has spread into the cantons in Switzerland that were German speaking. I want to followup on that.

One of the things that you also said is the International Antiprohibitionist League was founded in Italy in 1988, but you said the Italian part, the Italian-speaking part of Switzerland was not so inclined to be infested or infiltrated with the drug problem.

What is the genesis or what is the beginning or who funds or who is the International Antiprohibitionist League in Italy?

Mr. MATTHIAS. The International Prohibitionist League was founded in Italy and then in each country in Europe they had a National Antiprohibitionist League. There were people from the flower power movement. There were also people from South America. There were very——

Mr. HASTERT. Do you have any idea who is the basic funding source of the International Antiprohibitionist League?

Mr. MATTHIAS. Not from open sources.

Mr. HASTERT. Not from open sources. So from concealed or other sources, sometimes you have said South America, it would be possibly Colombia and those countries who deal in drugs? Is that a possibility? Not a possibility, do you know that?

Mr. MATTHIAS. I can't say.

Mr. HASTERT. One of the things we found in this country is that the endeavors in California and Arizona, the referendums that we have had in this country last year were funded by a very well-funded group of people headed up by people who have interests in moving the drug situation. There is a lot of dollars there.

Let me ask you one other situation. We started to ask this and my time ran out. You said that people can register as a heroin addict; is that correct?

Mr. MATTHIAS. Yes.

Mr. HASTERT. If you register as a heroin addict, then you are also eligible for a pension; is that correct, or a fund from the State?

Mr. MATTHIAS. If you do not have enough money for your expenses, maybe you will get the pension. They pay for your flat. Also, they give you enough money to buy food.

Mr. HASTERT. Say, if I am eligible for a pension, how much money is that?

Mr. MATTHIAS. It is depending. But——

Mr. HASTERT. Approximately, per person.

Mr. MATTHIAS. Per person, between $1,000 and $1,500 per month.

Mr. HASTERT. If you are married, is there additional money?

Mr. MATTHIAS. Yes, and if you have a dog, too.

Mr. HASTERT. How much does the dog get?

Mr. MATTHIAS. It is about $3.50 a day. That is why our addicts have dogs.

Mr. HASTERT. And children?

Mr. MATTHIAS. Yes, of course.

Mr. HASTERT. So there is an additional amount of money per child?

Mr. MATTHIAS. Yes.

Mr. HASTERT. How much does a child get?

Mr. MATTHIAS. More than $100 a month.

Mr. HASTERT. Less than dogs, not to be funny.

So, there is an incentive, in your country. First, the needles that were given for illegal use; because the heroin was not legal, the needles were. And there is a moral situation, is that correct? As you said before, there was a moral situation because the Government was actually giving something that was legal away to use something that was illegal; is that correct?

Mr. MATTHIAS. That is correct.

Mr. HASTERT. So the next step, then, was to make the illegal substance legal under controlled situations.

Mr. MATTHIAS. Yes, under controlled situations.

Mr. HASTERT. So the needles that were being given away for an illegal product now were being given away for a legal product?

Mr. MATTHIAS. Yes.

Mr. HASTERT. What has happened in drug consumption since—then, of course, you had to take care of these people so what you did was to give people pensions and to actually have the Government support them because they couldn't support themselves so they were addicts. Has drug consumption in your country increased or decreased through these series of changes?

Dr. AESCHBACH. Unfortunately, we do not have exact surveys on that. But what I know for sure is that in 1980, we have had 2,000 registered opiate addicts. Now, it is estimated that we have 30,000. This number has not been officially changed in the last 8 years. We don't know that exactly but we can see it. We can see the problems on the street and in the earlier times in the drug scene. I think that we have an increasing problem.

Mr. MATTHIAS. It is also important not to focus on the needle and on the heroin distribution, because the whole attitude toward drugs has changed within the last 8 or 9 years. As I mentioned, the media brings out the new attitude. They have completely changed our strong will against drugs in the population.

Mr. HASTERT. I would imagine that if the Government gives away free needles and gives away free heroin and starts to give people pensions for use, then there is probably pretty much a blasé attitude toward the use of drugs.

Mr. MATTHIAS. For example, if you talk to teachers, they say, "kids in the classes, I know that more than 50, even 60 or 70 percent smoke cannabis. I have two or three taking heroin. I have two or three on the methadone program. What shall I do with them?

I cannot educate them." So you see the answer, if the drug consumption has increased, is obvious.

I would like to come back to the question of who funded the International Antiprohibitionist League. I couldn't answer that question. But today these people who are responsible for our heroin projects, one, his name is Ueli Locher. He was responsible for the Zurich project and is now responsible in the Federal Office of Health for the same thing. He got the prize on the board of the Drug Policy Foundation. I do not know how much, but it was a substantial amount of money. So there is an international connection.

Mr. HASTERT. Thank you very much. My time has expired. The gentleman from Maryland.

Mr. CUMMINGS. After the needle exchange program, talking about when it first began, after about a year or two, did you get a report, did you have any kind of report come out on it?

In other words, Ms. Pelosi agreed with you that you needed some scientific basis for whatever you were doing. I am asking you, did, say early on in the program, maybe before the needle exchange went to the distribution of heroin, was there any kind of scientific report that came out with regard to it?

Dr. AESCHBACH. Congressman, you mean about the effectiveness of the needle exchange program? They had provided some studies, but only based on interviews. That is my concern, that these kind of studies are not reliable.

Mr. CUMMINGS. So they were not scientific; is that right?

Dr. AESCHBACH. Well, in my opinion, a scientific study on HIV transmission that is based on interviews cannot be reliable, even if the scientific design is well done.

Mr. CUMMINGS. So in other words, you felt that whatever reports that were published were not valid?

Dr. AESCHBACH. Yes.

Mr. CUMMINGS. What did the report say? I am just curious.

Dr. AESCHBACH. Pardon me?

Mr. CUMMINGS. What did the report say?

Dr. AESCHBACH. Well, the report said that the HIV prevalence has decreased. The first data that were provided said that we have a prevalence of about 60 percent among drug addicts, and the data provided nowadays speak about 15, 16 percent, so I cannot explain this decrease in the prevalence of HIV.

Mr. CUMMINGS. What about drug usage, did it talk about that?

Dr. AESCHBACH. Among drug users?

Mr. CUMMINGS. What I mean is, did it talk about the increase of drug use or the decrease? Did it talk about drug use?

Dr. AESCHBACH. No, they talked about the—they talked about the prevalence of HIV among opiate users, abusers. Not about the—I am sorry. Maybe I don't understand your question.

Mr. CUMMINGS. You seem to be on track.

What I am asking you is that in the United States we have a situation where we were looking at either both of these factors, the decrease in AIDS cases, people with AIDS, and whether the needle exchange program resulted in an increase in drug usage.

Now you talked about what I understand you feel, you felt that it was invalid. I understand that. But I'm still curious as to what

it said. Did it address the whole question of an increase or decrease in drug usage, drug usage in and of itself? Did it even address that?

Dr. AESCHBACH. Well now I understand your question, but unfortunately we have no data about that because it is not done in Switzerland.

Mr. CUMMINGS. So if you had a study in Switzerland that you considered to be a valid study, and I understand you are a medical doctor, and let us say Johns Hopkins, are you familiar with Johns Hopkins University?

Dr. AESCHBACH. Yes.

Mr. CUMMINGS. Let us say you had a Johns Hopkins University in Switzerland and Johns Hopkins University evaluated your program and found that there was a decrease in the AIDS cases and that there was a decrease in drug usage, would you be coming to the same conclusions? Would you be here?

Dr. AESCHBACH. I am sorry. I do not fully understand your question. But because data are not available in Switzerland about that, also the Johns Hopkins University cannot draw the conclusions. The data we have are not reliable.

Mr. CUMMINGS. One last question, maybe this will clear it up. You would have felt a little bit more comfortable if there was some kind of valid study; is that right?

Dr. AESCHBACH. Yes.

Mr. CUMMINGS. You would have felt more comfortable about the program itself? In other words, I think, if I hear you right, if you had a valid study, is there anything that the study could say that would make you feel at all comfortable about the Switzerland program, assuming it is a valid study? For example, if it said AIDS cases were down and it said drug usage was down with regard to the program, would that have brought you any level of comfort with the program?

Dr. AESCHBACH. Congressman, this is an assumption, I think. I would never object to methods which are likely to decrease the HIV transmission rate, but this is an assumption. This is not reality in my country.

Mr. CUMMINGS. I understand. Thank you.

Mr. HASTERT. The gentleman from Indiana.

Mr. SOUDER. I am sure we will have a number of dueling studies. Let me ask one other variable along the same lines, though. Do you know, have drug overdoses increased in Switzerland over the last few years and violent crime? Do you know anything about those two statistics?

Dr. AESCHBACH. Well, concerning crime, we have an overall increase of crime. I am more familiar with the crime statistics of the canton of Zurich and there was an increase there. Also, the police have explained this increase in crime as related to drugs and drug consumption.

Mr. MATTHIAS. When the open drug scenes were closed down, the crime rates came down.

Mr. SOUDER. Have you seen it spread more among young people where it was not before?

Mr. MATTHIAS. Much more.

Mr. SOUDER. Even if we were saving lives on the side of HIV, we may be losing lives in people's, if not their actual dying, at least destroying their lives?

Mr. MATTHIAS. I think this is a question we must look at the whole attitude. If, like in our country, the whole society is more or less in a positive attitude toward the drug consumption, then you will lose more life.

Mr. SOUDER. Any increase in domestic violence, men beating their wives because they are addicted?

Mr. MATTHIAS. We do not know. There are no studies about it.

Mr. SOUDER. If I do not get through all my questions, I would like the record to be held open so we could see if we could get some data to put in.

Mr. HASTERT. Without objection.

Mr. SOUDER. Has the American Embassy been helpful in your Youth Without Drugs initiative and supportive?

Mr. MATTHIAS. We have not had any evidence about that, no.

Mr. SOUDER. Have they been——

Mr. MATTHIAS. They did not interfere actively. We did not——

Mr. SOUDER. So they have been more or less silent on the drug issue in Switzerland?

Mr. MATTHIAS. Yes. And what we were wondering about all the years why the United States did not care what is going on in Switzerland, because we thought, as I tried to explain, that the legalizing groups tried to build a model in Switzerland that should be exported as it is now. We have our expert at—the Federal expert who evaluates these heroin projects is invited to the Medellin conference, which will take place in, I think, a few weeks. And I think——

Mr. HASTERT. That is the Medellin conference in Medellin, Colombia; is that correct?

Mr. MATTHIAS. Yes. On drug medication or something like that.

Mr. SOUDER. Let me yield to the gentleman from Georgia.

Mr. BARR. Mr. Chairman, I have to leave to catch the last plane to Atlanta. I apologize to all of the witnesses, including the two that are here from Switzerland. We do have the written materials and I will read that. I am familiar with most of the witnesses. I appreciate all of the witnesses coming here this evening to share their background, their research, their observations with us. It adds considerably to the data on which we have to operate here so we can make better and more informed decisions.

I appreciate, Mr. Chairman, yourself and the staff putting together these important hearings which are just one more part of the overall issue of fighting the drug war. I know we will have further hearings on other aspects of it, but I appreciate these hearings and would respectfully ask permission to head to Atlanta.

Mr. SOUDER. No.

Mr. BARR. I wasn't talking to you.

Mr. SOUDER. We have had hearings in this committee on the movie industry in our country, the television industry, and the music industry. We have been very concerned about the so-called heroin chic look that came out of the west coast.

Did you see a lot of these phenomena? What role did the media play in softening up the general public and particularly young people for drug use?

Dr. AESCHBACH. We have not experienced this in this special way, but what is a common message that is communicated by media is that drugs are not so harmful and that a possible solution to drug problems could be that people learn to live with drugs, that they learn to consume it in a responsible way. They say that drugs, the substance itself, is not dangerous but the way, how it is consumed. This is one basic message that is communicated which is, from my point of view, likely to engage young people to start, to make experience with drugs.

Mr. SOUDER. I have one more—go ahead and answer that.

Mr. MATTHIAS. The other side of the media is that they, let us say, they block people who aren't informed about the effects drugs have, they block the scientific effects, and in the other way they attack groups who are against drugs and against drug legalization. So it is not easy to be against drugs in Switzerland.

Mr. SOUDER. The technical question I have is that to participate in these heroin experiments that you had been talking about, what are some of the criteria? Is there an age range? How young can you be? Are pregnant women allowed into the program?

Dr. AESCHBACH. Yes, that is correct. I think, I have to mention that the, actually, the target group for these projects are so-called hard core addicts, which means addicts who are addicted for a long time, who are in the bad health state, who have social problems and so on. The data I have in the final report that was published recently, and I gave you a translation in English about these figures into the files, I can show that the target group has not been reached, these are not hard core addicts.

For instance, three quarters of the addicts who are admitted to projects have only had one attempt in a residential therapeutic facility and another 74 percent have experienced at least between once and five times. They have been, I think about 73 percent of these addicts, have been once or never in a methadone maintenance program. So I think that this very clearly demonstrates that these addicts are not hard core addicts.

Also, it is the age—the age is limited to 20 years. They have to prove that they are severely addicted, but according to the data, 18 percent have not used heroin on a daily basis. According to the rules that have been set down, I think the criteria to admit these people in the projects are not very reliable.

Mr. HASTERT. The gentleman's time has expired. The gentlewoman from California.

Ms. PELOSI. I have no further questions, except I reject out of hand the Swiss project. Hearing what the gentlemen had to say, I think your time has been well spent here because the description that you make further convinces me that it is not a program that I would support or have anything associated with it. I thank you for that, and I thank you, Mr. Chairman.

Dr. AESCHBACH. May I make a comment on that?

Mr. HASTERT. Please.

Dr. AESCHBACH. Thank you very much.

Congresswoman, according to my standpoint, the Swiss model has relevance for other countries. And I want to say that because we know that this model has been exported to other countries. This final report on the heroin project has been published. The message has been communicated all over the world, and it has been said that this is a working model for heroin addicts all over the world. For instance, this conference in Medellin that has been mentioned here. The aim of this conference is to present a working model to the world. These people are coming from all over the world, from the States, from the United States, from South America, and they are discussing the solution of the drug problem at this conference. I think this is most relevant.

Ms. PELOSI. That is why I said to the gentlemen that your time was well spent coming here to make us more fully aware of the Swiss project. But in terms of the decision that is before the Congress of the United States, my colleague, Mr. Cummings from Maryland, made it very clear, there are two criteria: Is there scientific evidence that it reduces the spread of HIV/AIDS and does not increase the spread of drug abuse, indeed decreases the drug abuse. And that is what we are talking about here, something very narrow, very limited and with criteria. It is not indiscriminate needle exchange. It is with criteria.

I know that central to one of the proposals to undermine the needle exchange program here is to use the evidence, the description of the Swiss program. My point is your time is well spent. I have learned more, just speaking for myself, about what is happening there as a staunch supporter of measures to reduce drug abuse in our country and to fight in the war on drugs. I would never want anything close to that even to come into the United States. But the relevance that, I was using the word "relevant," was in terms of a very specific targeted exchange with criteria for scientific basis of reducing drug abuse and reducing the spread of HIV. This is a contrast. It is not a comparison. It is a difference, not a similarity.

Mr. HASTERT. I thank the gentlewoman.

Before I dismiss this panel, you mentioned a drug conference in Medellin, Colombia, in which somebody from your country is participating. Who sponsors that?

Mr. MATTHIAS. I do not know who exactly, but I know that the Drug Policy Foundation is involved somehow. There is a translation of an article in the German-speaking magazine, Der Speigel. I think is in the material I gave to you. And it is the Drug Policy Foundation. And you mentioned——

Mr. HASTERT. Do you know who underwrites that?

Mr. MATTHIAS. George Soros, who gives money to this foundation. Where all the money comes from, I do not know.

Mr. HASTERT. Thank you very much for joining us this evening. It was not planned to be this evening, but we appreciate it very much and God speed back to your homeland.

At this time I would like to introduce the second panel. First of all, Mr. Robert Maginnis is a policy analyst with the Family Research Council. Mr. David Jordan is a professor of government at the University of Virginia. He previously served as the Ambassador to Peru. Ms. Nancy Sosman is a member of the Coalition for a Better Community. And Dr. Peter Beilenson is the commissioner of the

Baltimore City Department of Health. I thank you, certainly all, for being here today.

In accordance with House rules, I will swear you in.

[Witnesses sworn.]

Mr. HASTERT. Let the record show that all the participants answered in the affirmative. Mr. Maginnis, would you please deliver your testimony.

STATEMENTS OF ROBERT MAGINNIS, FAMILY RESEARCH COUNCIL; DAVID JORDAN, PROFESSOR, UNIVERSITY OF VIRGINIA; NANCY SOSMAN, COALITION FOR A BETTER COMMUNITY; AND PETER BEILENSON, COMMISSIONER, DEPARTMENT OF HEALTH, BALTIMORE, MD

Mr. MAGINNIS. Thank you, Mr. Chairman, members of the subcommittee.

I appreciate this opportunity to share my perspective concerning needle exchanges, legalization of drugs, and the Swiss heroin experiment. I believe that needle exchanges are being used by some people to incrementally move public policy toward outright drug legalization. I also believe that Switzerland's just completed heroin experiment opens a frightening door to eventual drug legalization.

This conclusion is based on my personal observations in Switzerland. I visited four Swiss Government-run heroin clinics in three cities. In April, I helped produce a video exposing the flawed Swiss drug policy.

I learned the following: I visited Project Crossline in Zurich, 1 of 3 clinics in that city, and 18 in the country. Addicts and doctors work together to decide on the appropriate heroin dose and can decide at any time to change the amount. The addicts come to the clinic, as many as three times a day, to receive up to 900 milligrams of pure heroin. Addicts are expected to inject themselves, but the medical staff will provide advice on techniques.

One clinic doctor said his staff will inject the heroin for patients having difficulty. When addicts can't come to the clinic because they are in the hospital or on vacation, they are given take-home methadone.

In the past, the clinic gave heroin cigarettes, but according to the spokeswoman, smoking is not healthy. Recently, the Zurich clinics have introduced 200 milligram heroin tablets for addicts who cannot shoot up.

I visited the clinic in Bern. I met the head doctor, Robert Hammig, who is the president of the Swiss branch of the International Antiprohibition League. Dr. Hammig favors giving addicts heroin rather than methadone or morphine. He believes it is better for them.

He also favors giving alcohol to alcoholics and believes that heroin is no more toxic than alcohol. There have been some drug overdoses at the Bern clinic, but according to Hammig, the addicts are lucky because his staff is prepared to save them from certain death.

He has one pregnant woman in the project. Hammig believes that heroin is better for her than methadone. He rejects the notion that the baby will become addicted, and explained that rather than injecting heroin into her veins, they inject it into her fatty tissues

in the belief that this is safer. Hammig claimed to have friends in the United States who want to try heroin projects.

I visited Zurich's Zokl 2 heroin clinics. Next to the clinics steps sat, as you saw in the picture, an empty baby carriage. Some heroin addicts have children, obviously, and others have had babies during the project. Behind the clinic's glass window sat a woman who dispensed syringes preloaded with pure heroin. Clients literally raced up to the window, identified themselves, grabbed their preloaded syringe, and disappeared behind a wall to shoot up.

