Policy Alternatives to the '1000 Ft Rule' Governing Syringe Exchange Programs to Prevent HIV/AIDS Among Injection Drug Users in Washington, DC

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Abstract

Syringe exchange is an HIV prevention intervention based on the principles of harm reduction. It is intended to prevent the spread of HIV/AIDS and other blood-borne infectious diseases amongst injection drug users (IDUs) and their sexual partners. Syringe exchange programs (SEPs) accomplish these goals by allowing IDUs to exchange used injection equipment for sterile materials. As a result of their focus on prevention in large communities, SEPs meet the definition of a classic public health intervention. Despite this, SEPs are generally met with controversy and funding limitations—often at the federal and state levels. In Washington, DC, SEPs operate under the “1000ft rule”, which makes it illegal for any person to distribute needles and/or syringes for the injection of any illegal drug in any area within 1000 feet of any school (Brady & Fedynyshyn, 2009). The goal of this paper is to review the 1000ft rule and provide alternatives to it while alleviating some of the controversy surrounding SEPs.

The research methodology employed included a systematic review of journals, qualitative interviews, and information available on the World Wide Web. On the basis of the information obtained in this review, recommendations for policy change in D.C. include: development of a formal stakeholder coalition and educating members on the issue; removal of the 1000ft rule from the D.C. code; maximizing access to sterile injection materials; and packaging SEPs with other services such as opioid substitution therapy, antiretroviral drugs, or talk therapy, to make the intervention more palatable to opponents.

This paper presents several areas that should be considered for further research including more in depth strategies for repealing the 1000ft rule, inclusion of more expert ideas for alternatives, and exploration of what has been successful in other jurisdictions facing similar challenges with implementation and garnering support of SEPs. All community based organizations (CBOs) providing syringe exchange services should be solicited for their input. Evaluation of the effectiveness of SEPs at reducing HIV incidence amongst D.C.’s population of IDUs must be conducted and the data must be shared with the greater community as soon as possible.
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*Note: Prior to being known as HAHSTA, this agency was previously identified as HAA until it was merged with other branches of the D.C. Department of Health between 2008 and 2009.*
Introduction

Over 600,000 Americans have died of AIDS since the early 1980’s. One-third of these deaths have been associated with injection drug use (Playing a Deadly Game With AIDS, 2009). Paraphrased from the Public Health Agency of Canada, injection drug use is: ‘the consumption of drugs by injection with a needle and syringe. Injection may be intramuscular, subcutaneous, or more commonly, intravenous. Intravenous injection creates faster delivery of the drug effect and causes less local tissue damage’ (PHAC, 2007). Injection drug use leads to HIV/AIDS infection when HIV positive users share needles with others. In the 40 states participating in confidential, name-based, HIV testing, injection drug users (IDUs) accounted for 9% of all new HIV infections. When reviewing diagnoses of AIDS in 2009, it is reported that 14% of cases in the United States (US) and the District of Columbia (D.C.) can be attributed to IDU, with African-Americans and women representing the majority (CDC, 2009; National Center for HIV/AIDS, 2008). Fifty to 90% of all HIV positive IDUs are co-infected with Hepatitis C virus (Sulkowski & Thomas, 2003). Risk behaviors for IDUs involve using needles that the user suspects (or knows) may have previously been used by another IDU. This is particularly disconcerting as only 29% of IDUs disinfect needles with bleach prior to use (SAMHSA, 2009). Persons infected through injection drug use are more likely to progress to AIDS within twelve months of testing positive for HIV than persons in other HIV-positive subgroups. This is possibly due to lower testing rates, late testers/delays in accessing care, or inadequate care amongst IDUs (Grigoryan, Hall, Durant, & Wei, 2009; HAHSTA,
Syringe exchange programs (SEPs) link IDUs to care and may reduce this progression rate.

