A Pilot Syringe Exchange Program in Washington, DC

David Vlahov, PhD, Caitlin Ryan, MSW, Liza Solomon, DrPH, Sylvia Cohn, MPH, Maude R. Holt, and Mohammad N. Akhter, MD, MPH

ABSTRACT

The Washington, DC, City Council authorized a pilot syringe exchange program to operate for only 60 days at a single drug abuse treatment facility in the District. Only adults on the waiting list for treatment were eligible (n = 467). Of the 33 who enrolled, median duration of drug injection was 18 years. Twenty-seven participants denied needle sharing. Of 209 needles distributed, 69% were returned. Low enrollment might have been due to restrictive entry criteria, inconvenient location, incorrect syringe size, and attitudes of treatment staff. For future efforts to have a public health impact, wider accessibility will be needed. (*Am J Public Health.* 1994;84:303–304)

Introduction

Strategies to prevent parenteral transmission of human immunodeficiency virus (HIV) infection among injection drug users include education, counseling, testing, drug abuse treatment, needle disinfection, and sterile needle exchange.[1,2] Syringe exchange programs, although widespread elsewhere, are sparse in the United States because of official concern that they might undermine the political "War on Drugs" by at least appearing to condone drug use.[3,4] However, faced with the highest incidence of acquired immunodeficiency syndrome (AIDS) in the country and estimating the number of injection drug users in Washington, DC to be 16 000,[5] the District of Columbia's City Council authorized a syringe exchange program in 1992. The council had both proponents and opponents of such an exchange, and program design was achieved only with compromise; the program was authorized to operate for only 60 days, with the impact to be reviewed by the council prior to further action.

The City Council specified the following criteria for inclusion in the program: adult injection drug users residing in the District who had applied for entry into treatment for drug abuse at the city's central intake unit but were placed on a waiting list because treatment slots were full. This report summarizes the results of this pilot program.

Methods

Brochures about eligibility were distributed to treatment programs starting 30 days after the program started. Eligible individuals were referred to a single site (a drug abuse treatment center) in a separate quadrant of the city, where they were required to undergo medical examination to document injection drug use (i.e., track marks), receive counseling for drug abuse and HIV infection, and give informed consent.

Consenting individuals completed a risk interview; were offered confidential HIV testing on a voluntary basis; and were then provided with up to three specially marked syringes, bleach (with instructions and demonstration on use), cotton, alcohol swabs, condoms, and a pamphlet about reducing HIV risks. Participants were encouraged to return daily Monday through Saturday to exchange used for new program syringes. Participants were informed that only the specially marked program syringes could be exchanged and that it was not unlawful to possess these program syringes for the duration of the program.

In addition to tallies of injection drug users who were potentially eligible (i.e., on the waiting list) and those who entered the program, tallies were made for distribution (and return) of equipment. At baseline and at 2-week follow-up, standardized interviews were administered face to face by trained interviewers in private rooms to obtain information on drug use, sex practices, and risk reduction activities. Frequency distributions were generated.

Results

During August and September 1992, 467 drug users were seen at the city's central intake unit, 93 of whom (20%) were referred to the Syringe Exchange program. Of those referrals, 36 (39%) arrived, 33 of whom (92%) were eligible, consented, and enrolled. Among those participants, 31 enrolled in the first month, 2 in the last month.

Demographics and risk histories were limited to the 30 participants on whom interview data were available. The mean age was 38 years old (range 24 to 55 years); 80% were men, 83% were Black

David Vlahov, Liza Solomon, and Sylvia Cohn are with the Department of Epidemiology at The Johns Hopkins School of Hygiene and Public Health, Baltimore, Md. Caitlin Ryan, Maude R. Holt, and Mohammad N. Akhter are with the Commission of Public Health, Government of the District of Columbia.

Requests for reprints should be sent to David Vlahov, PhD, The Johns Hopkins University Program of Infectious Disease, Room 894, 624 N Broadway, Baltimore, MD 21205.

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(17% White), 43% were living with a sex partner, 83% had no health insurance, 45% were unemployed, 10% had been fully employed for the past year, and 30% had been arrested in the past year.

In terms of drug use, the mean age of initiating injection was 20 years old and the mean duration of injection drug use was 18 years. In the month prior to joining the program, all subjects reported injection with heroin (83% daily), 66% reported speedball (30% daily), and 38% reported cocaine alone (19% daily); 70% reported sniffing, snorting, or smoking heroin, 57% reported cocaine, and 62% reported crack; 57% used nonprescription methadone; and 67% used marijuana. In the past month, the proportion reporting that at least two thirds of injections occurred in "their own place" was 57%; in a friend's place, 29%; and in shooting galleries, 7%. In the past month, 90% claimed that they never rented already used needles, 93% never borrowed used needles, and 90% never lent equipment to others.

In the prior month, the mean number of sex partners was two for men and one for women; consistent use of condoms was rare. Previous HIV testing was claimed by 90%; all claimed to be seronegative.

Of the 33 participants, there were 97 visits. However, 18 participants (55%) used the program only once. Of the 15 who returned, the median duration between first and second visit was 2 days; between second and third visit, 3 days. Nine participants subsequently entered drug treatment based upon openings that became available; mean time to entry was 19 days after starting the needle exchange program. Follow-up interviews were obtained on only three participants.

During the 60-day program, 209 needles and syringes were distributed and 144 (69%) were returned. In the same period, 82 bleach kits, 237 condoms, and 47 HIV information kits were distributed.

Discussion

The major finding from the DC Syringe Exchange program was the small number of participants recruited and retained. Although the program was authorized for 60 days, recruitment into it virtually ceased after 30 days. Direct observation and interview with program staff identified several possible contributors to this result. First, the single location of the program was probably inconvenient to many eligible persons. However, the commissioner had decided on one site on which to concentrate resources for this limited pilot effort.

Second, a 3-cc syringe had been selected, which the evaluator (D. V.), drawing on experience in other cities, thought might be too large. The staff reported that selection was based on what they had learned from methadone clients. Later, feedback from participants and community presentations noted that both the needle and the syringe were too large. Thus, program success probably depends on providing equipment that is similar if not identical to that used in the community.

Also important, some staff on the methadone program that housed the needle exchange program were adamantly opposed to the distribution of needles in a treatment setting. Others noted that restriction of eligibility to persons who already had made a decision to cease drug use seemed illogical, and that the persons most in need of clean needles were systematically excluded.

The experience with this program in Washington, DC, is similar to the experience of the first syringe exchange program in New York City[6,7]: eligibility criteria were highly restrictive, only a single location of an existing city bureaucratic agency was used, and turnout was low and consisted of persons not at highest risk for HIV infection. In contrast, in syringe exchange programs in Tacoma, Wash, and New Haven, Conn, which have used a broadbased community outreach approach with few eligibility restrictions, response has been higher and there has been no evidence to suggest that these programs stimulated new or higher levels of drug use.[8,9] For future efforts to have a public health impact, wider accessibility and flexibility such as the programs in Europe and Australia have will be needed.[10,11] □

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