I was briefed by Dr. Van der Linde, who runs the St. Gallen heroin clinic. He guessed that perhaps 10 percent of his patients contracted HIV from sex and dirty needles. His clinic does not give clean needles, but outside there are 18 local places to buy clean needles, and street social workers actually give free needles to whoever asks for them, including adolescents.

Our video project interviewed a former heroin clinic patient, Roland Seitz. He's HIV positive. Roland said, "I went to the heroin clinic every day, and at first I thought I could reduce the dosage, but that was self-deception. You just take more and more. One doesn't reduce; I tried, but the urge became overwhelming. I eventually thought, hey, what do I need the heroin program for? I'm doing the same crap I did on the street. Only one thing is different. I'm more addicted and dependent. I depend on the State, I depend more on the doctor, I depend more on the staff. There are simply more organizations I depend on. And then I said to myself, 'That's over now,' and then the government clinic wanted to keep me in the program. I just said, 'No, that's it.'"

Well, Mr. Chairman, I believe that if the Swiss people's referendum fails this September 28, Switzerland will rapidly expand heroin giveaway programs pushing that nation into outright drug legalization.

Switzerland's heroin experiment has also affected other countries. This August, Australia's Federal Government debated projects. Two weeks ago the Dutch parliament debated the issue. President Clinton has been approached by Mr. Schmoke of Baltimore, in May 1997 at the Mayors' Conference, to start heroin programs in this country as reported in the Boston Globe.

The Swiss Government, Mr. Chairman, has embraced a dangerous drug policy. Our response should be to learn from Switzerland's tragic errors to encourage the Swiss "Youth Without Drugs" movement and to avoid following in their footsteps.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Maginnis follows:]

Maginnis

Testimony of Robert L. Maginnis
Senior Policy Advisor

before

House Subcommittee on National Security,
International Affairs and Criminal Justice

on

September 18, 1997

Mr. Chairman, Members of the Subcommittee, Ladies and Gentlemen:

I appreciate this opportunity to share my perspective concerning needle exchanges, legalization of drugs and the Swiss heroin projects.

I've provided for the committee's consideration my work on these issues. I have written about needle exchange programs and last month published the results of a nationwide voter survey on the issue. I have also written on the topic of drug legalization and believe that needle exchanges are used by some advocates as a wedge issue to incrementally move public policy in that direction.

I also believe Switzerland's just-completed heroin experiment opens a frightening door to eventual drug legalization. This conclusion is based on my personal observations in Switzerland.

I have visited four Swiss government-run heroin clinics in three cities (Zurich, Bern and St. Gallen), one government-run shooting gallery, one methadone clinic and numerous public drug scenes. I have attended three government-run briefings hosted by Swiss doctors and public health officials. In April, I worked with a Swiss citizen's organization to produce a video featuring numerous addicts, their family members, medical experts and political leaders. The video which has been widely circulated in Switzerland, tells the tragic story of the Swiss government's accommodation of heroin addicts and manipulation of the media and public opinion.

The following summarizes what I saw and learned from visiting Swiss heroin clinics.

On **April 11**, I visited "Project Crossline" in Zurich, one of three clinics in that city and 18 in the country. This clinic is on the second floor of a large office building in the back. The

entryway leads into a large, nondescript waiting room with 15 chairs. The seated patients face an injection room with large picture windows. The man behind the injection room counter first confirms the addict's identity and then hands him or her a preloaded syringe with the agreed-upon heroin dosage.

Addicts and doctors work together to decide on the appropriate dose and can decide at any time to change the amount. The addicts come to the clinic as many as three times a day to receive up to 900 milligrams of pure heroin.

The injecting room has two steel tables against opposing walls. Hanging from hooks above the tables are tourniquets and on the table are squirt bottles with alcohol sitting next to boxes of bandages and towels. Addicts are expected to inject themselves, but the medical staff will provide advice on techniques. One of our briefers, Dr. Christoph Burki, said that at his clinic in Bern his staff will inject the heroin for patients having difficulty.

When addicts can't come to the clinic because they are in the hospital or on vacation, according to Rosanne Waldvogel, a Zurich city counselor and overseer for the Zurich project, they are given take-home methadone (a drug used for progressive detoxification of heroin addiction). In the past, the clinic gave heroin cigarettes, but, according to Waldvogel, smoking is not healthy. This is a strange and contradictory standard. Recently, the Zurich clinics have introduced 200- milligram heroin tablets for addicts who can't shoot up.

Burki and Waldvogel profiled the Swiss national program. The project's objectives are to determine whether hardened heroin addicts can be helped and to gain knowledge on how opiates work. While abstinence from heroin is not an objective, on occasion addicts have been known to abstain, said Waldvogel.

In the 18 clinics (spread among five cities) 800 addicts receive government-provided pure heroin. The addicts are charged 15 Swiss francs per day, which is typically taken from the 2500 Swiss francs of social welfare given to addicts each month.

Admission to the program is selective. According to Burki, vacancies are filled within a matter of hours. For example, in 1994 317 new addicts joined the project and 104 left. Almost half of those who left went to methadone projects, a few to abstinence treatment facilities, some died, and others are not accounted for.

Project addicts must have at least two years of daily intravenous heroin experience and at least two treatment failures to gain admission to the project. They must be at least 20 years old, be "marginalized" people with severe health and social problems, and be willing to abide by the project rules. Eighty percent are male.

One of the program objectives is to improve addict health. They come to the program with high rates of hepatitis B and C as well as AIDS. Many have open sores from shooting up daily, and they are generally malnourished, have sexual diseases and a variety

of other ailments. At least one in 10 are schizophrenic, and most are multi-drug users with various psychoses.

Some of the addicts have jobs, which is another objective of the Swiss normalization program. These people are under no obligation to tell their employers that they use heroin. When asked about work-related drug testing, Waldvogel indicated that it wasn't a problem in Switzerland.

A small study was done with 43 project addicts to determine whether their participation reduced crime. Police records showed that addicts were arrested less often after joining the project than when they were on the streets but Burki admitted that the sample was too small to draw any project-wide conclusions. A major criticism is that the police were not included in the experiment's design and operation.

On **April 14**, I visited the heroin project at the Inselspital (hospital), Bern. This project is located behind the hospital's emergency room and next to the Catholic and Protestant chapels. It's on the second floor of the Alte Pathologie (old pathology) building. There are 130 addicts in the Bern project.

The Alte Pathologie is a rundown, dark building. The wood floors creak as one walks down the sterile-looking hallway. There was a young man, perhaps 20 years old, slumped in a chair outside a closed door. I guessed he was waiting for the doctor.

At the end of the hallway I walked into the room and asked to speak to someone about the project. A man in his mid-thirties with long blond hair asked if I had permission from the government health ministry to be there. I didn't. He insisted this was required before we could speak. I told him I was in Bern for only one day and wanted to learn about the project. I had a cameraman with me and wanted to do an interview.

He led me to an adjoining office where I met the head doctor, Robert Hammig. I stood at Hammig's door speaking through an interpreter and explained my desire to conduct an interview. Hammig is the president of the Swiss branch of the International Anti-Prohibition League which believes in the liberalization of drug policy.

Hammig, who wore a T-shirt and jeans, began to speak English. He said it was impossible to do an interview without government permission. His body language and words were more Pavlovian than sincere. I insisted on asking questions and slowly he settled down and began answering my probes. He became positively sanguine once my cameraman left. Hammig said that he wouldn't give an on-camera interview, but it would be okay to interview the addicts outside the clinic.

On the walls inside Hammig's office were a Grateful Dead poster, a condom advertisement and a picture of the Pope. Condom cartoons adorned the wall outside his office and on the bulletin board was a staff continuing-education schedule. On May 21,

1997, the staff was scheduled to be briefed by government health officials on "Youth without Drugs," a constitutional initiative which would stop the heroin projects.

Dr. Hammig favors giving addicts heroin rather than methadone or morphine, the substances given at some Swiss projects. He believes it's better for them. He also favors giving alcohol to alcoholics and believes that heroin is no more toxic than alcohol.

There have been some drug overdoses at the Bern clinic, but according to Hammig the addicts are lucky because his staff is prepared to save them from certain death.

He has one pregnant woman in the project. Hammig believes that heroin is better for her than methadone. He rejects the notion that the baby will become addicted and explained that rather than injecting heroin into her veins, they inject it into her fatty tissues, in the belief that this is safer.

Hammig encouraged me to write about the Swiss projects, suggesting, "Tell how good our projects are." He complained that the Swiss projects are not getting good press and claimed to have friends in the United States who want to try heroin projects but say that opposition in America's press has hurt their chances. Other nations, like the Netherlands, Germany, Denmark and Belgium, according to Hammig, want to start heroin programs but fear disapproval by the United Nations.

While at the clinic, I saw numerous addicts arrive for their third daily fix. Most were men. Disheveled, downcast, some moving erratically, the addicts comprised a sad-looking group. Two brought their dogs, which were tied to the stairwell's rail while their masters went inside for their heroin. In Switzerland, addicts get 300 Swiss francs each month to keep a dog. The government wants to encourage addicts to have "man's best friend," believing it's good medicine.

Outside I spoke with several addicts, but one was especially interesting. Heidi (a pseudonym) is a 25-year-old French Swiss who is a project participant. She defended the program.

If not for the hard drug life, Heidi would be an attractive woman. When she joined the project she took 800 milligrams of heroin each day and now proudly says she's down to 100 milligrams each evening plus some methadone in the morning. She admits to taking cocaine when she can and never expects to stop.

Heidi is a brunette who wears her hair in a bun. Her eyes are dull. She wore a blue denim jacket, a long sailor shirt that didn't quite cover her partially exposed rump, and tightly-fit jeans. Her black pumps were scuffed. Her hands were puffy and scarred from needle punctures and her neck was bruised.

If she could start all over again, Heidi would not rule out drug use. Although she doesn't like her life today, she wouldn't tell kids to stay off drugs. When asked why she started

using drugs, she explained that she had problems with her mother. Her mother has repeatedly tried to get Heidi into abstinence treatment.

Obviously a very bright woman, she spoke about returning to college one day, but was completely self-consumed with getting her next fix. She feared that lives would be lost if the clinic were to close.

On **September 6**, I visited Zurich's "ZokL 2" heroin clinic, a nondescript two-story building on a busy street identified only by a small sign "ZokL 2" and a sticker on a window which reads "Stop AIDS" (the "o" is a condom). Next to the steps sat an empty baby carriage. Some heroin addicts have children and others have had babies during the project.

Most of ZokL 2's patients are young, scantily dressed women. Female addicts are often prostitutes, their arms scarred from long term drug abuse, their eyes sunken and distant.

Behind the clinic's glass window sat a woman who dispensed syringes pre-loaded with pure heroin. Injections are offered three times per day and dose rates vary based on addict "needs." Clients literally raced up to the window, identified themselves, grabbed pre-loaded syringes and disappeared behind a wall to shoot up. One young woman stepped out from behind the partition revealing that she was injecting into her exposed hip.

On **September 6**, I was briefed by Dr. Francois van der Linde who runs the St. Gallen heroin clinic. Van der Linde is a national advocate for the program. He said Switzerland had one of the highest rates of drug addiction in Europe and is number three in Europe in HIV behind Spain and France. Dr. van der Linde said heroin projects are not about legalization but about medicine. He told me that of 1,035 who started the heroin projects, 68 over three years are free of addiction. There have been 36 deaths among project addicts. Ten percent of his patients are HIV positive. He is not sure how they contracted HIV but guessed it was either via prostitution or sharing dirty needles. His clinic does not give clean needles for outside use, but there are 18 local places to buy clean needles and street social workers give free needles to whomever asks for them, including adolescents.

Our video project includes interviews with former addicts about the Swiss government's heroin programs. This is what they said.

Boris Piske: "I have met people in favor of legalization and I say with terror that these are people with a clear ideological position. I would dare say that these are people willing to walk over dead bodies because they know full well that there are people dying fast because of drugs. I think that if we young people go on like this, the next generation will be poisoned, exterminated."

Roland Seitz: "I had been doing drugs for 14 years and then the heroin program started. I thought that it wouldn't be so difficult to get drugs, no harassment with the police, I would always have my heroin, no monkey on my back in the mornings, everything would

be more relaxed. And then I went there, they admitted me to their program since I met the requirements and then we started with 50 milligrams. I went up there every day and at first I thought that I could reduce the doses again. But that was self-deception, you just take more and more. One doesn't reduce. I tried, but the urge became overwhelming. That's the way I entered the heroin program."

"I eventually thought, 'Hey what do I need the heroin program for? I'm doing the same crap I did on the street. Only one thing is different: I'm more addicted and dependent. I depend more on the state. I depend more on the doctor. I depend more on the staff. There are simply more organizations I depend on.' And then I said to myself, 'That's over now. I'll go back to methadone. I don't give a damn what the others say.' And then they wanted to keep me in the program, that's clear isn't it? I just said, 'No, that's it.'"

"With free heroin, one tends to increase the dose. As I've said, one is more dependent. And I believe abstinence-oriented therapy is far more effective. I no longer have the craving or the stress. I can go into other things, I can have feelings you can't have under the influence of heroin."

Andrea Eberle: "For every addict who is in the heroin program, hope is being taken from them for getting out because he is stamped as sick and incurable. And that's what he thinks of himself anyway and why should I try to get out when I get what I want from the state, who has become the dealer here, and I also get it from the money I need to live that the government gives me -- I'm hopeless, I can't get out because I won't get all of this otherwise. It is also not fair towards every addict to introduce this, and, most importantly, it just doesn't stop with a heroin program, because when they hear of this, coke addicts will come and say, 'Hey, we're being discriminated against, we want coke!' and then those who want ecstasy will say, 'I want ecstasy!' and it goes on and on until everyone can come and say, 'I need my drugs or else I can't live!'"

The Future for Switzerland and The West

If the people's referendum "Youth Without Drugs" fails to win a majority of votes on September 28, I firmly believe Switzerland will rapidly expand heroin giveaway programs pushing that nation into outright drug legalization within a few years.

Switzerland's declaring the heroin project a success has already had a domino effect. This August Australia's federal government debated a heroin project and two weeks ago the Dutch parliament debated the issue as well. Other nations like Germany, Belgium and Norway are seriously looking at this alternative policy. Even Baltimore Mayor Kurt Schmoke encouraged President Clinton at the May 1997 National Mayor's Conference here in Washington to consider these programs.

The advocates of drug legalization see heroin projects as the next incremental step beyond needle exchanges to the goal of outright drug legalization.

George Soros has been an advocate of "medical" marijuana and needle exchanges. He has funneled millions of dollars of his own money into efforts to advance these so-called "harm reduction" efforts. Soros' drug policy mouthpiece Ethan Nadelmann, who directs the Lindesmith Center, is on the record as favoring heroin projects.

American media have cited the Swiss model as something to be emulated. On March 26, 1997, *ABC News* ran a story about Switzerland's government-run heroin projects. The story claimed that by giving drugs to addicts, crime is lowered, money is saved (because maintaining addicts in their addiction is cheaper than traditional abstinence programs), and the lives of people doomed to early deaths are prolonged. *ABC* painted a picture of the drug problem that prefers solutions with a medical, rather than law-enforcement, focus. The report ended with Peter Jennings saying, "Drug activists in the U.S. concede that attitudes are such that distribution of heroin to addicts in America at any time in the foreseeable future is, in their words, 'out of the question.'" I wouldn't bet on this prediction.

With this story, Jennings joined other liberal journalists who sound the mantra of drug legalizers: "Medicalize it!" For all its clinical trappings, however, medicalization of illicit drugs is nothing more than a stalking horse for outright legalization.

Former *ABC* hostess Catherine Crier and *CBS*'s former anchor Walter Cronkite have also hosted programs declaring the drug war lost, expressing the view that medicalization of drugs is the only answer to the drug scourge. The print media, including the pop icon *Rolling Stone* and the mainstream *New York Times*, enthusiastically support this approach. Perhaps that's why these outlets for legalization have enthusiastically embraced the Swiss heroin experiment as a model for the United States.

Conclusion

I believe needle exchanges are part of the drug legalization agenda and most American voters agree. A recent national voter survey found that a majority of Americans believe government funded needle exchanges would represent an official endorsement of illegal drug use, encourage teenage drug use, and have an effect on drug legalization.

Despite Switzerland's sophisticated culture, world famous economic power and conservative traditions, the Swiss government has embraced a dangerous drug policy. Our response should be to learn from Switzerland's tragic errors, encourage the Swiss "Youth Without Drugs" movement, and avoid following in their footsteps.

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7 Enclosures as

1. Swiss Vote Whether to Legalize Drugs (Perspective)
2. "Harm Reduction" An Alternative to the Drug War? (IS96J1DR)
3. Will Exchanging Needles Save America's Future? (IS96E1DR)
4. An Update: Free Needles for Junkies? (IS97F2DR)
5. In Switzerland, money talks louder than blood or drugs (Rome News-Tribune)
6. America Assesses Needle Exchange Programs (BL030)
7. Europe's Shining Knights (IS97B2)

Mr. HASTERT. Professor Jordan, would you please proceed with your testimony?

Mr. JORDAN. Mr. Chairman, members of the subcommittee, it is a privilege for me to testify before this subcommittee on the importance of the Swiss drug experience for fully understanding the threats to the United States national drug control strategy.

I have divided my comments into five parts. The first part deals with lessons we learned from the Swiss experience, the second part covers the generic threat to democracy from the narcostatization process under way in Switzerland, the third describes how supporters of this process target the United States, the fourth warns of the vulnerabilities of the United States strategy, and the fifth section suggests some immediate actions that may be undertaken to blunt the threats to our strategy.

Because a great deal of time has been devoted to the Swiss experience, I am not going to read my comments, or summarize those briefly, but I would like to develop with you very briefly the problem of the narcostatization process and the threat to democracy.

I was fortunate enough, Mr. Chairman, to work with two distinguished Members of this Congress, Congressman Rangel and Congressman Gilman, when they chaired the Select Committee on Narcotics, and I remember to this day being in the office of Congressman Rangel when he told me about how his brother died of an overdose of heroin.

I worked with those two gentleman, when I was the Ambassador to Peru, to try to combat the development of narcotics exports from that country. We were together up in the Alto Huallaga trying to combat, eradicate the coca bush and trying to develop interdiction policies, crop substitution, and to reduce the consumption in this country.

As a result of my experiences serving the United States, I came back and decided we needed to develop a model for understanding how a country, despite the fact that it may have the procedures of democratic participation, in fact becomes a narcostate, or what some people call a narco-democracy; and in this, you'll notice in the appendix to this testimony, I have five stages in which a country develops from an incipient stage to an advanced stage of narcostatization, something that leads the Congress of the United States to decertify these countries as cooperating with the U.S. drug strategy and trying to prevent this scourge from coming onto our shores and from impacting upon our people.

As a result of my investigations into the problems in Switzerland, I came across the fact that the Swiss process has led, in terms of my index, to what I call the "developing stage" of narcostatization. That is where, under the guise of harm reduction and demand reduction, the components of the government combat their own forces and their own country that are trying to reduce the narcotics consumption of their people. This is a beginning, or incipient, stage in the narcostatization of the country, but it is something the Congress of the United States should be deeply concerned about.