Syringe exchange is a harm reduction intervention in which IDUs who are clients of SEPs may exchange used injection equipment for sterile materials. The goal of harm reduction is “the prevention of collateral health and social damage associated with drug use and limitation of the other medical conditions that rampant and poorly treated addictions foster” (Drucker & Clear, 1999). One of these prevented medical conditions is HIV/AIDS. Syringe exchange programs do not provide drugs to clients, but rather prevent the spread of HIV by removing contaminated syringes from the streets, reducing needle sharing, and encouraging the use of clean syringes for each injection. These programs do all of this while providing vital health and medical services such as condom distribution; hepatitis education and testing; HIV counseling, testing, and referral; STD screening; tuberculosis (TB) screening; overdose prevention; and safer sex education. SEPs may also provide clients with referrals to other agencies to receive services the initial intake agency may not provide (Drucker, Lurie, Wodakt, & Alcabes, 1998; Laufer, 2001). Together, the components of SEPs make them a classic public health intervention in that these programs have preventative components as well as health education aspects that are directed at the community level.

SEPs are vital because during an average time period of 23.5 days, a syringe may be re-used more than seven times when there is no exchange available. This fact is important as studies have shown that HIV-1 remains viable
in contaminated syringes for up to 30 days. Localities with SEPs saw the average lifetime of a used syringe drop from 23.5 to under three days (Laufer, 2001). Jurisdictions that support SEPs have lower rates of HIV amongst IDUs than those that do not, and experience a safer environment as less used syringes are improperly discarded in public areas (CDC, 2005; GMHC, 2009; Laufer, 2001). Communities must remember that contracting HIV through a contaminated syringe is not an “IDU problem”. Sexual partners of IDUs (who may or may not be users), and their unborn children are also at risk of contracting the disease (Playing a Deadly Game With AIDS, 2009). By improving the microenvironment, this public health intervention also protects the health of community members using public areas for recreation.

In an analysis of SEP in NYC, researchers found SEPs to be cost-effective as compared to the cost of HIV treatment. According to this study, seven SEPs in NYC spent $20,947 per each HIV infection prevented (assuming 87 avoided infections for this population), saving nearly $17million in treatment costs for the same 87 infections, had they not been prevented—the cost of a syringe is minute in comparison to the costs associated with a lifetime of HIV treatment (Laufer, 2001). Although syringe exchange is more cost effective than treating HIV/AIDS, the programs do require resources to provide services in their communities. The provision of funding is necessary for SEP success, however, as discussed further in the “Current Policy” section, we will see that conditional funding may harm a community, even when it is intended to support an intervention such as syringe exchange. Syringe exchange funding conditions
and regulations vary across jurisdictions, impacting where and how each city may operate its programs. This paper includes a review of the policy, related issues, and suggestions for a modified policy.

**Syringe Exchange—The Issue**

Numerous articles have been published that prove the effectiveness of SEPs in reducing the incidence of HIV. A review by Drucker et al. of all the available research at the time, found that the presence of SEPs does not correlate with an increase in drug use at the individual or at the community level. The literature shows that SEPs help to reduce HIV rates by influencing the behavior of IDUs (i.e., sharing needles less often, decreasing the number of injections, increasing the mean age of users) and by taking contaminated needles off of the street. Many of these studies have found that IDUs who do not participate in SEPs are more likely to contract HIV than those that are SEP clients (Drucker, et al., 1998).

Despite the astounding evidence in support of the effectiveness of syringe exchange, it is not an intervention that exists without controversy. Some predominately African-American New York City drug and AIDS treatment agencies have argued that SEPs are tantamount to genocide. This opinion stems from the thought that SEPs allegedly give people the means to kill themselves via drug abuse (Drucker & Clear, 1999). This is particularly troubling as African-Americans are at higher risk at contracting the virus through injection drug use than other ethnic groups (HAHSTA, 2010). A Georgia republican was once quoted saying that “There is no evidence whatsoever that providing addicts
an easy way (to inject themselves) with deadly mind altering drugs is diminished or reduced by providing them the means to inject deadly mind altering substances...” which is of course, true, as the aim of SEPs is to decrease the spread of HIV, not to decrease drug use (Drucker & Clear, 1999). These opponents often insist that even sterile needles are dangerous, particularly to those who succumb to overdose (Kane, 2010). Other common arguments against SEPs suggest that they are influencing children to use drugs and that these programs make it harder to protect them from drug use, suggesting that SEPs are a gateway to drug legalization, and that they condone the use of drugs (Drucker & Clear, 1999).