On the basis of my index, I have been able to identify that the Swiss situation is now past stage two; it has elements of what we call stage three and stage four, including the fact, as we found in

Mexico, large numbers of journalists that are on the pay of forces that are supporting the narcostatization of the country.

So anyone who is concerned about how this process works with respect to what has happened in Latin America should be deeply concerned about this process that is under way in Western Europe, an area that we all believed could combat and resist this situation.

My next point, Mr. Chairman, is to point out how the United States is a target of this operation. What is going on here is that the Swiss themselves have been concerned about it, and they asked themselves why this has occurred. Among their possible answers has been the claim that Switzerland is a pilot project for those experimenting on how to bring about drug legalization in a highly developed, moral, democratic and independent country. If such a country, widely known as both conservative and humane, can be brought to legalize drugs, then others will undoubtedly follow. The prolegalization forces in Switzerland have a laboratory for experimentation, and Switzerland is the first domino of a developed country.

Another answer is that Switzerland is important for the money laundering interests of the drug trade. Carla del Ponte, the Swiss public prosecutor, argues that, "A liberalization or legalization of the sale and consumption of drugs will lead to an influx of money into Switzerland because the money, after legalization, will no longer be dirty but clean."

Both the pilot project thesis and money laundering argument have merit, but need to be understood in the context of the worldwide narcotics traffic agenda where the United States is the primary barrier to restricted narcotics trafficking. How then does a Switzerland fit into the strategy to legalize narcotics?

And I see my time is up, but I will be happy to further illuminate what I think is how the United States is targeted, which includes the operations in Colombia which is bringing the mayors of La Paz, Buenos Aires, Lima, Santiago de Chile, and the police commissioner of Caracas to a group that is talking about how the cities can operate independently and confront and undermine the United States strategy to prevent the consumption of narcotics in this country and worldwide.

Thank you, sir.

Mr. HASTERT. Thank you.

[The prepared statement of Mr. Jordan follows:]

Testimony of David C. Jordan
Before the National Security, International Affairs and Criminal Justice Subcommittee
of the United States Congress
September 18, 1997

"The Swiss Experience and the Threat to the U.S. National Drug Control Strategy"

Mr. Chairman, Members of the Committee:

It is a privilege for me to testify before this Committee on the importance of the Swiss drug experience for fully understanding the threats to the U.S National Drug Control Strategy.

I have divided my comments into five parts. The first part deals with the lessons we learned from the Swiss experience. The second part covers the generic threat to democracy from the narcostatization process underway in Switzerland. The third describes how supporters of this process target the United States. The fourth warns of the vulnerabilities in the U.S. strategy, and the fifth section suggests some immediate actions that may be undertaken to blunt the threats to our strategy.

I
The Swiss Experience

I have just returned from participating in a conference sponsored by a Swiss organization, Verein Zur Forderung Der Psychologischen Menschenkenntris (VPM). It was important for me to see first hand the drug problem that has developed in Switzerland and talk with numerous people representing different sectors of society. I believe there is cause for concern.

Switzerland is generally thought to be an idyllic country with a modern, civilized, highly educated population living peacefully in a drug-free society with a model democratic system. It was a shock to find crime in the villages, urban decay in the cities, widespread drug consumption, decline in educational standards with the press ignoring and disparaging a major anti-drug movement and government officials finding anti-drug sentiment among citizens a threat to their efforts to decriminalize the hardest of drugs.

Through the early 1980s Zurich had a small drug scene. Before 1989 there were only 300 methadone addicts in the Canton of Zurich. In the mid-1980s a Red/Green (Socialist/Environmentalist) coalition took over Zurich's small town council. One of the new Councillors, Emilie Lieberherr,[1] was linked to the Radical Party, an Italian party that founded the International League Against Drug Prohibition which seeks the liberalization and the legalization of narcotics. The Radical Party has openly

[1] Patricia Morgan, "Radicals Hijack Swiss Idyll," *The Sunday Telegraph*, May 2, 1995

courted Italian criminals and has sponsored membership drives in Italian prisons. It has been funded by convicted murderers and organized crime figures. Voting analysts have demonstrated that its support has come from "areas of so-called high-density mafia vote."[2]

The International League Against Drug Prohibition was founded in Rome in April 1989. The Radical Party made clear that the League's aims were: 1) to legalize drugs, and 2) to abolish the UN Single Convention of 1961 which prohibits members from legalizing drugs. Two members of the League, Guido Jenny and Hans Schultz, have been the Swiss government's legal consultants on drugs.[3]

The results of liberalization in Zurich have been troubling. First came the needle exchange program followed by the opening of Needle Park (Platzpitz). 15,000 syringes and 6,800 substitute needles were distributed daily. Three thousand addicts received methadone; of 20,000 addicts, 4,000 were HIV positive. Despite the drop in price of drugs stemming from the government's subsidized program, organized crime continued to control a piece of the market.[4] During this period crime increased and death among addicts who took legal drugs was 2.4 times higher than among those who did not.[5]

In short, the Swiss experiment was a disaster. The authorities were forced to close Needle Park. However, the claim of the social services to dispense drugs to addicts was not abandoned. Advocates of drug legalization continue to advance harm reduction, as this method is called, as the way to manage the drug problem.

II
Narcostatization and the Threat to Democracy

For democracy to exist, it requires at the minimum that public servants be accountable to their electorate. If they are not, then the regimes are pseudo democracies or elitist systems even if they have the formal attributes of elections. Narcostatization is the process where governing elites, in alliance with drug trafficking and other interests, are able to insulate themselves from accountability to the electorate. The accompanying Index of Narcostatization Indicators demonstrates how a state may be placed in that process.[6] The process underway in Switzerland suggests it is already at level 2 (the developing stage) of narcostatization with one element each from levels 3 and 4 (serious and critical).

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[2] Alexander Stille, Excellent Cadavers: The Mafia and the Death of the First Italian Republic, New York: Vintage Books, 1996, p. 207

[3] Patrick Henderson, "Something Rotten in the State of Switzerland," *The Salisbury Review*, March 1995, p. 10

[4] David Moller, "Drugs; why we must stay tough," *Readers Digest*, July 1994

[5] Franziska Haller, "Harm reduction: a declaration of surrender in the face of human suffering," October 17-20, 1996, VPM paper, p. 6

[6] David C. Jordan, Depraved New World: An Analysis of How Drug Trafficking and Corruption Affect Democracies and the International Environment, (to be published)

Swiss citizens have responded to the growing narcotics corruption of their country by forming lobby groups such as VPM and calling for a referendum to block the open needle supply centers and shooting galleries. The government held off the referendum until September 28, 1997. It was clearly alarmed by initial polling data showing 44% of the electorate in favor of blocking supply centers, 25% opposed, and the rest undecided. In the period since the referendum acquired the necessary signatures, the government sought through anti-referendum allies to limit debate, bar VPM and allied groups from the media, promote coalitions against the referendum and demonize members of the opposition, calling them "fascists" and charging them with belonging to a sect.

The left-wing of the Swiss media has pushed harm reduction arguing that this approach should be substituted for prevention. Many school teachers were alarmed with the armed guards patrolling the local schools and the drug scenes open to the view of thousands of students on their way to school. Teachers who voiced opposition to the permissive drug scene or who were members of VPM were fired. A British journalist writes:

"Education officials and trendy left-wing politicians talk of "cleansing" the schools of VPM teachers and have set in motion an awesome system of witchhunts, fueled by hate meetings and defamatory leaflets.... At least 100 VPM teachers have been sacked on trumped-up charges so far. Countless more have been turned down at job interviews on the grounds of actual, or rumored association with the group."[7]

The legalization movement in Switzerland openly seeks to by-pass the checks of the electorate. The Councillor Liebehen is quoted as saying "we are looking for a way past the people."[8] The electorate is facing an alliance of left-wing ideologues, public health officials such as Ruth Dreifus, the Swiss Minister of Health and Family Affairs, some police chiefs and government advisors backing narcotics policy of "harm reduction," mafia fronts, marginal groups such as addicts, foreigners and radical feminists. These indicators have contributed to raising the Swiss government to level 2, the developing stage, in the Index of Narcostatization.

III
The U.S. Target

The Swiss often ask why they have been targeted for what seems to them to be an international effort to force drug legalization on them against their wishes. Among their possible answers they claim Switzerland is a "pilot project" for those experimenting on how to bring about drug legalization in a highly developed, moral, democratic, and independent country.[9] If such a country widely known as both

[7] Patricia Morgan, op cit.

[8] Annemarie Buchholz-Kaiser, "Swiss Drug Policy: The Present Situation" (VPM, April 28, 1992), p. 7

[9] Franziska Haller explores this answer in "The Swiss Drug Situation and its Impact on Europe" (VPM, March 12, 1996)

conservative and humane can be brought to legalize drugs, then others will undoubtedly follow. The pro-legalization forces see Switzerland as a laboratory for experimentation and Switzerland as the first domino.

Another answer is that Switzerland is important for the money laundering interests of the drug trade. Carla del Ponte, the Swiss public prosecutor, argues that "a liberalization or legalization of the sale and consumption of drugs will lead to an influx of drug money in Switzerland because the money, after legalization, will no longer be dirty, but clean."[10]

Both the pilot project thesis and money laundering argument have merit but need to be understood in the context of the world-wide narcotics trafficking agenda where the United States is the primary barrier to unrestricted narcotics trafficking. How then does Switzerland fit into the strategy to legalize narcotics?

In 1990 four cities -- Zurich, Frankfurt, Hamburg, and Amsterdam -- founded the European Cities on Drug Policy (ECDP) which adopted the Frankfurt Resolution. This resolution is the center piece to the legalization network designed to bring the U.S. into the fold. The Frankfurt Resolution called for the distribution of heroin to addicts, the legalization of marijuana, the introduction of shooting galleries, and the termination of the 1961 UN Single Convention on Narcotic Drugs.

The ECDP cooperates with Italy's Radical Party, the International League against Drug Prohibition, and the U.S.-based Drug Policy Foundation. ECDP membership has spread to some thirty European cities since its founding in addition to Switzerland's six largest German-speaking cities. The ECDP is now scheduled to spread its legalization network to Latin America. The mayor of Medellin, Colombia, has invited two leading Frankfurt Resolution advocates from Germany to address mayors of major Latin American cities including Lima, Santiago de Chile, Buenos Aires, and La Paz along with the Police Commissioner of Caracas.

According to *Der Spiegel*, a "Medellin statement" is in draft form and attacks the U.S. position against drugs and calls for "treatment of drug addiction."[11] The preliminary objective is to provide hard drugs to addicts under medical supervision. Apparently, the Drug Policy Foundation, which is heavily supported by George Soros, is involved in the preparations for the Medellin conference.[12] This conference is seen by observers as a clear challenge to the U.S. "sphere of influence" and extends the legalization network into areas of vital U.S. interest.

When the pilot project and money laundering elements of the legalization effort in Switzerland are added to the extension of the Frankfurt Resolution to Latin America the design to transform America's resistance to legal or regulated narcotics trafficking is readily apparent.

[10] The Senior Committee of VPM, "VPM is troublesome in the Drug Problem" (VPM, n.d., p.2)
[11] Der Spiegel 36, 1997 (7.9.15:15)
[12] ibid.

IV
Vulnerabilities in the U.S. Narcotics Strategy

Within the United States there has been a growing literature and lobby to shift the emphasis in the war on drugs from the supply side to the demand side, the so-called "public health" paradigm.[13]

Chroniclers of this shift observed that "Clinton believed that his electoral constituency and political agenda were not served by a high-profile war on drugs."[14] In his 1992 campaign, Clinton "argued for a policy of drug treatment on demand."[15] Nevertheless, candidate Clinton claimed that he would fight a real war on drugs. President Clinton's first drug czar Lee Brown stressed also that substance-abuse should be seen as a health problem and that criteria other than total abstinence should be employed.[16]

The shift in strategy began under the National Drug Control Policy leadership of czar Brown. The aim was to break the cycle of hard-core drug use. 20 percent of the drug users were hard core and were consuming 80 percent of the street sales of cocaine.

The Anti-Drug Abuse Act of 1988 created the Office of National Drug Control Policy (ONDCP) and its director who is often called the "drug czar."[17] Public health paradigm proponents stated that Clinton "made a bold move to downsize the ONDCP"[18] but retreated under congressional pressure and that "drug reform under Clinton failed because he was unwilling to pay the political costs of doing battle."[19] Nevertheless, the main thrust remained to address treatment for hard core drug users.

Despite the shift in emphasis from the supply to the demand side in the war on drugs, prevention and reduction of drug addicts is still a goal. The resources were not allocated to prevention programs for casual and non-users on the assumption that hard core users are the main source of demand for drugs. Since 1995 the White House National Drug Control strategy identifies its top priority as support for drug treatment "so that those who need treatment can receive it."[20] For this priority requests for funds increased in FY'95 ($2.647 billion), FY '96 ($2.827 billion) and FY '97 ($2.908 billion).

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13 See Eva Bertram, Morris Blechman, Kenneth Sharpe, and Peter Andreas, Drug War Politics: The Price of Denial (Berkeley and Los Angeles, University of California Press, 1996), p. 7

14 Ibid, p. 116

15 Ibid, p. 117

16 Ibid., p. 118

17 Pub. L. No. 100-690, 102 Stat 4 189

18 Bertram, op cit., p. 120

19 Ibid., p. 125

20 National Drug Policy, 1995, p. 119

The focus on treatment has not reduced the number of daily users among American teenagers. Statistics released in August 1996 revealed teen drug abuse rose 105 percent between 1992 and 1995 and increased 33 percent from 1994 to 1995. From 1994 to 1995 monthly use of LSD rose 54 percent, cocaine use rose 166 percent, and marijuana use rose 37 percent.[21]

The shift in the emphasis to demand reduction via treatment requires that the removal of hard core users from the treatment centers exceed the number of casual users who become hard core users. The Swiss experience suggests that if treatment provides hard drugs for the addicts then the numbers in the treatment centers increase. The U.S. experience suggests that if more resources are directed at hard core users than casual users then the number of casual users increase. If this relationship is not understood then it will not be recognized how the current treatment policy of the U.S. in both its domestic and foreign applications will lead to the increase in both hard core and casual use of drugs; something one must presume is contrary to the intention of the President's shift to the demand-reduction emphasis in his Drug Control Strategy.

This vulnerability in the U.S. strategy is clearly being exploited despite the efforts of the current drug czar, Barry McCaffrey. McCaffrey opposes physician certification of the medicinal uses of marijuana and of needle exchange programs. However, the objective of those exploiting the U.S. demand reduction strategy is to bring about the liberalization and then the legalization of drugs. The alliance includes the already mentioned cities belonging to the ECDP, organized crime and its front parties, financial interests, permissive sex and drug electoral constituencies, journalists, politicians, and intellectuals and the remnants of the narcotics trafficking organizations of the former Soviet Union and East European intelligence services. These intelligence services became involved in narcotics trafficking during the Cold War and sought through the drugging of the West to expand crime, unemployment, and internal conflict thereby promoting a crisis in the West's democracies. The chairman of the Drug Aid Cologne Association was the former Stasi agent Wilhem Vollman who was also a member of the North Rhine-Westfalia Parliament. According to Swiss sources he was a Stasi agent for twenty years and cultivated relationships with Swiss journalists.

The legitimate effort to reduce demand and to treat victims of drug abuse has demonstrated a vulnerability to those who have taken the slogan "harm reduction" to bring about drug liberalization. The objective of those exploiting the U.S. demand reduction strategy is to bring about the liberalization and then legalization of drugs. Liberalizers have developed alliances both within and without the United States and have undoubtedly assisted those forces a legitimate demand reduction program must oppose.

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[21] The National Household Survey on Drug Abuse, Robert Suro, "Teens' Use of Drugs Still Rising", The Washington Post, August 21, 1996, p. A1

V
What may be done?

The core of demand reduction must be made clear to aim at the *decline* of both hardcore and casual users of addictive drugs. These are measurable categories over both the short and long term. Prevention is critical to lowering the casual numbers and therapeutical and rehabilitation facilities that do not use hard drugs on their patients are essential to reduce hard core users. Sweden has a particularly effective program for hard core drug users that might serve as a model for U.S. treatment procedures. In any case U.S. government policy must openly and insistently object to state distribution of heroin, cocaine, LSD, cannabis, opium, hallucinogens, designer drugs and the like in the guise of a treatment program. Such programs expand the addict population, undermine the casual users' hesitation to experiment with hard drugs, and make enforcement of anti-drug laws a farce for police and citizens.

U.S. policy must be clear and concise and give its support to domestic and foreign groups that fight drug consumption. Thus, U.S. embassies must assist the opponents of drug legalization. The failure of the VPM to receive U.S. Embassy support in Switzerland must be presumed to have occurred because it did not understand the forces behind the treatment and harm reduction slogans.

Finally, the protection of children and families from drug propaganda backed by the powerful liberalization-legalization lobby and its activists is critical. This requires open and constant public statements from responsible officials that at least equal those devoted to attacking tobacco. It might help to point out that cannabis has 50 to 70 percent more cancer-causing chemicals than tobacco smoke and adversely affects the respiratory, cardiovascular, and immune systems, is dependency-provoking, decreases spermatogenesis and sperm mobility, increases abnormal forms of sperm, and develops apathy.[22]

A demand reduction program aimed at abstinence and linked to a vigorous foreign policy supporting anti-drug lobbies would help close some of the vulnerabilities that have emerged in the U.S. strategy.

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[22] Ways to a Drug-Free Society and Physiopathology of Illicit Drugs (Zurich: VPM 1991)

Index of Leading Narcostatization Indicators
Narcostatization: the process of becoming a narco-state

Level 1--Incipient

* Bribery of low-level officials
* Widespread drug consumption and inability either through lack of capability or will to reduce demand
* Increasing cultural support for drug consumption

Level 2--Developing

* Denigration of anti-drug organizations
* Anti-drug activists removed from educational/cultural institutions
* Government institutions (e.g., education, security, judicial) infiltrated/run by pro-drug officials

Level 3--Serious

* Massive bribery and corruption of public officials
* Substantial intimidation of resisting officials, including murder
* Corruption of local and regional police and judicial officials

Level 4--Critical

* Corruption at highest levels of national police and judicial systems, endemic extortion rather than bribery
* Top-level police enter drug trade, protect it, and authorize political assassinations
* Financing of journalists and magazines by drug lords; "narco-journalists" become known and remain in place

Level 5--Advanced

* Compliance of ministries, in addition to judiciary and police, with organized crime
* The president is surrounded by compromised officials
* Possible complicity of the presidency itself--president may be charged as "capo di tutti capi" and public not surprised

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Mr. HASTERT. Ms. Sosman.

Ms. SOSMAN. Good evening. I'd like to say, first of all, that I really appreciate this opportunity to speak before you gentlemen and the lady this evening because there has literally been, since 1992 when I got involved in needle exchange, an almost complete press blackout on people who are opposed to this program.

My name is Nancy Sosman, and I live two blocks away from the Lower East Side Needle Exchange in Manhattan. From the time the program began operating in a storefront in a solidly residential part of our poor working community, local residents—sanitation workers, parks workers, school principals, parent-teacher associations, supers of buildings, and local clergy—have complained about the dirty syringes they find discarded and about the public display of addicts shooting up.

As a result of persistent community complaints, resulting in four public hearings where aggressive addicts told community residents that if they were tired of finding needles all over the streets, they should pick them up themselves and stop complaining; and if they were concerned about their children, they should move—as a result of these hearings, and our local community board is made up of 50 nonpaid members of our neighborhood, a resolution was passed which stated that the program services the entire tri-State area, provides no supervision of clients and much-needed law enforcement is withheld by police because of the ambiguous legal status of the anonymous needle exchange clients;

Whereas the fears of the community are disregarded and requests for better supervision are ignored;

Whereas the surrounding community is inundated by drug dealers and the quality of life for area residents has diminished, and senior citizens and children are denied the use of parks, sidewalks and school yards; whereas law-abiding businesses are being abandoned as lucrative illegal drug businesses expand;

Whereas the exchange refuses to mark the syringes they dispense, which are a million a year, 20,000 a week, and probably more by now;

Community Board 3 requests that all funding for the needle exchange be discontinued and the program be closed because of the undue hardship placed upon the surrounding community.

Despite the strong words of the board's resolution, the New York State Department of Health refused to entertain the board's suggestion that at the least the exchange mark the syringes they dispensed, so we could identify the source of the needles we find on the street and also identify who is OD-ing if those needles were coming from the needle exchange.

Rather, with the complete support of almost every one of our elected officials, the State Department of health allocated additional funding for the exchange, and they expanded into another storefront.

On March 8, 1997, I personally visited the needle exchange, with John Tierney, who is a reporter from the New York Times. Without 1 needle to exchange, I was given 40 clean needles, which I have here today, alcohol wipes, cotton swabs and cookers, along with a graphic description of the proper way to shoot up so as to protect

my health and prevent my loved ones from knowing I was using drugs.

I was also provided a needle exchange card, making me exempt from arrest or prosecution if I were to be found with syringes, which under New York State law is a felony. In exchange for this bag filled with drug paraphernalia, I was asked my initials, my mother's initials, my birth date, my ZIP code, my race and the length of time I've been injecting drugs. I lied in response to every question and told the exchange worker that I had only been shooting up for 6 months, trying to see if he would at least try to get me into drug treatment or counseling. He didn't.

In parting, I asked him whether I had to return the needles that I had gotten in order to get more. He said no, but advised me to put them in an opaque container so no one would see them. His sheer willingness to supply me with 40 needles without 1 to exchange leaves one unanswered question. What happens to these needles after they are used and you don't return them?

The Lower East Side Needle Exchange Program dispenses upward of 20,000 syringes a week and, in effect, has de-facto legalized drugs in our neighborhood, turning it into a centralized distribution center for Manhattan, Brooklyn, New Jersey and Connecticut, where drug possession is still illegal. The State Department of Health by-laws state that there be no shooting up on the exchange premises, so instead the addicts fan out into our community and shoot up on our premises.

Needle exchange participants do not have to go into treatment, do not have to return syringes, nor are they expected to follow the laws that we all have to follow.

One of the most disturbing elements of needle handouts is that proponents do not differentiate on the basis of age. On Friday nights a van is parked outside the exchange, handing out drug paraphernalia to teenagers. No one is too young or too far gone to receive clean needles.

The damning effects can be seen in the alarming increase of drug use among teenagers across the country, exemplified by a recent article appearing in our local Village Voice, entitled "Tips for Junkies." In it, users from the Santa Cruz Needle Exchange Program describe ways of injecting drugs safely using boxes of cereal to parody drug use. Using a box of Sugar Smacks, a frog appears to be selling smack, or heroin, not unlike the Joe Camel ads used to lure teenagers into smoking cigarettes. According to Donald Grove, a needle exchange activist with the Lower East Side Needle Exchange Program, "Most needle exchange programs serve as sites of informal organizing and coming together. A user might be able to do the networking needed to find good drugs in the half-hour he spends at a street-based needle exchange, networking that might otherwise have taken half a day."

I'm almost finished.

Needle exchange is not what it seems. In their attempt to change public policy, proponents of needle programs exploit the misery and despair of drug addicts by trivializing the complex nature of addiction. They attempt to create the illusion that drug addiction is normal and that rather than promoting abstinence, government should help the addict remain an addict. What they fail to understand are

the real problems faced by addicts, their families and loved ones and the impact drug addiction has on society.

Finally, needle exchange programs, by their ambiguity, promote a breakdown in law and order and cripple communities politically and economically, further serving to marginalize poor neighborhoods.

Thank you.

Mr. HASTERT. Thank you.

Dr. BEILENSON. Thank you, Mr. Chairman.

I'm not going to address, obviously, many of the topics that have been dealt with today; I'm going to take my cue from Congresswoman Pelosi and deal with the issue that I think we're dealing with specifically today, and that is needle exchange.

Let me first say, this is not a war or a battle. I don't like those terms particularly, as a physician. This is about people and caring for people who suffer. And in San Francisco, Baltimore, Chicago, and perhaps Indianapolis—certainly high on the list—AIDS is the No. 1 killer, black and white, male and female, of 25- to 44-year-olds in this country.

It's also about kids. One hundred percent of the babies born with AIDS in Baltimore City last year were born to IV drug users. This is about children.

You can find quotes from individuals to say anything that you want to say, but you have to do what many of the Congress people here have been saying today, and that is look to the science. They are not dueling studies in the United States. You look at Columbia, you look at the Yale-New Haven study, you look at the Institute of Medicine, the National Academy of Sciences, University of California-San Francisco, the CDC study, and at Johns Hopkins, they all very clearly show that needle exchange does not increase drug use, it does decrease the spread of HIV–AIDS, and I'll get to ours in minute.

Let me get to how our program works, and I'm sorry to hear from Miss Sosman how the program works on the Lower East Side, because that's not at all how many programs in the United States work, and it is not a needle exchange.

How does our program work in Baltimore? We operate out of two vans, approved by the communities in which they exist. We went to the communities first, and they voted upon having them in their sites. Our vans exchange needles on a one-for-one basis. You must bring in a used needle in order to get another clean one. If you're a first-time user, a first-time user of our program, you may get two needles only. After that you must bring 1 for 1, none of this 40 stuff.

On the van the people are tested for syphilis and for tuberculosis, two problems that are existing throughout the country, particularly in drug users, and they are talked to about drug treatment. The mayor, who has been disparaged very unfairly in this hearing, Mayor Kurt Schmoke of Baltimore, who has been courageous in dealing with this issue, has put aside a quarter of a million dollars for drug treatment slots reserved specifically for our needle exchange clients, which I'll get to in a minute. We have referred about 1,000 people into these treatment slots that have been reserved for our clients, and they have been very successful in them.

As a physician, I took an oath to do no harm, and I've been very concerned today to hear some of the concerns raised about the harms that needle exchange may be causing, so let me address them. As the only witness, I feel a lot of pressure here; and I may go slightly over the 5 minutes.

First, that this is going to increase discarded needles in the community. Clearly, commonsense dictates that that's not going to happen if you have a one-for-one exchange if—at worst, people are going to pick up dirty needles on the way into the exchange, so they can get clean ones back; and in fact, Hopkins, who we have done our evaluation with, did a very elegantly designed study in concentric circles out from our needle exchange sites, compared to controlled heavy drug use sites as well, before needle exchange and after needle exchange and found a statistically significant decrease in the number of needles found on the ground in the areas of our needle exchange, compared to the controlled drug areas—to the control areas where there is heavy drug use as well. It does not decrease discarded needles.

Second, it's going to increase crime if there are police-free areas; that's a fallacy. In the census tracts, which are small areas, smaller than ZIP codes, census tracts surrounding our needle exchange sites, crime during the hours of operation of our needle exchange has dropped 5 percent, and that is—equivalent to what's going on in the rest of the city. It does not increase crime.

Third, the concern is that it's going to increase drug use. In fact, the frequency of drug use among our 6,000 needle exchange clients has dropped 22 percent since the beginning of the program.

Fourth, the concern is, this is going to make drugs real easy for kids to get and all these young people are going to start using drugs. In fact, as Congressman Cummings said, of our 6,000 clients in our needle exchange, only 2 are under the age of 19; the median age of use of our needle exchange program is 39. We are not initiating young people into this program.

The two most important things we found, however, are our priority issues, the priorities we have with this needle exchange program—which Congressman Cummings mentioned has been approved twice now by the Maryland General Assembly in a very bipartisan manner, by the way—are, first, that it serves as a very effective link to drug treatment for those who otherwise wouldn't be going to treatment.

Ninety percent of the clients in our needle exchange shoot up once a day or more often. They are the hardest core of the hard core. Virtually none of them have gone to treatment before. As I've already mentioned, we have gotten close to a thousand into drug treatment, and they are succeeding at the same rate as less hard core users. It is an effective link to drug treatment.

The second is probably the gold standard, and that is, we have a 40-percent decrease in our HIV-zero conversion rate from our clients to the other—to the comparison addict group in Baltimore. What does that mean? That means the average addict in Baltimore is converting from HIV negative to HIV positive at a 40 percent greater risk than our needle exchange clients are. We are reducing HIV.

I strong—and one further difference between New York and here. We mark all of our needles. All of our needles are bar-coded. We follow them with a computer reader, bar code reader, just like in a supermarket. We know who got what needles, and we're able to support if someone says, I don't share needles any more because you're worried about reporting. We know that you're participant No. 25; you've got needles 1,007 through 1,015. We collect the needles in batches. We look in the needle at Hopkins and find that there are three types of DNA; we know you're lying, so we can support what people are saying.

And last we know our HIV conversion rate is going down because we draw bloods on all of our study participants.

Let me finally say that I strongly encourage you to come to Baltimore which—I got to Washington in 43 minutes, trying to get here for the 5 o'clock hearing; I'm faster than Congressman Cummings. Travel the 55 minutes north to Baltimore and visit our program. The most conservative Republican in the General Assembly, on the health committee from western Maryland, who was adamantly, philosophically opposed to our program when it first came before the General Assembly in 1994, came with several of her Republican colleagues to west Baltimore and Congressman Cummings' district to see our program in operation.

In 1997, we were up for renewal in perpetuity of our needle exchange program. She stood up at the beginning of the hearing in the health committee and said, Mr. Chairman, I want to tell you that the program is doing exactly what they said they were going to do. They've shown tremendous success, as is evident from their statistics, and I want to tell you that everyone in this room should support this bill; and it passed unanimously, Republicans and Democrats alike, and passed the house of the General Assembly, 111 to 23, 3 months ago and it's going to continue to operate in Baltimore whether or not we get Federal funding.

Thank you.

[The prepared statement of Dr. Beilenson follows:]

Written Testimony of Dr. Peter Beilenson
Baltimore City Health Commissioner
to the Subcommittee on National Security, International Affairs and Criminal Justice
of the Congress of the United States
September 18, 1997

Description of the Program

The Needle Exchange Program (NEP) operates out of two 26 foot mobile health recreation vehicles. The program operates at six sites; two in East Baltimore, one in West Baltimore, two in Park Heights and one in Cherry Hill, and is open four days a week. Enrolled clients are able to exchange used needles for sterile needles on a "one-for-one" exchange basis. Clients receive counseling about drug treatment programs, harm reduction in the use of needles, and education regarding HIV, tuberculosis, and sexually transmitted diseases. Blood tests and counseling for HIV, syphilis and skin tests for tuberculosis are also available.

Client placement in drug treatment programs is an important aspect of the NEP. Various drug treatment options are available on demand for interested participants. NEP participants who request treatment are enrolled in a comprehensive drug treatment program at Bon Secours' New Hope Treatment Center, Johns Hopkins Bayview Medical Center or the University of Maryland on demand within 24 hours, depending on the availability of NEP-designated treatment slots.

Funding Sources

FY 96: State/City Targeted Funds:

$250,000 for drug treatment
$310,000 for operation of the needle exchange

Potential Cost-Savings

The average cost of caring for an adult AIDS patient, from the time of diagnosis with AIDS (not HIV infection) to death, is approximately $102,000. Since the vast majority of our clients are either Medicaid eligible or uninsured (and thus, the cost of their care is passed on as uncompensated care), virtually all of AIDS care for this population is borne by state taxpayers. Since the actual program operation will cost about $300,000 to serve an

estimated 6,000 clients, if even three cases of AIDS are prevented, the program will be cost-effective.

Clients Served

Although we estimated during our initial testimony in 1994 that our NEP would serve between 500 and 750 clients in the first year of operation, the program has been far more popular than we anticipated. After the first 36 months of operation, approximately 6,000 clients had registered at one of the six program locations, making over 50,000 visits to exchange over 1.1 million needles. We are currently serving between 325 and 550 new and return clients per week.

Community Acceptance and Police Cooperation

The NEP has been well-accepted by the community, and we have had excellent cooperation from the Baltimore Police Department. There has been only one call for police assistance during the entire period of operation. It is important to note that despite the fact that virtually all of our clients have been in trouble with the law at one time or another, the program is basically self-policed by clients, who have "bought into" the program and have become very supportive of it.

Success in Providing Drug Treatment

Through City funds provided by the Mayor, approximately 90 treatment slots (which will be able to treat about 200 clients per year) have been earmarked for NEP participants. We have discovered some interesting facts about our NEP participants seeking treatment. First, our NEP clients in general, as well as those who seek treatment, tend to be "harder core" addicts than those in the typical Baltimore addict population which has been studied previously. The NEP clients going into treatment are significantly less likely to have been in treatment and have significantly more medical problems than those who enter treatment who are not NEP clients. Despite these facts, NEP clients in treatment are doing as well as non-NEP clients in terms of successful retention in treatment.

The average delay before a client of the NEP can obtain a slot in one of our two dedicated treatment programs is 7-10 days, a significant improvement over the city-wide average delay for non-dedicated treatment slots which is 2-4 weeks for drug-free programs and 2-4 months for methadone maintenance.

Major Preliminary Findings from the Evaluation Study

1. Discarded Needles Do Not Increase After the Opening of Needle Exchange. There was some concern during initial legislative hearings that used needles would be discarded in the areas surrounding the NEP, despite the fact that the program is a one-for-one exchange (i.e. bring in a dirty needle in exchange for a clean, sterile one). In fact, a well-designed study looked at discarded needles around the two program sites compared to other high drug-use areas in the city and found no increase in the number of discarded needles in the areas surrounding the exchange.

2. The Average Age of Needle Exchange Clients is 39 Years Old. Another concern raised by a few of the legislators in hearings was that the program would make it easy for youngsters to get needles. The average age of our clients is 39 years old; and our records show that only two of our 6,000 clients are under 18. Other demographic characteristics of our clients: a) they are predominantly unemployed (92%), African-American (87%), and are very frequent injectors; b) 90% inject at least daily (compared to 40% from a community sample of users); c) heroin and cocaine are the drugs of choice, with over 90% of clients reporting use of both drugs; d) about half of enrollees become active exchangers, returning on average every two weeks for on average 14 needles and syringes.

3. Needle Sharing Is Reduced. Obviously, the major goal of our NEP is to prevent the spread of HIV/AIDS in the injection drug use community. To do that, we need to change our clients' drug use behavior. The preliminary results of our study look promising in this regard. Our clients reported significant drops in the following unsafe drug behaviors after starting the NEP: a) using needles after someone else; b) using cookers after someone else; c) using cotton after someone else; and d) letting a friend use your needle and syringe.

   In addition, prior to the initiation of the NEP, 63% of clients reported their source of needles as the "street", compared to only 39% two weeks after starting the program. The program has also been successful at getting some addicts to stop injecting in "drug houses" or on the street, with 25% more of our clients reporting that they inject in their home two weeks after starting the NEP than prior to joining the program. Also, very importantly, we have found that the average circulation time of our clients' needles has dropped by 33%.

Finally, although some legislators expressed concerns that the program would make it more likely that injection drug users would use more frequently, that has not been the case--our clients report a 22% decrease in their frequency of drug use since joining the NEP.

4. 65% of Baltimore City Residents Favor Needle Exchange. In a survey conducted in Baltimore City in October 1995, 65% of the respondents were supportive of needle exchange. Respondents were supportive based on their perception that needle exchange reduces the number of discarded needles on the street, that needle exchange does not increase drug use, and that needle exchange programs decrease the incidence of HIV.

5. Injection Drug Users Care About HIV Prevention. Needle exchange clients were asked about their attitudes and behaviors regarding the desirability and safety of existing needle sources. The findings indicate that the clients clearly have a good understanding of health risks associated with existing needle sources (off the street, shooting galleries) and prefer to use sources that they know to be medically safe.

HIV Seroconversion

The bottom-line goal of this program is to decrease the transmission of HIV. Currently, in Baltimore, the HIV seroconversion rate among injection drug users (IDUs) is about 4% per year. In other words, 4% of IDUs who are HIV-convert to HIV+ each year. If our program is working, we would hope to be able to demonstrate that the seroconversion rate among our NEP clients will be lower than 4%. We are showing a 39.7% decrease in HIV seroconversion among the injection drug using population that we are serving.

SUMMARY

After more than three years of operation, we are very pleased with how the NEP is going. The program is attracting much larger numbers of clients than we expected. The program is well-accepted by these clients as evidenced by the numbers making repeat visits to the NEP and by the way in which our clients self-police the program. The NEP is also well-accepted by the communities in which it operates and by the police, who have been extremely cooperative. Finally, **the program is accomplishing its mission of reducing the transmission of HIV among injection drug users, their sexual partners and their offspring.** It serves as a much-needed point of access to care for hard-core addicts who otherwise have had virtually no access to drug treatment or other health care.

Peter Beilenson, M.D., M.P.H.
Commissioner of Health
September 1997

Mr. HASTERT. I thank the gentleman.

Mr. Maginnis, you hear there are conflicting reports here, as a matter of fact, that needle exchanges are good, that we do reduce drug use, that there is a reduction of HIV, and we have a lot of—quote, unquote—science and a lot of studies quoted.

You wrote in the public—in the publication American Assesses Needle Exchange Programs, you cite studies which support the opposite. Can you talk about that a little bit?

Mr. MAGINNIS. Yes, sir.

I was impressed by what I just heard. I'm going to have to look at the Baltimore program in some detail such as he describes.

The Montreal study obviously has already been gone through by Mr. Barr and Mr. Souder. The Vancouver study, which was briefed by the 11th International AIDS Conference this summer, was a very comprehensive one, although it's—in Canada, it's still, I think, apropos to the United States because it gives 2.3 million needles every year and, unfortunately, what they have found is that one of the independent variables in that particular study was that you were going to—if you're inside a needle exchange program, going to contract HIV far higher, or much more, than if you are not in that particular NEP program. The briefers, they were startled themselves, quite frankly, by the outcome.

There was a study that took place that was published in the January JAMA, the Journal of the American Medical Association, and it was out in Los Angeles; and what was interesting is that sharing of needles also took place amongst intravenous drug users who were in the exchange program. They said they shared as often as those that weren't.

So this evidence, unfortunately, has not been considered by the American Medical Association. I've got their decision from the panel that looked at it—not the entire AMA; and that's only less than 40 percent of the doctors in this country, by the way.