America has a strong tendency towards an abstinence only approach to drug treatment, leading to the creation and enforcement of punitive drug laws that do not support SEPs and thusly, further the HIV/AIDS epidemic. Laws leading to intense police surveillance of SEPs have been shown to be detrimental to program success, in that clients are less likely to access services. This is particularly true in the African-American community—program use decreased twice as much amongst this IDU sub-population as it did for white IDUs during a time of increased police surveillance of an SEP (Davis, Burris, Kraut-Becher, Lynch, & Metzger, 2005). For these reasons, many SEP experts teach that increased police activity should never be employed as a measure to “scare people straight”, crackdown on IDUs, or harass their clients—IDUs need continued support until they are ready to seek treatment options (Katel, 2006).
By reviewing the history of SEP and methadone clinic policy development in the US, one obtains an understanding of the current state of SEP policy in America and the associated challenges with establishing and maintaining SEPs. These policies shed light on the fact that the United States prioritizes ending illicit drug use over preventing the spread of diseases such as HIV (Drucker & Clear, 1999). Although the US pioneered the use of methadone as a heroine maintenance intervention (using methadone to wean IDUs off of heroine without the symptoms of withdrawal), the growing popularity of rehabilitation centers which champion complete drug withdrawal as the only treatment option demonizes the use of methadone as drug treatment, as well as stigmatizes IDUs and SEPs (Drucker & Clear, 1999). This strict abstinence only view and its associated policies have devastating health consequences for users who are not ready to cease using drugs as well as for those who have tried to quit un成功fully. Although it has been found that heroin addicts in methadone treatment engage in injection drug use associated risk behaviors less often, more than 80% of IDUs relapse after ceasing methadone—once again increasing their risk of contracting HIV, the virus that causes AIDS (Drucker, et al., 1998).

Syringe exchange advocates must counter these arguments with data and examples from their experiences in the field. SEPs have garnered support from several law enforcement agencies because they protect officers from accidental needle sticks while on the job and reduce the number of contaminated needles in communities (amfAR, 2009). It has been proven that youth in neighborhoods with SEPs are not more likely to participate in illicit drug use because of the
presence of an SEP and also benefit from having parks and playgrounds where there are not used syringes lying about (amfAR, 2009; Bluthenthal, 2009). Additionally, many IDUs desire to enter drug treatment but may be on a waiting list, may not be fully prepared to enter treatment, or may reside in a community that is underserved by drug treatment facilities. Despite the controversy and complexities surrounding SEPs, it is important to remember that the primary focus of SEPs is to prevent the spread of HIV/AIDS in high-risk areas. SEPs do this work by providing vital health services IDUs might not otherwise receive, and without encouraging drug use, all while being underfunded and with restrictions that make their work unduly challenging (Bluthenthal, 2009; CDC, 2010b)

**Current Policy and the ‘1000ft Rule’**

As discussed previously, much of the explanation for the current policy correlates with the opinions and perspectives of members of Congress who are opposed to this intervention (Cooper 2000). Members of Congress who are not strong supporters of SEPs have instated a policy known as the “1000ft rule” in D.C. As stated in the D.C. Code, the 1000ft rule makes it illegal for any person to distribute any needle or syringe for the injection of any illegal drug in any area of the District that is within 1000 feet of a public or private elementary or secondary school, including public charter schools (Brady & Fedynyshyn, 2009). To many SEP advocates and community members, the 1000ft rule is believed to be representative of a general discomfort of the federal government towards interventions that address diseases with a great amount of stigma. D.C. Council member David Catania has spoken out in favor of SEP, stating that the 1000ft
restriction will “kill needle exchange in D.C.” (Sticking Point- Congress could end the ban on federal funding of needle exchange programs -- and still kill DC’s vital effort, 2009). D.C. is a city of only 68.25 square miles, with numerous schools throughout. The 1000ft restriction severely limits where SEPs may operate.