As far as, does this contribute to more drug use, well, the court's quite frankly out. You know, in today's Washington Post, Donna Shalala's spokesman says, We don't know, quite frankly, whether or not it contributes to more drug use. And every one of the studies, they don't address that except anecdotally, because really that's a hard nut to crack. It's very difficult to determine whether or not we're having residual drug use by not only addicts, but also by the 68 million kids in this country under age 18.

And the Congressman mentioned the heroin chic epidemic in this country. Well, that's probably subsiding, but clearly we've had a 12-fold increase in the use of heroin by 12- to 17-year-olds in the last 7 years, so we do have a serious problem. We want to send the right sorts of antidrug messages to kids at very vulnerable ages.

So I think that the science is really divided, and unfortunately, like one of the pieces that I often get cited out of New York, Beth Israel, the very people that are funding the study are the people that are selling the needles through Nancy Sosman's needle exchange in her very neighborhood. They're funding that type of research. And, in most circles that just would earn some very large scowls on the faces of people that are concerned about fairness.

So I'm not really convinced, after listening to the CDC—and even the CDC admits in this particular statement that there is a prob-

lem. I'm not convinced that the science has been exhausted and, quite frankly, I think the science is divided and it needs to be relooked—we even heard a statement from Mr.—from Dr. Kleber, Herb Kleber up at Columbia, and Lawrence Brown. There are only two or three physicians on the Institute of Medicine's study that—they came out and said, no, this isn't a panacea. We don't know if this doesn't contribute to more drug use. Yeah, we think it might slow the spread of HIV.

You know, if every program is as good as what I'm hearing in Baltimore, it might have an impact, but we don't know.

So that's a long answer, but I think the science is not as conclusive as is being pointed out, Mr. Chairman.

Mr. HASTERT. Mr. Jordan, you talked a little bit about one of the dangers and, one of the things that some folks have said here, that there's actually no connection with what happens in Switzerland and what happens here. But you said that the gentleman from Switzerland had testified and said, that their government officials are going to a drug conference in Medellin, Colombia, you're very much familiar with the South American situation.

What do you think the purpose of that drug conference is, and maybe you can enlighten us, who sponsors that and what the purpose is.

Mr. JORDAN. The problem, as I see it, is that we are facing a very clever method of subverting the American national control, narcotics control strategy, because in the shift to demand reduction, they've spotted that there was a possible weakness in the U.S. resistance because it's clear that that demand reduction program is designed to reduce the consumption of narcotics. If, on that basis, you can sneak in the idea that you have harm reduction and then that harm reduction becomes a basis for truly the distribution of narcotics, which is what is going on in Switzerland, clearly that is not the intention of the American demand reduction. But that is the intention of those who are seeking to legalize it.

So what happened was, there were four key cities in Europe—Zurich, Frankfort, Hamburg, and Amsterdam—that formed a European cities drug policy which was designed to establish their own independent policies for drug legalization. This, in turn, has spread, as you have already heard, to six cities in Switzerland and some 30 cities throughout Western Europe.

In addition to this, they have then moved to try to spread this arrangement to the cities in Latin America, and that's the reason for the Medellin Conference which is bringing, as I suggested to you, some of the largest cities of Latin America, which would then introduce their own legalization program for the distribution of narcotics.

Now who's behind that? If you look carefully, and I have this in my testimony, the Radical Party of Italy was the party that initiated the Anti-Prohibitionist League. The evidence that we have from the studies that are done in Italy show that this is the party that operates as a front for the Italian Mafia. The Italian Mafia, on this basis, was of course interested in the legalization of narcotics, and the spread of this was also linked to the financial interests which the Swiss believe was—once they get this legalized, that is—those who are opposed to the legalization will allow the money to

come into the banks there, without their having any problem of reporting, and will free them from the problems of dirty money.

So what you then want to look at is who are some of the banks. For example, George Soros' name has been mentioned because he financed the legalization campaigns in California and in Arizona. He also has a piece of a bank in Colombia, and I think it would be very interesting for you to look to see, and bring sometime, who benefits from the legalization of narcotics.

One of the things that we had to do when we were looking at any of this problem was noticing, for example, the banks that were bringing $35 million a week out of the Alto Huallaga; and it's certainly clear that those financial interests were interested in having that money legal.

Mr. HASTERT. Thank you. My time's up.

Ms. SOSMAN. Mr. Chairman, can I just——

Mr. HASTERT. Let's take—my time is up. I'm sure we'll ask more questions. We'll have another round here.

The gentleman from Maryland.

Mr. CUMMINGS. Let me preliminarily say this: That, Ms. Sosman, I understand your concerns about your neighborhood; I really do. I live in a neighborhood where—as I said a little bit earlier, I bought my house years ago, 15 years ago, for about somewhere around $85,000, put in about $60,000 in repairs and renovations and cannot sell it today for $55,000. A lot of that has to do with drugs and so I understand your concerns.

I also want you to understand too that—and I notice this whole discussion has had a thread running through it about legalization of drugs. I just watched my brother-in-law die from drugs, watched him die, over the course of about 13 days watched his systems go down, esophagus, veins collapse, just his liver went, the whole bit, and he had AIDS. So you will never hear this Congressman be for the legalization of any kind of drugs; it pains me.

And I guess that's why, you know, I don't want it to appear—and I think Congresswoman Pelosi put it quite clearly. It seems to me an assumption that folks have come to a point that they want to see drugs legalized because they're trying to stop AIDS—I mean prevent, AIDS. It's—I'm telling you, you've got death on one side—both sides have death, the use of drugs and AIDS. And that goes—that leads me to you, Dr. Beilenson. You, in a discussion that we had a few days ago, you said that a lot of the communities in Baltimore were asking for this program. Can you try to shred some light on why that is? I mean, especially in light of what—I wanted to make sure I'm pronouncing—Ms. Sosman said. Can you shed some light on that?

Dr. BEILENSON. Our initial program we started off was run by the Baltimore City Health Department within the jurisdiction of Baltimore City, and we started off with two sites and actually kind of put out a request for communities that wanted them. We did not have a NIMBY not in my backyard problem. In fact, we have got seven different communities asking to have the needle exchange located in their community. And as I mentioned earlier, we went to different communities to have meetings, and they voted on it, and we chose the two that seemed to be the heaviest drug use areas.

Actually, most of the others have now gotten the needle exchange because we've got six sites, but it has been very well supported, and it's been very well supported by the police. Not only do we meet with the community beforehand, we met with all the district commanders in Baltimore City to explain the needle exchange, why it was important; and they have been extremely supportive of our program.

And again getting back to the crime issue, not only has there been a reduction of crime in our areas where needle exchanges occur, but in fact, we've had only a single police call in the over 3 years in which this has now been operating to come to the van, and it's basically self-policed by clients who want to get clean needles because they care about their health.

Mr. CUMMINGS. Why do they want it? Why do the neighborhoods want it?

Dr. BEILENSON. The neighborhoods wanted it because, as I mentioned earlier, AIDS is by far the No. 1 killer of young adults in Baltimore City, and everybody throughout the city knows someone or knows of someone that's died of AIDS; 75 to 80 percent of the AIDS cases in Baltimore now are IV drug users, their partners or their babies. I've already said 100 percent of the babies are babies of IV drug users.

This is a scourge in Baltimore; it's an epidemic. It's true in San Francisco, particularly in the gay population and the IDU population. I know you have Congresswoman Ros-Lehtinen from—I'm probably not pronouncing it right from Miami. It is the same problem in Miami; it's the same problem in Newark, New York, Richmond, and DC, et cetera. This is a huge problem. Communities realize this is a huge problem, which is why they ask for it.

And let me add one further thing. A woman behind me approached me before and said, we had this argument back in Annapolis a couple years ago. Why are we wasting taxpayers' dollars on needle exchange? Why aren't we spending money on treatment and abstinence?

Well, we do. We spend $310,000 on needle exchange programs in Baltimore City—all city and State funds, no foreign foundations, no magical Mafia connections, city and State funds because we care enough about our population to do that. A single case of AIDS in an adult costs 110,000 taxpayer dollars; a single case of AIDS in a baby costs 230,000 taxpayer dollars. Quick math tells you, you prevent three cases in adults and we save money. In fact, we're estimating we prevented, because we know from science, by getting the blood results of our patients—this is not surveys, this is actually blood results. We prevented probably 300 cases in the last 3 years, which comes to about 30—this is just adult cases, direct prevention, 30 million taxpayer dollars.

We spend $310,000, and we've raised in Baltimore City, with some of the help of Congressman Cummings, $28 million on treatment. We do care about treatment and prevention. And I've already mentioned, the mayor actually set aside some treatment money to get people into treatment from our needle exchange.

But let me point out again, these are the hardest core users. What are they going to be doing if we don't have a needle exchange? They're not going to magically appear in drug treatment

centers; they're going to be on the street shooting up, putting themselves, their partners and their babies at risk. We have to do something to protect at least their partners and their babies and the taxpayers by having a needle exchange program.

Mr. HASTERT. The gentleman from Indiana.

Mr. SOUDER. Ms. Sosman, I think one of the problems that we face in our society—and I want to first say, in defense of myself, I grew up in a small, rural town of 700 surrounded by Amish; I didn't grow up in New York City or—like Mr. Cummings, and so this isn't personal experience. But this is from observation, and that is that often when our society not only wants to use people as guinea pigs in a process, they also use neighborhoods that don't have much political clout.

Did they hold hearings in your neighborhood as to whether they were going to put this in there?

Ms. SOSMAN. In fact, our community board did, I believe, in 1991 approve the concept of needle exchange; however, when the needle exchange came into the neighborhood, they did not come to the community board. They just opened up 1 day there, and nobody even knew the needle exchange was there until people started pouring into the community board meetings complaining about needles all over the streets.

So our neighborhood is not a NIMBY—not in my backyard neighborhood—it's probably the most liberal, international, wonderful community in the entire world, but the fact is that these needle exchange programs—and they don't sound anything like the one in Baltimore—are all run under the harm reduction banner. All the needle exchanges across the country that are run in storefronts have drug addicts handing out needles to other drug addicts, who are stealing needles and selling them to buy more drugs.

Mr. SOUDER. Have you visited other places in New York City as well?

Ms. SOSMAN. No, but I'm on the Internet, and the Drug Policy Foundation, which is the George Soros homepage which runs articles on a regular basis written by Dr. Don Des Jarlais, who is the head of the chemical addiction unit at Beth Israel Medical Center, who touts the manufacture of safer drugs and making that whole concept of drug use be seen as normal and limiting the harm they produce and that the Government should produce and manufacture safer drugs, and Dr. Lurie out of California. They're all under this harm reduction banner; they're all intertwined under this Drug Policy Foundation, and they're all involved in—they're involved in the Santa Cruz Needle Exchange, and they write studies where they quote each other, and they quote their friends. And the New York study, which Dr. Don Des Jarlais wrote, compared heroin users on the Lower East Side in 1992 to methadone users in another community at another time and place, which Dr. Brown, who was on the IOM panel said, this is not science. And even Dr. Don Des Jarlais and Dr. Lurie, who wrote the infamous California study, they themselves in their studies, if you read them, say, we cannot infer from these studies that this lowers HIV incidence. My point is that no one, any time ever, discusses the impact on neighborhoods.

You know, I'm compassionate; I don't want to see somebody dying of AIDS or—but I'm concerned also about the bigger picture. What happens to communities? It's not discussed anywhere in any forum that I've ever been in. And this program has been hell for our neighborhood, and nobody wants to deal with our concerns. The New York State Department of Health basically writes letters to us that are saying "up your behind." It's like they don't care.

So the way he's describing this needle exchange program is completely different from the one in our neighborhood and completely different from, I would say, most of the needle exchange programs throughout the country.

Mr. SOUDER. Dr. Beilenson, I wanted to first say, you did a very good job for being the only witness on your side. I thought you presented your facts very well, and if I supported what I believe is enabling drug addicts, yours is a type of way to try to do it. And I think—how's that for a backhanded compliment—that you seem to have gone through some of the processes.

I'm kind of confused, and we've heard mention of the Department of Health and New York and so on. Are you directly appointed by the mayor? You were defending him a minute ago.

Dr. BEILENSON. Yes, approved by the city council; but yes.

Mr. SOUDER. So I don't make a misstatement, your mayor has been—you describe him as courageous, but in fact he's supported legalization.

Is that just of marijuana or other——

Dr. BEILENSON. He supported medicalization, which is really quite different, probably a whole different topic to discuss, but it's very different. Legalizing is selling, as is—what goes on in Switzerland. Medicalization—and that was what I believe Mr. Maginnis was talking about earlier, because the communication with the President by the mayor was written by me. So what we said was, medicalization is treating drug abuse as a medical problem as much as a criminal justice problem, and we need to do things like needle exchanges and treatment availability on demand, which I would challenge anybody in this room or the U.S. Congress would oppose.

Mr. SOUDER. To clarify this point, to finish off this point, he's made statements prior to that himself on TV because——

Dr. BEILENSON. Nightline, in 1988, he made a semantic misstatement about legalizing or decriminalization. He's changed—I mean, he did not mean legalizing.

Mr. SOUDER. In other words, you think he's backed away.

Dr. BEILENSON. No, he used an incorrect word. And it's not just semantics; legalizing means legalizing. Anyone can use, anyone can sell, you can do what goes on in Switzerland.

Medicalizing is very different, and that's what he actually meant, but we didn't have that term 10 years ago.

Mr. SOUDER. And you agree with that?

Dr. BEILENSON. What I just said before, which is treating it as a public health——

Mr. SOUDER. You agreed with—in other words, you weren't doing it because he told you? You actually agree with that position as well?

Dr. BEILENSON. Right. I think for myself.

Mr. SOUDER. Well, I mean, when you work for somebody—I as a former staffer—sometimes you get to think for yourself and sometimes you—but in the medical profession, I realize you also——

Dr. BEILENSON. I would have left my position if I did not agree with him on that issue.

Mr. HASTERT. Ms. Pelosi.

Ms. PELOSI. I want to thank all of our witnesses for their very sincere presentations. Ms. Sosman, I think what you have been through is a nightmare; and that is not what we are advocating here. Our experience in San Francisco is similar to Dr. Beilenson's experience in Baltimore. In fact, as a native Baltimorean, I'm very proud of what you presented here. And that is why I'm pleased to be associated with Mr. Cummings in his very smart legislation in this area, because it is targeted, it is specific about an exchange, not a distribution; about if it can be demonstrated that it reduces the spread of HIV, does not increase drug abuse, and that has been testified to by the head of the National Institutes of Health, National Institute of Mental Health, National Institute of Drug Abuse, and other health professionals.

So while it may not be a unanimous verdict when you use the expression "the jury is not in," the fact of the judgment—maybe if—expression, the fact is that the medical experts at the highest level in our country, in whose judgment we place much confidence, have stated for the record before our committee that this is the nature of the science.

I also want to just talk about the San Francisco experience for one moment, because it meets the criteria that I described.

In San Francisco for the past 2 years, as a result of the needle exchange program, no infants have been born with HIV. None. Also, for the past 5 years there has been no increase in zero prevalence among IV drug users. So we note things anecdotally, empirically, scientifically; whatever, we see a reinforcement across the board on that point.

Dr. Beilenson, would you do me a favor? I was going to place some observations about the Montreal study in that it is—"study" is using the term loosely—that it's not a published report and the rest, and some of the reasons why it isn't scientific. Could you tell me what your view is of the Montreal study?

Dr. BEILENSON. Since it's been quoted several times as the single study, I guess along with the Vancouver one, which I don't know about, as the reason why needle exchange may not work and the—I think Mr. Barr was mentioning the statistics; I think he meant zero positivity, which means the HIV positive rate among addicts—and the needle exchange in Montreal was 36 percent or so, and 16 or 13 percent city wide.

The reason that that's not a very well accepted study is because—exactly what I presented about our needle exchange clients; and that is that those who use needle exchange tend to be harder core users, probably who share more often, and therefore of course they would be at higher risk. So it's not because of the needle exchange program that they're more HIV positive; it's because of their behaviors going in.

So that's why it's a fairly widely debunked study. I mean, it's just that simple.

Our study in Baltimore compared exactly matched—exactly matched addicts in terms of frequency of drug use, length of time of drug use, number of sharing partners before, et cetera, age, et cetera; and the only differential was used needle exchange, didn't use needle exchange, and that's where we show the 40 percent drop.

So we did control for that extremely important point, and that was not the case in Montreal.

Ms. PELOSI. Also, it could be among that population and the very discrete sample that they used that indeed it may have put a lid on the transmission of HIV.

Dr. BEILENSON. Yeah, but they don't know. I mean, we've been filing over 3 years; we know it's been happening. It's continual decrease in Baltimore. Yes, you're right on your point.

Ms. PELOSI. Thank you.

Mr. Chairman, I thank you for allowing me to participate in your hearing, and I think that one thing that should come out of it is that as we discuss the needle exchanges, and that is the major interest of this hearing, that there are certain criteria that we have in our legislation that I think, listening to the witnesses over and over again, are the correct criteria: Does it reduce HIV infection, save lives? Does it reduce drug abuse, and is it a real exchange?

And some of the concerns that Ms. Sosman put forth certainly should be addressed as well. But I think that that can be—all of our witnesses, the testimony, they have given us enough reason to say that if there is to be a needle exchange program, certainly it confirms what we have said all along about the criteria it should meet. But I think we have to pay very serious attention to the lives that can be saved from it and the reduction in drug abuse and all of its accompanying vices and crime rate, et cetera.

So for that reason and many others I want to thank you very much for holding this hearing and allowing my participation.

Mr. HASTERT. Thank you. It has been a pleasure having you today.

Ms. PELOSI. Thank you.

Mr. HASTERT. I would like to continue the questioning; and, Mr. Maginnis, in your study of this issue, the real question here that I think is that some difference in points of view and how you construe the evidence and studies.

First of all, what is the linkage between—is the real crux of the question, needle exchanges, and of course our friend from California likes to say that we need to have stronger criteria when you give away needles and——

Ms. PELOSI. Exchange.

Mr. HASTERT. Exchange needles, in some cases; it depends on where you're at——

Ms. PELOSI. That's a must.

Mr. HASTERT [continuing]. And drug use? What have you found in your studies of the criteria? When you give away needles or exchange needles, do you have more drug use?

Mr. MAGINNIS. Well, the short answer is that we don't know.

The longer answer is like the one in Baltimore and the glowing report here—I've seen one that I think is working reasonably well in New Haven. I was up there this summer, went through Matthew

Lobes' program and was—and he, by the way, is a Yale classmate of your boss, Mayor Schmoke, who we talked to—talked about in some detail with me. But that was the exception.

The other programs, and there are lists of them, whether you be in Seattle at Second and Pike where they give out needles without exchanging or you're up in Willimantic, CT, where they're discarding needles from the exchange and a young child last fall pricked herself on a discharged needle, a serious problem.

But as far as drug use, you know we don't have a good parallel other than to see from the lessons that we've learned from Switzerland. You know, maybe we can't cross those cultures, but frankly we are not any smarter, I don't believe, than the Swiss; and the Swiss have already come through several stages, as the good professor has pointed out. It seems to me that having been over there, talked to the teachers, talked to the counselors, seen the progression through a series of stages of that particular culture, I see exactly the same thing happening in my culture. I asked the American people last month in a national poll, and they're concerned about the same issues.

So the American people are not supportive of this because they fear that their own children are going to be jeopardized at the expense of some people that are at increased risk of contracting HIV. We have got to be compassionate, but we have balanced—you know, I'm a retired colonel in the Army; and it seems to me that I'm trying to save the lives of a lot of kids that I'm finding on the streets today that are using drugs more than they have in the past; and we heard from the Congressman from Indiana that the age is going down.

Well, that should be sending what I call a "red star cluster" in the sky. It should stop all action. We have got to focus on getting that down and not sending mixed signals out there; and frankly, I think we are sending mixed signals.

We already have an example in another culture that's not terribly dissimilar to ours. I believe that unless the numbers radically turn around in this country from the National Household Survey, from the Pride Survey, from monitoring the future survey which we have and we're going to get in the next couple months, unless they radically turn around, we'd better be very, very careful about proceeding down the path that might lead to more drug use.

I applaud the good program in Baltimore. There are a couple of other good programs I'm aware of, but a lot of them don't work, and we're sending bad messages if we adopt legislation.

Mr. HASTERT. Two questions.

First of all, do you view then that if we have a national needle exchange program, that we're sending a signal to our kids that, you know, here's a legal needle, but you can use it for a illegal substance? So we can wink and nod that it's OK to use legal needles for illegal substances; is that the message that you see that we're giving?

Mr. MAGINNIS. I think so, and certainly 66 percent of the American people told our surveyor that, yes, they believe that this is sending the wrong signal to their kids and they are concerned as parents about these mixed signals. Just like this medical marijuana debate and anything else that glosses over, makes kind of lu-

dicrous the notion that drug use and certain drugs can be used, quote, for medicine, in reality, kids on the streets, you know, based on the surveys that just came out, have clearly stated, look, you know, I've got a friend that used drugs recently; you know, no one is telling me not to use it; you know, my best friend has used a hard drug recently.

The numbers are all going up. We have a group of children in this country who are drug saturated, and unfortunately, you know, if we're not careful at the national policy level, we're going to send mixed messages. Let the local communities—from my estimation, I've seen some good programs; the local communities can decide for their own self, but as far as the national policy, I think that's very dangerous.

Mr. HASTERT. One last question I wanted to ask.

In your view, the George Soros funding for legalization, marijuana legalization for medical use terminology in California, of course, the movement in Arizona, what effect has that had, in your opinion, on the youth of our country and where we're going?

Mr. MAGINNIS. Well, without George Soros, there wouldn't have been a referendum, I do not believe, in California. The last minute, within 3 weeks, he dumped about $1 million into a campaign to buy people to go out and get signatures. You know, I talked to the director of the opposition of that particular issue, and you know, it was very enlightening.

Without George Soros, you probably wouldn't have the same thing in Arizona. Without George Soros, it's interesting. I just saw a listing that was given on where some of this money has been used for other campaigns. I would mention the good Governor from Massachusetts; I have a list of Soros contributions to his Senate campaign, a long list of contributions from people, by name, on specific dates and so forth. I believe that Mr. Soros through the Lindesmith Center and Ethan Nadelmann his spokesperson up there, has a very clear agenda. Nadelmann has a clear agenda because he talks to the High Times, which is a pro-pot magazine. He talks to anybody that will listen to him on drugs. He's also a member of the Drug Policy Foundation board, as is Mr. Schmoke, at least he was at one point.

So you have a group of people in this country who I believe have a very clear agenda on drug legalization. They don't make any bones about it. They want the decriminalization of certain illicit substances.

This has a impact on our children. We need to be very careful about that, because we have a crisis that's brewing right now.

Mr. HASTERT. The gentleman from Maryland.

Mr. CUMMINGS. Mr. Chairman, I'm not going to—I'm just going to take a few minutes here, and I will not use all my time.

First of all, I want to ask unanimous consent to put into the record a letter dated February 18, 1997, from Donna Shalala addressed to the Honorable Arlen Specter with an attached report, Mr. Chairman, which was given on that same day. It is the report of the Committee on Appropriations for the Departments of Labor, Health and Human Services, Education on needle exchange programs in America.

Mr. HASTERT. Without objection.

[The letter referred to follows:]

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

FEB 18 1997

The Honorable Arlen Specter
Chairman
Subcommittee on Labor, Health
and Human Services, and Education
Committee on Appropriations
United States Senate
Washington, D.C.

Dear Senator Specter:

In accordance with the request of the Committee included in Senate Report 104-368, I am transmitting the enclosed report reviewing completed and ongoing research on the efficacy of needle exchange programs in reducing HIV transmission and their impact on illegal drug use.

A number of communities have established outreach programs for out-of-treatment drug users to get them into treatment and to get them to reduce high risk sexual and drug using behaviors. Needle exchange programs have also been developed in many communities to reach injecting drug users who are not in treatment and to reduce the transmission of hepatitis and HIV through the reduction of drug use behaviors and unsafe injection practices.

The intravenous use of illegal drugs is wrong and is clearly a major public health problem as well as a law enforcement concern. Among the many secondary health consequences of injection drug use are the transmission of hepatitis, HIV and other bloodborne diseases. The Department supports a range of activities to cope with these public health issues, from basic research supported by the National Institute on Drug Abuse to substance abuse prevention and treatment programs at the community level.

HIV disease is also an urgent public health problem in our Nation as the leading cause of death among adults age 25-44, and the seventh leading cause of death for all Americans. Injecting drugs with nonsterile equipment is one of three key risk factors for HIV infection, along with unprotected sexual intercourse and untreated sexually transmitted diseases. Unsafe drug injection is the second most frequently reported risk behavior for HIV infection, accounting for a growing proportion of new HIV infections among users, their sexual partners and their children. To realize our goal of effective HIV prevention, it is vital that we identify and evaluate sound public health strategies to address the twin epidemics of HIV and substance abuse.

Page 2 - The Honorable Arlen Specter

The Department has played an important role in supporting evaluations of needle exchange programs as they impact HIV transmission and patterns of drug use. As requested, this report provides the Committee with the findings of published studies conducted in our country, and a description of current research and interim findings where these are available.

Sincerely,

Donna E. Shalala

Donna E. Shalala

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

FEB 18 1997

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Ranking Minority Member
Subcommittee on Labor, Health
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Committee on Appropriations
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REPORT TO THE COMMITTEE ON APPROPRIATIONS
FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES,
EDUCATION AND RELATED AGENCIES

NEEDLE EXCHANGE PROGRAMS IN AMERICA: REVIEW OF PUBLISHED STUDIES AND ONGOING RESEARCH

DONNA E. SHALALA
SECRETARY OF HEALTH AND HUMAN SERVICES
FEBRUARY 18, 1997

REPORT TO THE COMMITTEE ON APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

NEEDLE EXCHANGE PROGRAMS IN AMERICA: REVIEW OF PUBLISHED STUDIES AND ONGOING RESEARCH

Introduction

On September 12, 1996, the Committee on Appropriations for the Departments of Labor, Health and Human Services, Education and Related Agencies made the following request of the Department of Health and Human Services:

> "The Committee understands the Department is continuing to support research, reviewing the effect of clean needle exchange programs on reducing HIV transmission, and on whether such programs encourage illegal drug use. The Committee requests that the Secretary provide a report by February 15, 1997 on the status of current research projects, an itemization of previously supported research, and the findings to date regarding the efficacy of needle exchange programs for reducing HIV transmission, and not encouraging illegal drug use." Senate Report 104-368, p.68

In response to the Committee's request, this report provides an overview of the current status of knowledge regarding needle exchange programs (NEPs) with a compilation of relevant reviews and abstracts pertinent to the issues of efficacy of NEPs in reducing HIV transmission and their effect on utilization of illegal drugs. In reviewing the body of literature gathered, it is important to note the wide range of methodologic approaches utilized and the impact of these study design choices on the conclusions drawn. For example, studies varied significantly in terms of study populations, survey instruments, and assumptions made in the design of mathematical models used to predict seroincidence and seroprevalence. Given the significantly different design elements, making comparisons or drawing conclusions across studies requires an understanding of these complexities.

In the Department's assessment, providing the findings and conclusions from specific studies without benefit of the context of their specific methodologies would not facilitate a sound understanding of this issue, as the nature of the findings is not consistent. For these reasons, the original reviews and source documents with their discussions of methodological issues are being provided to the Committee for consideration along with the findings and conclusions. The data presented are limited to published studies conducted in the United States, consistent with the approach taken by the National Academy of Sciences, as the legal and cultural

environments of other countries differ sufficiently enough to raise questions about whether the conclusions are applicable to the United States.

The report is presented in four parts. Part One provides a review of completed studies and published abstracts addressing the efficacy of needle exchange programs for reducing HIV transmission and their effect on illegal drug use. Several major reviews, including a report by the National Research Council/Institute of Medicine (NRC/IOM) analyzes those studies published prior to 1995; subsequent studies are identified individually. Part Two describes the status of federally supported evaluation studies of needle exchange programs, with preliminary findings noted where these are available. Part Three provides the results of a national survey of State and local regulation of syringes and needles. Part Four is a set of Appendices which include the reviews of needle exchange programs described in Part One, two studies published since the NRC/IOM review, and relevant abstracts presented at the XI International AIDS Conference in Vancouver, BC in July, 1996.

I. Review of Published Studies

Three reviews of the literature on needle exchange programs have been commissioned by the federal government: (1) Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy, United States General Accounting Office, March 1993; (2) The Public Health Impact of Needle Exchange Programs in the United States and Abroad, prepared by the faculty and research staffs of the San Francisco and Berkeley campuses of the University of California for the Centers for Disease Control and Prevention, U.S. Public Health Service, in September 1993; and (3) Preventing HIV Transmission: The Role of Sterile Needles and Bleach, National Research Council and Institute of Medicine, September 1995.

Report of the U.S. General Accounting Office

The U.S General Accounting Office (GAO) was requested by the Chairman of the House Select Committee on Narcotics Abuse and Control to: (1) review the results of studies addressing the effectiveness of needle exchange programs in the United States and abroad, (2) assess the credibility of a forecasting model developed at Yale University that estimates the impact of a needle exchange program on the rate of new HIV infections, and (3) determine whether federal funds can be used in support of studies and demonstrations of needle exchange programs.

The GAO conducted a literature review and site visits to two needle exchange programs. While the GAO noted that there were 32 known needle exchange programs in operation in 27 different U.S. cities or counties, their staff visited only those programs located in Tacoma, Washington and New Haven, Connecticut. Needle exchange programs studied by GAO were located in Australia (1), Canada (1), Netherlands (2), Sweden (1), United Kingdom (3), and the United States (1).

The full report with data from nine needle exchange programs and GAO findings are provided at Appendix A. The Results in Brief are abstracted below:

"Measuring changes in needle sharing behaviors is an indicator often used to assess the impact of needle exchange programs on HIV transmission. We identified nine needle exchange projects that had published results. Only three of these reported findings that were based on strong evidence. Two of these three reported a reduction in needle sharing while a third reported an increase.

One concern surrounding needle exchange programs is whether they lead to increased injection drug use. Seven of the nine projects looked at this issue, and five had strong evidence for us to report on outcomes. All five found that drug use did not increase among users; four reported no increase in frequency of injection and one found no increase in the prevalence of use. None of the studies that addressed the question of whether or not the needle exchange progams contributed to injection drug use by those not previously injecting drugs had findings that met our criteria of strong evidence. Our review of the projects also found that seven reported success in reaching out to injection drug users and referring them to drug treatment and other health services.

We also found the forecasting model developed at Yale University to be credible. This model estimated a 33 percent reduction in new HIV infections among New Haven, Connecticut, needle exchange program participants over 1 year. Based on our expert consultant review, we found the model to be technically sound, its assumptions and data values reasonable and the estimated 33 percent reduction in new HIV infections defensible. This reduction stems from the program's ability to lessen the opportunity for needles to become infected, to be shared, and to infect an uninfected drug user. To gather data in assessing program impact for use in the New Haven model, the researcher developed a new system for tracking and testing for HIV in returned needles.

While these findings suggest that needle exchange programs may hold some promise as an AIDS prevention strategy, HHS is currently restricted from using certain funds to directly support the funding of needle exchange programs. Under the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reorganization Act of 1992, block grant funds authorized by title XIX of the PHS Act may not be used to carry out any needle exchange program unless the Surgeon General determines that they are effective in reducing the spread of HIV and the use of illegal drugs. However, HHS does have the authority to conduct demonstration and research projects that could involve the provision of needles." Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy, GAO/HRD-93-60, pages 3-4.

Report of the University of California

Under a contract with the Centers for Disease Control and Prevention (CDC), faculty of the University of California, at Berkeley and San Francisco, undertook a review and analysis of the literature on needle exchange programs to answer a set of 14 research questions, including the effect of needle exchange programs on HIV infection rates and prevention of HIV infection and effect on drug using behavior. At the time this study, 37 active needle programs were known to exist in the U.S.; the 33 programs which were up and running for sufficient time to be included in this review operated a total of 102 sites. Over 1900 data sources were analyzed and ranked according to the quality of study design and evidence reported; study results report only on those judged to be of acceptable quality, or better. A complete summary of findings and data sources utilized is provided in the final report at Appendix B.

The Executive Summary of the report is provided below:

"**How and Why did Needle Exchange Programs Develop?**
Needle exchange programs have continued to increase in number in the US and by September 1, 1993 at least 37 active programs existed. The evolution of needle exchange programs in the US has been characterized by growing efforts to accomodate the concerns of local communities, increasing likelihood of being legal, growing institutionalization, and increasing federal funding of research, although a ban on federal funding for program services remains in effect.

How do Needle Exchange Programs Operate?
About one-half of US needle exchange programs are legal, but funding is often unstable and most programs rely on volunteer services to operate. All but six US needle exchange programs require one-for-one exchanges and rules governing the exchange of syringes are generally well enforced. In addition to having distributed over 5.4 million syringes, US needle exchange programs provide a variety of services ranging from condom and bleach distribution to drug treatment referrals.

Do Needle Exchange Programs Act as Bridges to Public Health Services?
Some needle exchange programs have made significant numbers of referrals to drug abuse treatment and other public health services, but referrals are limited by the paucity of drug treatment slots. Integrating needle exchange programs into the existing public health system is a likely future direction for these programs.

How Much Does it Cost to Operate Needle Exchange Programs?
The median annual budget of US and Canadian needle exchange programs visited is relatively low at $169,000, with government-run programs tending to be more expensive. Some needle exchange programs are more expensive because they also

provide substantial non-exchange services such as drug treatment referrals. The annual cost of funding an average needle exchange program would support about 60 methadone maintenance slots for one year.

Who Are the IDUs Who Use Needle Exchange Programs?
Although needle exchange program clients vary from location to location, the programs generally reach a group of injecting drug users with long histories of drug injection who remain at significant risk for human immunodeficiency virus (HIV) infection. Needle exchange program clients in the US have had less exposure to drug abuse treatment than IDUs not using the program.

What Proportion of All Injecting Drug Users in a Community Uses the Needle Exchange Program?
Studies of adequately funded needle exchange programs suggest that the programs do have the potential to serve significant proportions of the local injecting drug user population. While some needle exchange programs appear to have reached large proportions of local drug injectors at least once, others are reaching only a small fraction of them. Consequently, other methods of increasing sterile needle availability must be explored.

What Are the Community Responses to Needle Exchange Programs?
Unlike in many foreign countries, including Canada, proposals to establish needle exchange programs in the US have often encountered strong opposition from a variety of different communities. Consultation with affected communities can address many of the concerns raised.

Do Needle Exchange Programs Result in Changes in Community Levels of Drug Use?
Although quantitative data are difficult to obtain, those available provide no evidence that needle exchange programs increase the amount of drug use by needle exchange program clients or change overall community levels of non-injection and injection drug use. This conclusion is supported by interviews with needle exchange program clients and by injecting drug users not using the programs, who did not believe that increased needle availability would increase drug use.

Do Needle Exchange Programs Affect the Number of Discarded Syringes?
Needle exchange programs in the US have not been shown to increase the total number of discarded syringes and can be expected to result in fewer discarded syringes.

Do Needle Exchange Programs Affect Rates of HIV Drug and/or Sex Risk Behaviors?

The majority of studies of needle exchange program clients demonstrate decreased rates of HIV drug risk behavior but not decreased rates of HIV sex risk behavior.

What is the Role of Studies of Syringes in Injection Drug Use Research?
The limitations of using the testing of syringes as a measure of injecting drug users' behavior or behavior change can be minimized by following syringe characteristics over time, or by comparing characteristics of syringes returned by needle exchange program clients with those obtained from non-clients of the program.

Do Needle Exchange Programs Affect Rates of Diseases Related to Injection Drug Use Other than HIV?
Studies of the effect of needle exchange programs on injection-related infectious diseases other than HIV provide limited evidence that needle exchange programs are associated with reductions in subcutaneous abscesses and hepatitis B among injecting drug users.

Do Needle Exchange Programs Affect HIV Infection Rates?
Studies of the effect of needle exchange programs on HIV infection rates do not and, in part due to the need for large sample sizes and the multiple impediments to randomization, probably cannot provide clear evidence that needle exchange programs decrease HIV infection rates. However, needle exchange programs do not appear to be associated with increased rates of HIV infection.

Are Needle Exchange Programs Cost-effective in Preventing HIV Infection?
Multiple mathematical models of needle exchange programs impact support the findings of the New Haven model. These models suggest that needle exchange programs can prevent significant numbers of infections among clients of the programs, their drug and sex partners, and their offspring. In almost all cases, the cost per HIV infection averted is far below the $119,000 lifetime cost of treating an HIV-infected person." The Public Health Impact of Needle Exchange Programs in the United States and Abroad, Volume 1, pp.iii-v.

Report of the National Academy of Sciences

In 1992, Congress included a provision in the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reorganization Act directing the Secretary of DHHS to request the National Academy of Sciences (NAS) to conduct a study of the impact of needle exchange and bleach distribution programs on drug use behavior and the spread of infection with the human immunodeficiency virus (HIV). The National Research Council and the Institute of Medicine (NRC/IOM) of the NAS convened an expert panel in 1993, conducted a thorough review of the scientific literature on these issues, and published the report Preventing HIV Transmission: The Role of Sterile Needles and Bleach, in September, 1995.

Approximately 75 needle exchange programs had been initiated in 55 US cities at the time of this report. Data was also newly available assessing the effects of a 1992 Connecticut law decriminalizing the possession of syringes without a prescription.

The scope of the NRC/IOM study extended well beyond the information requested for this report. A review of the scientific data on the effects of needle exchange programs on reduction in HIV transmission rates and impact on drug utilization is presented in Chapter Seven of the report. The text of the full report is provided at Appendix C. The study reviewed and expanded on the previous studies of the GAO and University of California as well as analyzing subsequently published studies through 1994. The NRC/IOM study panel included a discussion of experimental study design and data quality issues in weighing the contribution of published studies. The conclusions and recommendations of the report were based in part on an assessment of the patterns of evidence, and not solely on the quality of evidence in individual studies.