A comprehensive look at how policies and laws such as the 1000ft rule impact how people use drugs is necessary in order to develop the foundation for D.C. policy suggestions. Policies that allow for the operation of SEPs help users to inject more safely, preventing many cases of HIV. Depending on how possession laws are crafted, IDUs may be penalized for participation in SEPs, or they may be more favorably allowed to access the intervention without police interception (Burris, Strathdee, & Vernick, 2002). Paola Barahona, who has been engaged in SEP in D.C. for over a decade, authored a document that provides a summative legislative history of SEP in the U.S. and D.C. (Barahona, 2010). In 1988 the federal government banned the use of federal funding in support of SEPs nationally. In 1998, after the provision of evidence demonstrating the positive impact of SEPs, the federal funding ban remained in place, but local jurisdictions were permitted to fund SEPs with local tax dollars, if they choose to do so (Barahona, 2010). Although the rest of the country was free to use local tax dollars to fund SEPs, Congress had imposed a ban on using local funding for SEP in D.C. through an addition to the D.C. Appropriation, or budget (Barahona, 2010). During this time, SEPs in D.C. depended upon charitable donations from private sources. In 2000, operation of SEPs in D.C. became more onerous as language was added to the D.C. budget restriction that
included the 1000ft rule. Later, in 2001 the budget restriction for 1000ft rule became D.C. law—no longer requiring yearly inclusion in the city’s budget. In 2007, the local funding ban was lifted in D.C. and programs were allowed local tax dollars to support SEPs. In 2009, the ban on federal funding was lifted and indicates that federal funds cannot be used in locations “that [have] been determined by the local public health or law enforcement authority to be inappropriate for such distribution” (CDC, 2010a). Despite this federal law, in D.C., Congress has significant power over how local funding is used, and the 1000ft rule has remained local law (Barahona, 2010).

Table 1: Summary of “U.S. Syringe Exchange Policy Overview”
Source: Barahona, 2010

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<th>Summary Timeline of SEP Funding Nationally &amp; in Washington, DC</th>
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To compare how other jurisdictions have implemented SEPs in light of the removal of the federal funding ban, a review of SEP location regulation in 19 U.S. cities was conducted. Researchers found that the majority (10) of these cities have no formal rules governing SEPs sites. Seven have laws/regulations/policies concerning SEP locations and others give community based organizations (CBOs) the flexibility to operate SEPs in areas where they are most needed,
without restriction, while others require some form of community consultation prior to determining a site for syringe exchange (Burris, Anderson, Case, & Davis). Many of these cities can be used as models for SEP implementation in D.C.

**Purpose and Methodology**

The purpose of this paper is to analyze the current SEP policy in Washington, DC and to present a proposal for modifications to the 1000ft rule. The methodology to address this goal included a systematic review of the literature conducted between September 2010 and February 2011. In this review, the following search terms were explored: effect of 1000 foot rule needle exchange DC; needle exchange program policy; needle exchange program policy (evaluation OR effective OR effectiveness); needle exchange; and needle exchange HIV. The following databases were searched: Google Scholar, PubMed, Web of Science (ISI), CQ Researcher, and the New York Academy Grey Literature Report. In addition to journal articles and publications found from these sources, an array of unpublished sources with information specific to the District of Columbia that documents the history of syringe exchange in the city as well as identifies key players in the development of the current policy. Additionally, individuals closely involved with policy development and/or syringe exchange in D.C. were contacted for interviews and data was collected from various sources available on the World Wide Web.

Much of the research needed to support this document was conducted as part of the practicum experience at the DC Appleseed Center, under the
guidance of Paola Barahona, MPH. DC Appleseed is a public interest advocacy organization that researches, reports, and monitors numerous issues of importance to the District of Columbia. In 2005, DC Appleseed issued the report *HIV/AIDS in the Nation’s Capital: Improving the District of Columbia’s Response to a Public Health Crisis* (Appleseed, 2005). This 130-page report was the first document from Appleseed that assessed the District’s response to the HIV epidemic and made recommendations for improvements. Since the first report, Appleseed has released six report cards, which grade various aspects of D.C.’s response to the epidemic. The *Fourth through Sixth Report Cards* discuss SEP in D.C.—progress that has been made in providing this intervention, and suggestions for improvement (Appleseed, 2008, 2009, 2011).

As a second phase of the methodology for this policy analysis a series of interviews were conducted. The purpose of these interviews was to take the initial steps to broad stakeholder engagement. In attempting to contact persons with varying roles in, and perspectives about, syringe exchange, the intent was to develop the foundation for inclusive discussions regarding changing the 1000ft rule. Representatives from Helping Individual Prostitutes Survive (HIPS); Bread for the City; Family Medical Counseling Services (FMCS); and PreventionWorks! (PW) (all SEP providers in D.C.) as well as, HIV/AIDS Hepatitis, STD, Tuberculosis, and Syphilis Administration (HAHSTA); the DC Metropolitan Police Department (MPD); and the North Carolina Justice Center were contacted. Interviews were successfully scheduled and conducted with Adam Searing, JD, MPH, Project Director of the Health Access Coalition of the NC Justice Center
(personal communication, December 15, 2010); Nestor Rocha, Bureau Chief of Prevention & Intervention Services, HAHSTA (personal communication, January 10, 2011); and Mary Beth Levin, Director of Programs and Services, PW (personal communication, January 24, 2011). Sergeant Raul Mendez of the MPD replied to the inquiry via email stating that it would not be possible to speak with a representative from MPD on this issue, but did provide a link that he believed established proof that there was no restriction in D.C. (R. Mendez, personal communication, February 15, 2011). All interviews were conducted with the approval of the UNC Chapel Hill IRB under study no. 10-1673. Each interviewee was asked the same basic questions, with additional questions asked as appropriate, depending upon their responses:

1) Describe the 1000ft rule as you understand it.
2) What would you suggest as a method to having the law repealed?
3) What stakeholders would you involve?
4) What other suggestions would you like to add?

Many of the suggestions provided by these individuals will be discussed in detail in the alternative section and included in the suggestions for further research. Common threads found in the interviews include:

- broad stakeholder involvement in working to spread the availability of syringe exchange;
- involving HIV specialists/physicians in advocacy work;
- and giving local authorities sole power to make decisions regarding SEP locations in D.C.
HIV/AIDS & Injection Drug Use in Washington, DC

Of all persons living in the District, 3.2% are living with HIV/AIDS, more than three times what the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Centers for Disease Control and Prevention (CDC) define as a “high prevalence epidemic” (HAHSTA, 2010). In 2006, 9% of new HIV cases and 19% of all AIDS cases in D.C. were attributed to injection drug use. In the five-year period from 2001-2006, 13% of all new HIV cases were attributed to injection drug use (HAA, 2007). In the period from 2004-2008, 21.4% of new AIDS cases were attributed to injection drug use. In 2008, injection drug use was the third leading cause of AIDS in men and second leading cause in women. Nearly one third of all HIV/AIDS related deaths in D.C. from 2004-2007 were attributed to injection drug use (HAHSTA, 2010). Of all the HIV/AIDS cases attributed to injection drug use in D.C. in 2007, nearly 94% were African-Americans (HAA, 2008). Statistics such are these are particularly important in D.C. where 54% of residents are African-American (U.S. Census, 2010). To address these data it is imperative that D.C. has a strong policy in support of SEPs in place.

Strengths and Weaknesses of the Current SEP Policy in D.C.

Before we consider alternatives to the current policy in D.C., we should identify the strengths in the current program that we wish to maintain. Despite challenges presented by the 1000ft rule, there is notable strength in the ways CBOs in D.C. have executed the syringe exchange intervention. PW, the first SEP in D.C., which closed its doors in February 2011, intentionally employed ex-
IDUs (Directors, 2011; Gerson, 2009; Kerr et al., 2010; Terry, 2009). Using a peer-run model facilitates building relationships with the most difficult to reach IDUs as well as with maintaining client contact (Gerson, 2009; Kerr, et al., 2010). Additionally, such a model may create job opportunities for users who may otherwise have difficulty finding viable employment options.