Provided here is a summary of the conclusions of the NRC/IOM panel on the scientific assessment of needle exchange program effectiveness:

Scientific Assessment of Program Effectiveness

" On the basis of its review of the scientific evidence, the panel concludes:

- Needle exchange programs increase the availability of sterile injection equipment. For the participants in a needle exchange program, the fraction of needles in circulation that are contaminated is lowered by this increased availability. This amounts to a reduction in an important risk factor for HIV transmission.

- The lower the fraction of needles in circulation that are contaminated, the lower the risk of new HIV infections.

- There is no credible evidence to date that drug use is increased among participants as a result of programs that provide legal access to sterile equipment.

- The available scientific literature provides evidence based on self-reports that needle exchange programs do not increase the frequency of injection among program participants and do not increase the number of new initiates to injection use.

- The available scientific literature provides evidence that needle exchange programs have public support, depending on locality, and that public support tends to increase over time." Preventing HIV Transmission: The Role of Sterile Needles and Bleach, Executive Summary, page 4.

Other Recent Studies

Other studies and abstracts published since the NRC/IOM report which address the effects of needle exchange programs on HIV transmission and drug-using behavior are provided at Appendix D. These include: (1) a study published by Des Jarlais et al in Lancet, October 1996 researching the question if NEPs have an individual-level protective effect against HIV transmission, (2) an evaluation commissioned by the Massachusetts Department of Public Health on the effects of a pilot needle exchange program, presenting Year One and Year Two data, and (3) abstracts accepted at the XI International Conference on AIDS held in Vancouver, BC July 1996. Although many abstracts included findings relevant to NEPs, only those designed to specifically study the research questions raised by the Appropriations Committee are included in this report.

(1) Des Jarlais DC, et al. HIV incidence among injecting drug users in New York City syringe-exchange programmes. Lancet 1996; 348: 987-991.

This study employed meta-analytic techniques to compare HIV incidence among injecting drug users participating in syringe-exchange programs in New York City with that among non-participants. Data from three cohorts (total n=1630) was pooled to assess HIV incidence rates.

- Findings HIV incidence among continuing exchange users in the Syringe Exchange Evaluation was 1.58 per 100 person-years at risk (95% CI 0.54, 4.65) and among continuing exchange users in the Vaccine Preparedness Initiative it was 1.38 per 100 person-years at risk (0.23, 4.57). Incidence among non-users of the exchange in the Vaccine Preparedness Initiative was 5.26 per 100 person-years at risk (2.41, 11.49), and in the National AIDS Demonstration Research cities (non-exchange users) 6.23 per 100 person-years at risk (4.4, 8.6). In a pooled-data multivariate proportional-hazards analysis, not using the exchanges was associated with a hazard ratio of 3.35 (95% CI 1.29, 8.65) for incident HIV infection compared with using the exchanges.
  Interpretation We observed an individual-level protective effect against HIV infection associated with participation in a syringe-exchange programme. Sterile injection equipment should be legally provided to reduce the risk of HIV infection in persons who inject drugs." p. 987.

(2) The Medical Foundation, Final Report: First Year of the Pilot Needle Exchange Program in Massachusetts, October 1995; and Second Year Update: Program Characteristics of Massachusetts Needle Exchange Programs, 1994-95, August 1996.

These two reports were prepared by The Medical Foundation under contract to the Massachusetts Department of Public Health, to evaluate the effects of a pilot needle exchange program (AHOPE) authorized by State law in 1993. Two needle exchange programs served 1,315 and 1,999 unduplicated clients in 1994 and 1995, respectively. The Executive Summary of the 1995 report and the Second Year Update of 1996 summarize study results to the following questions:

- What were the demographic characteristics of people who enrolled in the program and did the program reach those at risk for HIV infection in Metro Boston and Cambridge
- What were the reported injection behaviors and risks of program clients
- How many client-contacts did the program have and what supplies were distributed
- Did the program act effectively as a "bridge to treatment" for needle exchange clients
- Did crime increase in areas with needle exchange sites compared to areas without needle exchange sites
- Did needle stick injuries to public service workers increase as a result of the program

"Conclusion Upon completion of its first full year of operation, AHOPE has been successful in enrolling 1,315 clients, exchanging 37,575 syringes, and linking 16.6% of the eligible clients to drug treatment. Many of the major concerns regarding the establishment of the program -- namely the danger of increased crime, the initiation of young people into drug use and injection, the attraction of addicts from wide geographic areas into Boston, and the possibility of needle stick injuries to public workers -- did not come to pass. AHOPE appears to have significantly contributed to the reduction of HIV risk among a diverse population at high risk for HIV infection and transmission with little negative community impact." Final Report: First Year of the Pilot Needle Exchange Program in Massachusetts, October 1995, p.7.

"Conclusion The program is expanding into areas of the state where there is much need for prevention services while maintaining continuity of care in areas where the program is already established. There is no evidence that the program is attracting young or new injectors, there have been no other negative community impacts. The programs have had significantly positive impacts, both in preventing HIV through the provision of sterile syringes and prevention supplies and education and in the form of enhanced drug treatment linkage for the older, impoverished long-term addicts who utilize the program." Second Year Update: Program Characteristics of Massachusetts Needle Exchange Programs, 1994-1995, August 1996, p.3.

(3) Abstracts from the XI International Conference on AIDS, Vancouver, BC, July 1996. The following two abstracts reported on US needle exchange programs in Baltimore, MD and New York City.

Vlahov, D et al. Evaluation of the Baltimore Needle Exchange Program: Preliminary Results. [Abstract Mo.D.361] The following key variables were addressed in the abstract: frequency of drug injection, frequency of needle exchanges, needle sharing patterns, use of shooting galleries, number of injections on the street, and disposal of used needles on the street.

"Conclusion This NEP has recruited a large number of IDUs and preliminary data suggest that the NEP attracts high risk IDUs, and that a reduction in HIV risk drug use is observed."

Schoenbaum, EE et al. Needle Exchange Use Among a Cohort of Drug Users. [Abstract Tu.C.2523] The abstract reports on a prospective study of injection behaviors among IDUs enrolled in a methadone maintenance program who did and did not utilize a local needle exchange program in the Bronx, New York City between 1985-1993. The following key variables were addressed in the abstract: the percent of clients injecting over time, percent of clients using the needle exchange program, needle sharing behavior, and HIV seropositivity status.

"Conclusion Methadone treated IDUs with access to a needle exchange decreased injection and needle sharing. This pattern of harm reduction, which began years before the needle exchange program opened, occurred in those who did and did not utilize the needle exchange. Needle exchange, as a strategy to decrease injection-related harm, should not be viewed as discordant with methadone treatment."

II. Current Federally Supported Research on Needle Exchange Programs

The Department has taken an active interest in evaluating the public health impact of needle exchange programs since 1992, in light of the opportunity to reduce bloodborne transmissible diseases among IDUs and to serve as a gateway to substance abuse treatment. These research activities have been centered at the National Institute on Drug Abuse (NIDA). A description of NIDA's needle exchange research portfolio which includes 15 funded studies is described in Appendix E. All federally sponsored research is limited by statute to evaluations of existing NEPs and does not support the purchase or distribution of needles.

Of the 15 studies funded by NIDA, only two have been completed. A summary of findings to date follows here. Of 4 studies reporting data on frequency of injection, three report no evidence of increased injection frequency, and one shows a decreased rate of injections. All four of the 15 studies reporting data on multi-person reuse, or sharing, of syringes show a decrease in the reuse of syringes. Data on the prevalence or incidence of hepatitis and HIV is available for 2 of the 15 projects. In one study between 51% - 55% of syringes returned were seropositive; of note, multiple syringes may have been returned by a single

individual affecting interpretation of these results. In the other study, a 33 percent relative reduction in HIV incidence in needle exchange program users was predicted based on a mathematical model. This model was reviewed and assessed to be methodologically sound in the GAO report found at Appendix A.

III. National Survey on the Regulation of Syringes and Needles

A recent national survey of laws and regulations governing the sale and possession of needles and syringes in the United States and its territories is included at Appendix F, to provide the Committee with additional background on the variety of state and local drug paraphernalia laws, syringe prescription statutes, and pharmacy regulations in effect. A number of states and local ordinances have created exceptions to laws and regulations for operators of syringe exchange programs and their participants. An overview of the legislative history and the specifics of exemptions are included along with the results of the national survey.

Summary

This review provides the Committee with an overview of the current status of knowledge regarding the impact needle exchange programs may have on the seroincidence of HIV and their impact on drug using behavior of needle exchange participants. Overall these studies indicate that needle exchange programs can have an impact on bringing difficult to reach populations into systems of care that offer drug dependency services, mental health, medical and support services. These studies also indicate that needle exchange programs can be an effective component of a comprehensive strategy to prevent HIV and other blood borne infectious diseases in communities that choose to include them.

IV. Appendices

Appendix A. Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy. U.S. General Accounting Office. 1993

Appendix B. The Public Health Impact of Needle Exchange Programs in the United States and Abroad, Volume 1. San Francisco, CA: University of California. 1993

Appendix C. Preventing HIV Transmission: The Role of Sterile Needles and Bleach. National Research Council and Institute of Medicine. 1995.

Appendix D. Des Jarlais DC, Marmor M, Paone D et al. HIV Incidence Among Injecting Drug Users in New York City Syringe-Exchange Programmes. Lancet. 1996;348:987-991.

First year report (October 1995) and Second Year Update (August 1996) of the Pilot Needle Exchange Program in Massachusetts. The Medical Foundation, for the Massachusetts Department of Public Health.

Abstracts from the XI International Conference on AIDS, Vancouver, BC July 1996:

1) Vlahov D. et al. Evaluation of the Baltimore Needle Exchange Program: Preliminary Results. Abstract Mo.D.361

2) Schoenbaum, E. et al. Needle Exchange Use Among a Cohort of Drug Users. Abstract Tu.C.2523

Appendix E. NIDA's Needle Hygiene and Needle Exchange Evaluation Research Program Portfolio, 1992 - Present.

Appendix F. Gostin LO, Lazzarini JD, Jones TS, Flaherty K. Prevention of HIV/AIDS and Other Blood-Borne Diseases Among Injection Drug Users. JAMA. 1997;277:53-62.

United States General Accounting Office

APPENDIX A

GAO

Report to the Chairman, Select Committee on Narcotics Abuse and Control, House of Representatives

March 1993

NEEDLE EXCHANGE PROGRAMS

Research Suggests Promise as an AIDS Prevention Strategy

GAO/HRD-93-60

Prepared by the
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

CDC

APPENDIX B

THE PUBLIC HEALTH IMPACT OF NEEDLE EXCHANGE PROGRAMS IN THE UNITED STATES AND ABROAD

Volume 1

SCHOOL OF PUBLIC HEALTH,
UNIVERSITY OF CALIFORNIA, BERKELEY

INSTITUTE FOR HEALTH POLICY STUDIES
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

PREPARED FOR THE CENTERS FOR DISEASE CONTROL AND PREVENTION

October 1993

APPENDIX C

PREVENTING HIV TRANSMISSION

The Role of Sterile Needles and Bleach

NATIONAL RESEARCH COUNCIL • INSTITUTE OF MEDICINE

APPENDIX D

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HIV incidence among injecting drug users in New York City syringe-exchange programmes

Don C Des Jarlais, Michael Marmor, Denise Paone, Stephen Titus, Qiuhu Shi, Theresa Perlis, Benny Jose, Samuel R Friedman

Summary

Background There have been no studies showing that participation in programmes which provide legal access to drug-injection equipment leads to individual-level protection against incident HIV infection. We have compared HIV incidence among injecting drug users participating in syringe-exchange programmes in New York City with that among non-participants.

Methods We used meta-analytic techniques to combine HIV incidence data from injecting drug users in three studies: the Syringe Exchange Evaluation (n=280), in which multiple interviews and saliva samples were collected from participants at exchange sites; the Vaccine Preparedness Initiative cohort (n=133 continuing exchangers and 188 non-exchangers, in which participants were interviewed and tested for HIV every 3 months; and very-high-seroprevalence cities in the National AIDS Demonstration Research (NADR) programme (n=1029), in which street-recruited individuals were interviewed and tested for HIV every 6 months. In practice, participants in the NADR study had not used syringe exchanges.

Findings HIV incidence among continuing exchange-users in the Syringe Exchange Evaluation was 1·58 per 100 person-years at risk (95% CI 0·54, 4·65) and among continuing exchange-users in the Vaccine Preparedness Initiative it was 1·38 per 100 person-years at risk (0·23, 4·57). Incidence among non-users of the exchange in the Vaccine Preparedness Initiative was 5·26 per 100 person-years at risk (2·41, 11·49), and in the NADR cities, 6·23 per 100 person-years at risk (4·4, 8·6). In a pooled-data, multivariate proportional-hazards analysis, not using the exchanges was associated with a hazard ratio of 3·35 (95% CI 1·29, 8·65) for incident HIV infection compared with using the exchanges.

Interpretation We observed an individual-level protective effect against HIV infection associated with participation in a syringe-exchange programme. Sterile injection equipment should be legally provided to reduce the risk of HIV infection in persons who inject illicit drugs.

Lancet 1996; 348: 987–91

Beth Israel Medical Center (Prof D C Des Jarlais PhD, D Paone BSc, Q Shi MS), New York University Medical Center (Prof M Marmor PhD, S Titus MPH), and National Development and Research Institutes, Inc (D C Des Jarlais, T Perlis MS, B Jose PhD, S R Friedman PhD), New York, New York, USA

Correspondence to: Prof Don C Des Jarlais, Beth Israel Medical Center, Chemical Dependency Institute, 1st Avenue and 16th Street, New York, NY 10003, USA

Introduction

The provision of sterile injection equipment (syringe exchanges or pharmacy sales) has been the main method for reducing HIV infection among injecting drug users (IDUs) in most industrialised countries.[1] After nearly a decade of research on legal injection equipment for preventing HIV infection, there is no evidence that such programmes are associated with increased illicit drug injection, whereas that participation is associated with lower rates of drug-injection HIV-risk behaviour.[2,3] To date, however, there has been no direct evidence that participation is associated with a lower risk of incident HIV infection for the individual IDU.[3]

New York City had rapid transmission of HIV among drug injectors between 1978 and 1984, with seroprevalence reaching about 50%.[4] A small-scale pilot syringe-exchange programme was started by the City Department of Health in 1988, although this programme was discontinued by a new mayor in 1990.[5] Community activists then opened a number of "underground" exchanges. In 1992, the New York State Health Department permitted legal operation of five community exchanges. These exchanges expanded rapidly, providing services to about 36 000 IDUs by September, 1995, and exchanging 1·75 million syringes in 1994.

We report on incident HIV infections among IDUs in community-based syringe-exchange programmes in New York City from 1992 to 1995. We have reported on reductions in HIV risk behaviour among participants.[6,7]

APPENDIX D

[Mo.D.361] EVALUATION OF THE BALTIMORE NEEDLE EXCHANGE PROGRAM: PRELIMINARY RESULTS

Vlahov D, Junge, Benjamin, Beilenson P*, Brookmeyer RS, Cohn S, Armenian H. The Johns Hopkins School of Public Health; *Baltimore City Health Department.

Objective: To evaluate the first year of the Needle Exchange Program (NEP) for injection drug users (IDUs).

Methods: All participants between 8/12/94 and 8/11/95 who underwent enrollment interviews on sociodemographic and drug use practices. A systematic sample was interviewed at initial, two week and six month follow-up visits about needle acquisition, use and disposal practices during the 2 weeks before each interview. Data were analyzed using paired T-tests. In a community cohort (the ALIVE Study) demographics and HIV seroconversion rates were compared between participants who used vs. did not use the NEP.

Results: During the first year, 2965 IDUs enrolled in the NEP of whom 87% were African-American, 72% were male, 56% had < 12 years of education, 92% were unemployed and 90% injected | 1/day; the median age was 38 years old. Within the ALIVE cohort, NEP users were more likely to inject | 1/day, otherwise IDUs not enrolled in NEP were statistically similar. Of the 2965, 55% returned at least once to exchange, and 7% were high volume exchangers (> 50/visit); among high volume exchangers injection frequency and needles exchanged were similar. In the interviewed subset, there was a significant decrease ($p < .05$) of injections on the street, frequency of injection, needle sharing, use of galleries, and discarding needles on the street in the 2 weeks prior and subsequent to enrollment. These changes were sustained at the six month visit. Conclusion: This NEP has recruited a large number of IDUs and preliminary data suggest that the NEP attracts high risk IDUs, and that a reduction in HIV risk drug use is observed.

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APPENDIX D.

Second Year Update
Program characteristics of Massachusetts needle exchange programs, 1994-95

August 1996

APPENDIX D

THE MEDICAL FOUNDATION

Final Report

First Year of the Pilot Needle Exchange Program in Massachusetts

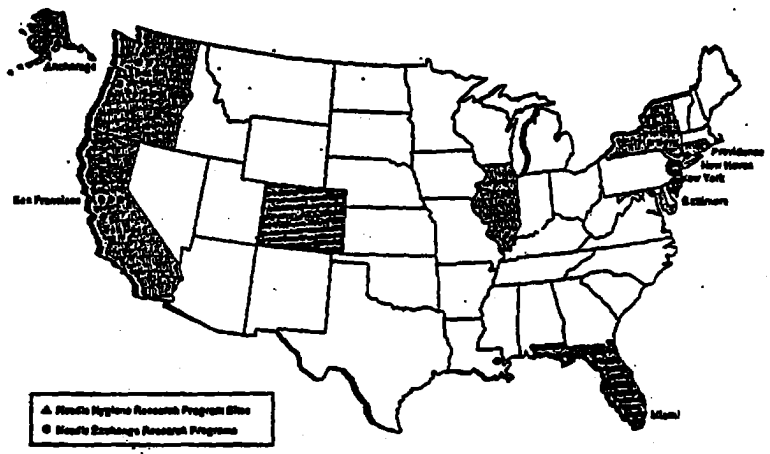
October 1995

The Medical Foundation
95 Berkeley Street
Boston MA 02116

APPENDIX E

NIDA's Needle Hygiene and Needle Exchange Evaluation Research Program Portfolio 1992-Present

Needle Hygiene and Needle Exchange Evaluation Research Program Sites:



Needle Exchange Research Program Grantees

Russell E. Alexander, Ph.D., Seattle, WA; *Frederick Altice*, M.D., New Haven, CT; *Don Des Jarlais*, Ph.D., New York, NY; *Dennis G. Fisher*, Ph.D., Anchorage, AK; *David R. Gibson*, Ph.D., San Jose, CA; *Holly Hagan*, Ph.D., Seattle-King County, WA; *Edward H. Kaplan*, Ph.D., New Haven, CT; *Peter G. Lurie*, Ph.D., San Francisco, CA; *Shelgia B. Murphy*, Ph.D., San Francisco, CA; *Lawrence J. Ouellet*, Ph.D., Chicago, IL; *Josiah Rich*, M.D., Providence, RI; *Merrill C. Singer*, Ph.D., Hartford, CT; *Thomas W. Valente*, Ph.D., Baltimore, MD; *David Vlahov*, Ph.D., Baltimore, MD; *Ricky Blumenthal*, M.A., San Francisco, CA.