A second strength that D.C. has working in its favor is a seeming willingness for law enforcement to work with local SEPs to prevent the spread of HIV/AIDS in the city. During conversation with the former Director of Programs & Services at PW, Ms. Mary Beth Levin, she stated that as of late, the restriction has not been incredibly onerous—law enforcement has been helpful and cooperative—when police officers are aware of high injection drug use activity in a given area, they have been known to tell SEP staff and suggest they go provide services in those areas. PW has also found that local high schools have been helpful, by sending volunteers to work with the program (M. Levin, personal communication, January 24, 2011). These relationships are to be nurtured as full community support is required to move forward on implementing policy changes.

Lastly, there seems to be a strong sense of interagency collaboration in D.C. Again, per conversation with Mary Beth Levin of PW (personal communication, January 24, 2011), organizations work together to support each other and clients when there is need. Examples of this include the former collaboration between Helping Individual Prostitutes Survive (HIPS) and PW which involved sharing and co-training volunteers to ensure that PW volunteers are properly educated on issues pertaining to the transgendered population. PW
also trains volunteers at the other programs on topics such as HIV testing/counseling, an area which other agencies may not be certified to train. PW often refers clients to Bread for the City, which offers free Narcan to its clients. PW staff and clients are referred to FMCS for HIV treatment as well.

Of course the current policy is not without weaknesses. First, the current policy and how the legislation was passed can be very confusing. Before changes can be made, stakeholders must be informed about the current policy and how it impacts the city. Secondly, stakeholders must examine the feasibility of operating SEPs in the most efficient way under the 1000ft rule. This law should be repealed or adjusted in some compromise. Third, the current policy limits access to syringes by requiring “one-for-one” exchanges from its clients. For SEPs to have maximum impact, this limitation should be eliminated from SEP practices. Lastly, agencies in D.C. must build upon the current collaboration and packaging of services they have now to further the effect SEPs have on HIV incidence.

**Suggested Alternatives to the 1000ft Rule and Current SEP Policy in D.C.**

Based on the strengths and weaknesses of the current policy, many policy alternatives need to be considered. To begin, CBOs and community partners must establish a coalition of all relevant stakeholders and educate them on the current policy. Education is essential so that all stakeholders are aware of the program’s value (Burris, et al., 2002). A process such as consensus on how to address policy issues cannot begin until all stakeholders are well versed on the
issue through education on the key issues and possible solutions. This coalition should include:

- SEP Advocates
- community members (particularly those uneducated about SEP)
- law enforcement officers
- schools
- D.C. City Council
- physicians (particularly of IDUs and HIV positive persons)
- the Mayor’s office
- members of Congress
- and the federal government (particularly the CDC)

The education and input of Congress, D.C. City Council, and the Mayor’s office are essential as they are key to creating the laws that we are to abide by, and they ideally represent the interests of the citizenry. SEP advocates, who are probably the best versed on the issue of SEP, will need to take a lead role in the education of the community and recruiting others to take part in this important work. Community members must know how SEPs better their communities and make informed decisions when giving input regarding SEP locations and deciding whether to work with advocates or against them. Schools, a vital part of communities, should be aware of SEP policies, as their proximity to schools is of great debate—it is important to hear the voice of the schools as they may have a different opinion on the necessary distance than lawmakers, especially as we have seen that many students have volunteered with SEPs in the city (M. Levin, personal communication, January 24, 2011). As exemplified in the email exchange with the MPD, all stakeholders may not be well versed on the 1000ft
rule. Sergeant Mendez essentially stated that federal law allows localities to determine syringe exchange locations with public health and law enforcement but stopped short of recognizing that the restriction exists in the D.C. police code—indicating a lack of understanding of local policy on this issue (R. Mendez, personal communication, February 15, 2011). It is important that members of law enforcement know the law so that they do not abuse their power and that they protect the rights of all citizens, including IDUs and similarly vulnerable populations. Together, these agencies and concerned individuals need to come to consensus on how programs can be run most effectively and with minimal federal input—evidence that the authority of local public health and law enforcement agencies is respected.

After all stakeholders have been educated on the issue, work can begin to repeal the federally imposed location restriction. Members of Congress must give D.C. the same jurisdictional discretion afforded other localities. Unrestricting locations ensures that programs can reach the most at-risk populations (Wood et al., 2002). According to the agency HIPS, the current location restriction presents a difficulty with finding locations to conduct exchanges. Typically, HIPS identifies areas where services are needed by word-of-mouth and by reviewing police arrest reports; unfortunately, they have found that high-need areas are often near schools (Terry, 2009).

While elimination of the location restriction promises to be the most meaningful change, according to advocates in D.C., lawmakers may be more willing to consider a distance shorter than 1000ft (such as 300ft). After a trial
period of 2-3 years, lawmakers could agree to evaluate program success at reducing the HIV rate and any associated neighborhood impact to determine feasibility of removing all distance restrictions and allowing communities to determine SEP locations. The evaluation should include community members, SEP clients, and law enforcement.

Evidence suggests that widespread syringe access may decrease HIV rates far better than restrictive policies that limit access to and distribution of syringes (Kerr, et al., 2010). The third set of recommendations to improve success at combating the HIV epidemic involves increasing access to clean syringes. HAHSTA must increase funding levels allocated to SEPs in D.C. and allow clients to obtain sterile syringes regardless of the number they return (Appleseed, 2009). These goals can be met in part with the use of federal funds to support SEPs, in addition to local funds (currently the only source of funding used for SEPs in the city) (Appleseed, 2011). Deregulating the sale of syringes and decriminalizing possession of syringes that have only trace amounts of drugs go hand-in-hand with increasing access to syringes. In areas underserved by SEPs, users may keep syringes to re-use for themselves. This is not the best solution, but is a better solution than needle sharing, although, with increased police surveillance, can be difficult to implement. Decriminalization also ensures that participants are not harassed as they take used syringes to SEPS in order to obtain sterile equipment (Burris, et al., 2002; The facts about syringe exchange programs (SEPs) and the "1000 foot rule", 2009).
Lastly, it is strongly recommended that strategies for reducing HIV incidence amongst IDUs in D.C. be packaged. When various strategies are already employed by SEPs, it is important that they market all facets of the program, ensuring the public is aware that the intervention is as comprehensive as possible, making their value more evident (Burris, et al., 2002). Services that should be considered in addition to the base intervention of syringe exchange (and the services generally provided such as safer sex education, condoms, and referrals to drug treatment centers) include the provision of opioid substitution therapy (OST), provision of antiretroviral therapy (ART) to known positive IDUs, and linkages to family therapy and/or support groups as appropriate for each given client (Degenhardt et al., 2010); (Wood, et al., 2002). Packaging services may take some of the unwanted focus away from syringe exchange by way of highlighting the other important ways SEPs can help the community. With the closing of PW at the conclusion of February 2011, CBOs and HAHSTA will have to shift the focus to maintaining the same level of service to the IDU population even in the absence of a provider. Agencies must commit to building on the strength of current collaborations and remain inclusive of current and former IDUs in program implementation and planning. In the interim, these same individuals will need to resolve to diminish the weaknesses of the current policy such as fighting to repeal the 1000ft rule, elimination of the one-for-one exchange policy, and finding creative ways to reach IDUs in high-risk areas near schools. Working towards these goals will help ensure the success of SEPs in reducing HIV incidence amongst IDUs. Changes such as these make the focus more
about “public policy giving the District more opportunity to address public health issues” (A. Searing, personal communication, December 15, 2010).

CDC guidance for SEP implementation should have more concrete recommendations for program implementation and administration in support of each of these policy alternatives. Messages on SEP implementation that come from this agency must clearly give the power to deliver SEP programs to local health departments. These regulations should allow SEPs to develop and adopt best practices as they become known. Each jurisdiction is held accountable for public safety & health of residents—the laws should reflect this.