Needle Hygiene Research Program Grantees

Michael Clatts, Ph.D., New York, NY; *Steve Koester*, Ph.D., Denver, CO; *Clyde B. McCoy*, Ph.D., Miami, FL.

APPENDIX F

Health Law and Ethics

Prevention of HIV/AIDS and Other Blood-Borne Diseases Among Injection Drug Users

A National Survey on the Regulation of Syringes and Needles

Lawrence O. Gostin, JD; Zita Lazzarini, JD, MPH; T. Stephen Jones, MD, MPH; Kathleen Flaherty, JD

We report the results of a survey of laws and regulations governing the sale and possession of needles and syringes in the United States and its territories and discuss legal and public health proposals to increase the availability of sterile syringes, as a human immunodeficiency virus (HIV) transmission prevention measure, for persons who continue to inject drugs. Every state, the District of Columbia (DC), and the Virgin Islands (VI) have enacted state or local laws or regulations that restrict the sale, distribution, or possession of syringes. Drug paraphernalia laws prohibiting the sale, distribution, and/or possession of syringes known to be used to introduce illicit drugs into the body exist in 47 states, DC, and VI. Syringe prescription laws prohibiting the sale, distribution, and possession of syringes without a valid medical prescription exist in 8 states and VI. Pharmacy regulations or practice guidelines restrict access to syringes in 23 states. We discuss the following legal and public health approaches to improve the availability of sterile syringes to prevent blood-borne disease among injection drug users: (1) clarify the legitimate medical purpose of sterile syringes for the prevention of HIV and other blood-borne infections; (2) modify drug paraphernalia laws to exclude syringes; (3) repeal syringe prescription laws; (4) repeal pharmacy regulations and practice guidelines restricting the sale of sterile syringes; (5) promote professional training of pharmacists, other health professionals, and law enforcement officers about the prevention of blood-borne infections; (6) permit local discretion in establishing syringe exchange programs; and (7) design community programs for safe syringe disposal.

JAMA. 1997;277:53-62

THE MAGNITUDE OF THE EPIDEMICS OF DRUG USE AND BLOOD-BORNE DISEASES

The dual epidemics of drug use and the human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS) are highly destructive of public health and social life in America.[1] The drug-related health problems of the estimated 1.5 million injection drug users (IDUs) in the United States[10] range from blood-borne infections such as hepatitis B and C, HIV/AIDS, endocarditis, and malaria[4-7] to physical deterioration and death. Illegal drug use and the drug industry that fuels it are associated with a multitude of crimes against persons and property. Drug use induces family disintegration, child neglect, economic ruin, and social decay. Drug use exacts an estimated annual cost to society of $58.3 billion—in lost productivity, motor vehicle crashes, crime, stolen property, and drug treatment.

Injection drug use is the second most frequently reported risk for AIDS, accounting for 184 259 cases through December 1995.[9] In 1995, 36% of all AIDS cases occurred among IDUs, their heterosexual sex partners, and children whose mothers were IDUs or sex partners of IDUs.[10] In contrast, in 1981, only 12% of all reported AIDS cases were associated with injection drug use.[11] In some areas, seroprevalence among IDUs is as high as 55%; in other areas, the rates are significantly lower.[12] Minorities, moreover, bear a disproportionately high burden. The rate of IDU-associated AIDS per 100 000 population is 3 for whites, 21.9 for Hispanics, and 50.9 for African Americans.

Transmission of HIV infection through injection drug use has a cascading effect; infections spread from IDUs to their sexual and needle-sharing partners and from HIV-infected mothers to their children. Of the 71 818 AIDS cases among women reported through December 1995, nearly 65% were IDUs or were sexual partners of an IDU. Further, of the 6256 perinatally acquired AIDS cases reported through December 1995, 60% had mothers who were IDUs or had sex with an IDU. These data suggest that drug use and related behaviors are a potent catalyst for spreading HIV throughout the population.[13] It has been estimated that approximately half of all new HIV infections in the United States occur among IDUs.[14]

THE ROLE OF SYRINGES IN THE TRANSMISSION OF BLOOD-BORNE DISEASE

Injection drug users transmit HIV infection and other blood-borne diseases to other users primarily through multiperson use (often called "sharing") of syringes.[2-3] (For the purpose of this article, "syringe" includes both syringes and needles.) Each time an IDU injects drugs, the syringe

From the Georgetown/Johns Hopkins Program in Law and Public Health, Washington, DC, and Baltimore, Md (Mr Gostin and Ms Flaherty); Harvard School of Public Health, Boston, Mass (Ms Lazzarini); and the Centers for Disease Control and Prevention, Atlanta, Ga (Dr Jones).

The views expressed herein are those of the authors and do not necessarily reflect the official policy of the US Department of Health and Human Services, the Carter Presidential Center, the Centers for Disease Control and Prevention, or the disponents of the consultation held at the Carter Presidential Center.

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Health Law and Ethics section editors: Lawrence O. Gostin, JD, Georgetown/Johns Hopkins University Program on Law and Public Health, Washington, DC, Baltimore, Md; Helene M. Cole, MD, Consultant Editor, *JAMA*.

Mr. CUMMINGS. Thank you very much, and I just want to just say to our witnesses, I want to thank you all for being here tonight. I think that we all have a concern about making sure that the lives of people who are in our neighborhoods and in our country are the very best that they can be. As the father of a 15-year-old and the father of a 3-year-old, I have those same kind of concerns, I really do. And as I listened to the back and forth, I guess what I—what concerns me is that—that, you know, when I hear Dr. Beilenson talk about people dying from AIDS, it really pains me. And I guess the reason why it pains me so much is that I attend a church that has about 8,000 members, and there was a time when we were burying two and three sometimes four people with AIDS a week, and these are people that I knew, and it's sort of sad, because what happened and one of the reasons why the Maryland legislature—by the way, we have our share of conservatives—but one of the reasons why they voted for this substantially the second time, after they had seen it working, is because they realized something that was very significant. They realized that a lot of the people who got AIDS never touched a needle. They never touched a needle. They were—maybe somebody got AIDS from a needle, then maybe they didn't tell somebody that they were involved with or whatever; and the next thing you know, you had children, you had women, you had people who never even thought about a drug.

And so the rationale was to create a program that was tight, very tight, as Dr. Beilenson described, to try to save some lives.

That is what it is all about, trying to save some lives, trying to save some pain, some anguish. That is all.

I think, Mr. Chairman, I think that this has been a very good exchange. I think that all of the witnesses have shed a lot of light on a lot of different things. But again, I think that we have got to look at this total picture and say, now, if we have got people dying, is it 23 to 44—what was it, 23 to 44 years old, let me tell you how significant that is. If it is the No. 1 killer in Baltimore, that means that a whole slew of people are being wiped out. Not only does it mean they are being wiped out, but it also means that they are being wiped out in their productive years.

It also means that they are being wiped out at a time when they could be producing children, which means that our population is being—I mean, our population is going down. It is going down quickly.

So I just wanted to address that to let you know that the Maryland Legislature and the people who support needle exchange are not some folks running around with this flag saying, we support the legalization of drugs. It is that we have seen so much pain, and we have seen so much death. We have seen that the No. 1, the No. 1 industry in Baltimore that is growing are funeral homes.

Dr. Beilenson will tell you, we have had funeral homes that would take up maybe two row houses. We have got mega funeral homes now, some of them holding seven and eight funerals at a time. So that is real. And so we have got to have a balance. We have to attack it with education, attack with interdiction. We have got to attack it with treatment, that is, the drug usage, and we have also got to address this whole issue of AIDS because AIDS is wiping out folks.

And I know that in the last 2 or 3 years, I know personally of at least 100 people who have died from AIDS. That does not even count the people who are suffering.

The legislation that we talked about earlier is not about the business of some scheme to get drugs legalized. I know that some of the best intentions—and I think this is basically what some of you all have said—the best-intentioned efforts a lot of times turn into something that is worse than you ever imagined. I understand that.

But I will tell you, the effect that drugs have had on me personally, I could never support the legalization of drugs. The medicalization, making sure people get treatment, yes, but not the legalization.

I appreciate and I respect you all for what you have said. Thank you.

Mr. HASTERT. I thank the gentleman from Maryland, certainly his contribution tonight and continually on this committee.

The gentleman from Indiana.

Mr. SOUDER. And also our sincere sympathies for his family and the struggle through this.

Dr. Beilenson, a question I should have asked earlier. Do you do any criminal background checks on people applying for needles? Are any of them dealers, abusers of their spouse? Do you check that type of thing?

Mr. BEILENSON. No.

Mr. SOUDER. So you, in fact, could be enabling somebody who is committing other crimes?

Mr. BEILENSON. What we are doing is focusing on drug treatment and AIDS prevention. That is what we do.

Mr. SOUDER. And I want to say that I believe that in this effort, that has been your complete intention, and you have—this is not a question of who is most sympathetic, because our heart goes out to all of that. One of our concerns is a deeply held concern, and I think Congressman Cummings addressed this, and that is, even if the intent is not to relax our drug laws in this country or seeming like we are doing that, what I hear from every prosecutor and every police department in my district, and we are hearing this across the country, as we have had hearings across the country, that 75 to 80 percent of all crime is related to drug abuse.

So when we talk about drug overdoses and things that are direct, that is one part of it. But when we have teenagers dying in automobile wrecks or the problems we have in families, they are usually related to drugs, often combined with alcohol. One of the core fundamental questions we have here is, what exact moral dimension does this whole impact have? We touched on that a minute ago.

But I would like to hear from Mr. Jordan and Ms. Sosman, also you, Dr. Beilenson, if we start referring to marijuana as medicinal, and maybe, Mr. Jordan, you can explain a little what—as we have been to South America and in Peru and other countries, how they perceive this in our country, when we start talking about marijuana as medicinal, when we start giving needles to people who are abusing and violating the law, if it was not coming from the Government. How can we be perceived as adults and as responsible fig-

ures in this society and then say, but do not get started on this? And how can we internationally try to crack down on it? And what message is there, particularly Ms. Sosman, in your area, what has been the reaction of the kids in the neighborhood to the fact that the Government seems to be supplying these needles?

So if Mr. Jordan could talk a little about the international; Ms. Sosman, in your neighborhood; and, Dr. Beilenson, you have obviously had to go through this and worked it through in your neighborhoods. Give us a mix.

Mr. JORDAN. With respect to the international side of your question, the problem is as the United States is seen to be moving more and more toward this treatment of medicinal purposes, we get the problem, for example, to get back to Switzerland, where those who are fighting the legalization do not find that what they are doing is understood by the representatives of the U.S. Government there.

Let me be very frank with you. An American ambassador abroad is able to influence his public affairs officer and the USIS to take direct action to support that country's efforts in the publicity area to resist the legalization of narcotics. It is a very interesting question; that is, if you have people there who think that the way to go is through demand reduction, they understand that as a treatment program, and then perceive another country's treatment program as in accordance with American policy, you are not getting the active role of the U.S. Government in the fighting of narcotics in those countries, and therefore you begin to find that those who are most active in trying to fight the narcotics problem in their country are not being assisted and are finding themselves having difficulty in getting access to the media without the support of the U.S. Government.

My experience has always been that when you had visitors from, let us say, the Select Committee of Narcotics, which it was in my time, which was then chaired by Chairman Rangel, and the minority leader was then Congressman Gilman, that they were there to help you do this, and you worked together to try to reduce narcotics consumption there and the whole spectrum from the growth, production, transshipment, the whole ball of wax.

To the degree that there is the perception that the American strategy is now moving toward treatment, is leading to a less vigorous U.S. Government process in assisting those who are fighting the legalization of narcotics abroad, that has been picked up, and that is why now you have cities in Latin America wanting to attend—the maze of cities wanting to attend a meeting at Medellin which is designed to further the legalization or the consumption of narcotics in these cities.

This is going to be devastating to the U.S. effort. And your concern about what is the problem for the United States and its reputation abroad is that they throw back in their face everything that happens in the United States. The United States is not fighting it. What are you doing? What is your attitude toward it? And every single time you are weak on that issue, they say, what are you asking us to do?

Ms. SOSMAN. I did not really hear your whole question because I am concerned about catching a flight back to New York.

I would like to say that in my neighborhood we have teenagers selling drugs in bodegas, which are little grocery stores. We had a Channel 9 news team come to our neighborhood last year, and they found 10-year-old children running around at 4 a.m., smoking pot with their cousins. And we have a 5-year-old little girl who lives in my building, one of my neighbors, and she knows what a junkie is.

Mr. SOUDER. Does the fact that the Government distributes the needles, do they raise that, hey, we can get this stuff there? Who are they to criticize us?

Ms. SOSMAN. I am sorry?

Mr. SOUDER. The fact that the Government distributes needles, does that impact the kids' mentality? Do they say, hey——

Ms. SOSMAN. When the parents of children in the local schools have to go there early in the morning to clean the needles off the front stoops of their schools before the children can come in; and then we have programs like Housing Works, which allocates money to drug addicts to buy drugs, gives them free needles and gets them baby-sitters for their children when they go on crack binges, this does not bode well for the communities. Families in our community are being ignored and abused by these kinds of programs.

Mr. SOUDER. Dr. Beilenson, I would like to hear your response. You said the community has been more supportive. What is their line? How are they reacting that the Government seems to be involved in things that heretofore have been illegal?

Mr. BEILENSON. We have not had a major problem because we have had a lot of community support from this. I have already talked, one of the reasons there is not increased crime, I already gave those statistics, that we do not get kids coming to our program. And, in fact, we purposely do not locate near schools or day care centers. All six of our sites, they are vans, they are not fixed sites, so we leave at the end of a 2-hour period, are located usually in alleys, often in front of a deserted or abandoned row house. So that has not been a problem.

Whether or not it increases drug use, we certainly have not seen that. I will not dispute the statistics, that younger kids are using, et cetera. Needle exchange, I do not at all buy into the fact that it has anything to do with what is going on. I mean, things cycle around. So a lot of it may be the media or whatever. It is not needle exchange that is doing that, and that is what we are focusing on in this hearing.

I need to close with one point, and that is, again, who are we serving in the needle exchange program? These are the hardest core addicts. So if you don't have a needle exchange program, and I leave this to you, what are you going to do with them?

Mr. HASTERT. Thank you. I just wanted to say to Ms. Sosman, if you need to catch a plane to New York, you may be excused.

Ms. SOSMAN. Thank you all very much.

Mr. HASTERT. The gentlewoman from California was so enticed by the line of questioning, she came back.

Ms. PELOSI. I listened from the back of the room, a different perspective there.

Ms. Sosman, I hope you will continue to be a resource to us as we try to make sure that the needle exchange programs which save

lives do exactly that without being the burden that you describe to the community. I thank you again for your testimony.

I serve on the Labor, Health and Human Services, where we heard the testimony of the Director of National Institutes of Health. I also serve on the Foreign Operations Committee, and, Mr. Jordan, you will be pleased to know that we spend over $200 million out of that appropriations bill for interdiction—I know the doctor does not like the word "war"—but in the fight against drugs, to keep drugs from coming into the country, for interdiction. I do not think we have been that successful, frankly, with that over $200 million each year because the drugs keep coming in because the demand continues.

What we want to do is reduce demand. What we want to do with the needle exchange program is reduce demand. We see it as a technique, a way to do it. But it must be done. And I will once again give a tribute to my colleague Mr. Cummings for his authorship of the legislation, because we are talking about a needle exchange program carried out in a community only if it is a part of a program for the prevention of infection with HIV, and such HIV prevention program makes referrals for the treatment of substance abuse and for other medical and support services and is otherwise carried out consistent with scientific studies that making sterile hypodermic needles available to the public without charge is an effective means of preventing the transmission of HIV and does not encourage the use of illegal drugs.

So we are talking once again of reducing HIV, reducing drug abuse, part of a larger comprehensive HIV program which discourages. So I think we at least can stipulate that we all agree that we all support demand reduction.

I agree with your comment, Dr. Beilenson, about your former colleague, associate, who mentioned, why are we not spending more on treatment. We certainly should be. The interdiction money, I don't think we have gotten the value for the dollar spent. But I do think that Mr. Jordan points out a big threat to us internationally, multinational threat, and that is the narcotics, and that we should all work together to fight that.

But we are grown-up people, and we can make distinctions, and we cannot say that because there are drug cartels in Colombia, and Mafia wherever they are—in fact, I thought organized crime wanted drugs to be illegal so that they could continue to have the profit motive in it. I am hearing something different tonight. But we can make distinctions and we can say, this is happening, and we all oppose it.

But we will not have people die and children die and people who have nothing to do with drug abuse, but they are the partner of somebody, and they did not even realize that the person was an IV drug user or was HIV infected, that they will die because we cannot handle distinctions because of this war on drugs. The magnitude of money involved is so huge and so life-altering to anybody who comes in contact with it, that it is one of the big—terrorism, narcotics, they are all up there, in my view. So I value your testimony and look forward to working with you.

I was so delighted, Mr. Maginnis, to hear you, as a representative of the Family Research Council, and Gary Bauer, for whom I

have the highest regard, comment favorably about the Baltimore needle exchange program on the record. I thought that was very, very valuable.

Mr. Beilenson, I once again want to thank you for your courage in that. Mayor Shmoke, as far as I am concerned, is a great leader and a courageous leader, but that is what this is going to take, a level of courage, because it sounds—it is too easy to just say, we can't do that because of all this big drug threat in the world. We have to do this, and we have to have the courage to do it because it is a matter of life and death.

Once again, Mr. Chairman, I have spent more time at this hearing tonight than I did at my own wedding. I say that because I think that this is as important an issue as we have to deal with and its many ramifications. I once again commend you.

Mr. HASTERT. I appreciate the gentlewoman for being here. We do not agree on a lot of issues, obviously. She has done very well using the bully pulpit here tonight. I also appreciate her help. The whole idea of interdiction, there has to be a balance. I agree. There has to be a demand balance and a supply balance. Your help in procuring the helicopters that will wipe out the heroin that is being used in these needles will be very much appreciated. I thank you for being here. I would like to invite you, the next time that we do take a trip to Colombia, Peru, Bolivia, and Panama and look at the problems and the interdiction, that you might learn something from that as well. Thank you very much.

Ms. PELOSI. Thank you, Mr. Chairman.

Mr. HASTERT. I would like to thank all the witnesses, and certainly the late start we got that was somewhat unavoidable on our behalf, I appreciate your patience in being here. I think you will find that this hearing is typical. There are a lot of tough questions asked, and there is a lot of difference of opinion. I hope that we gain knowledge out of that. I appreciate the participation that all the witnesses gave today.

The scourge of drugs in our communities is something I think we all can unite on and we want to stop. It is the kids on our corners, on the street corners, that are addicted and being tempted and falling into this morass of drug use. We have to stop it. And if we throw up our hands and say, well, we can't do it any more, we just have to do the best we can to control it, I think we have given up the spirit, the fight and the ability to stop.

I also appreciate our friends from Switzerland who came all these miles to talk about what is happening in their country, and whether all of us agree or not, it is the first stepping stone that we see here, the slippery slope that could happen here. I think we certainly can learn from their experience and appreciate their efforts in being here today.

So thank you all. With that, this committee is adjourned.

[Whereupon, at 9:20 p.m., the subcommittee was adjourned.

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