**Areas for Further Research**

There is a great deal of sources on the subject of syringe exchange, although not as many concerning the 1000ft rule. This paper is not meant to be an extensive review of all available research, but is meant to serve as a starting point for discussing alternatives to the 1000ft rule with local public health officials, law enforcement, community members, local policy makers, and, because of the policy development process in Washington, DC, Congress. There are several areas that should be considered for further research including strategies for repealing the 1000ft rule, inclusion of more experts for ideas for alternatives, and deeper exploration of what has been successful in other jurisdictions facing similar challenges. As a direct result of the time it takes to collect, process, and report data, there is currently not information available regarding HIV infection rates in the IDU population to compare from the time that the local funding ban was lifted in 2007 to the present. As soon as this information is available, it must
be utilized in discussions and evaluations regarding making changes to the current policy (HAA, 2007).

SEPs have lead to decreased HIV incidence amongst IDUs in many other jurisdictions, but it is important that Washington, DC develop its own body of evidence in support of changing policies that affect its citizens. Furthermore, as stated by HAHTSA in the 2009 Annual Update, ‘researchers must develop evidence for determining the scope and scale required of an SEP to create significant reduction in HIV incidence in IDUs’ (HAHTSA, 2010). Without this data, it is not possible to know how much more growth SEPs need to achieve maximum effect. Adding an evaluation component to SEPS will aid HAHSTA and CBOs in assessing and improving delivery of this life saving intervention.

By reaching out to various stakeholders connected to syringe exchange in D.C., the author attempted to include as many perspectives as possible; however, many more conversations with additional stakeholders will be critical to creating change in the District. It will be very critical to involve medical providers who may be against drug use BUT opposed to the increased costs associated with HIV infection and the related loss of life. These individuals work closely with SEP clients, will possess unique insight into strategies that will work with reaching this community. Additionally, connecting with all providers who conduct syringe exchanges in D.C., specifically Family and Medical Counseling Services and Bread for the City in order to gain their perspectives, especially as they work to close the gap left by the closing of Prevention Works. Any suggestions they
have for better servicing the IDU community must be taken into account (Directors, 2011; Sun, 2011).

OST was referenced as a successful combination approach when used in conjunction with syringe exchange. Further research on access to OST in the city and its impact on reduction of injection drug use should be considered to determine a feasibility of the success of this approach in the District and should most likely be spearheaded by the Addiction Prevention and Recovery Administration of the D.C. Department of Health (APRA). Tacoma, Washington is well-known for the success of its Point Defiance AIDS Project SEP programs and policies which have resulted in a HIV prevalence of less than 2% amongst IDUs (Drucker & Clear, 1999). The first attempt at a city-run SEP in NYC resulted in a similar 1000ft provision, which was excluded when SEPs were once again supported by the Mayor’s office in 1991 (Drucker & Clear, 1999). Advocates and community leaders in the District may consider researching the history of programs in New York and Tacoma to determine what can be applied in D.C. to help increase success of SEPs locally.

Lastly, as suggested by Adam Searing (personal communication, December 15, 2010), interested stakeholders familiar with D.C. legislation may consider exploring whether or not there are other political issues that are impacted by similar Congressionally imposed restrictions. If there are, any challenges created by them on issues unrelated to syringe exchange should be highlighted and presented as a part of the packet provided to lobby Congress on
creating greater access to syringe exchange (A. Searing, personal communication, December 15, 2010).

Conclusion

Syringe exchange improves communities while reducing HIV rates amongst IDUs and their sexual partners. Beyond curbing the spread of HIV/AIDS, SEPs have a broader community impact on the quality of life and health for all. For example, improperly disposed syringes impact the public’s health because they potentially put children and officers at risk, as both groups frequent sites (such as playgrounds) where syringes are commonly left unattended. Although we are not able to prevent injection drug use, syringe exchange is one method we can employ to lessen the harm associated with this practice. Infectious diseases that are transmitted through injection drug use not only effect IDUs, but also members in the communities where IDUs live, use, work, and play. Developing policies that allow local SEPs to properly saturate communities will benefit everyone living, working and playing in Washington, DC—simply by acting on the knowledge we have that SEPs have been proven to decrease the incidence of HIV amongst the IDU population.
References


*The facts about syringe exchange programs (SEPs) and the "1000 foot rule"*. (2009). Syringe Access Working Group. Washington, DC.


