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Missing Data, Moral Eyesores, and Marginalized People: Opposition to Needle Exchange and Harm Reduction in Drug Policy

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Abstract: An ongoing opiate use epidemic has given drug use and policy new importance in public discourse. This paper provides an historical overview of American drug history, questioning how policy became and remains generally punitive. But many opponents of imposed abstinence consider a certain amount of addiction unavoidable and advocate for "harm reduction," or to mitigate the personal and social consequences of some inevitable drug use. The second half of this paper considers an especially controversial idea in harm reduction, needle exchanges, and outlines the arguments against wider implementation of these programs.

Keywords: drug policy; drug use; harm reduction; needle exchange; politics; history

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1. Introduction

When one hears the word "sustainability," images come to mind of beach cleanups, commuters pedaling to work rather than driving, and engineering innovations designed to make everything from appliances to entire buildings more eco-friendly. But sustainability entails more than preserving the planet; it includes our capacity to manage chronic social problems like addiction.

Over the last decade drug use has assumed new importance, as the United States is currently experiencing its highest rates of opiate addiction in history. Each year the US Department of Health's Substance Abuse and Mental Health Services Administration (SAMHSA) compiles a number of reports outlining the prevalence of drug (including alcohol and tobacco) use in America. Figures from 2013 indicate heroin and pain reliever "dependence and abuse," words substituted for the embattled

concept of addiction, are at an all-time high: approximately 467,000 heroin addicts and 2,523,000 pain reliever addicts, or a rate of 7.98 per thousand [1]. Of course, this is a conservative estimate as SAMHSA excludes from its surveys some particularly susceptible populations, including the homeless, active-duty military personnel, and people institutionalized in jails, prisons, hospitals, and the like [2].

Calling attention to these staggering figures begs a more practical question. How should we address the problem? Critics of punitive drug policy would argue for a reorientation of what "the problem" actually is. Rather than naively impose abstinence through incarceration, many of these advocates seek to mitigate the personal and social consequences of drug use through other means. This movement, broadly referred to as "harm reduction," is, as William L. White defines it, "posited on the belief that many people with AOD [alcohol and other drug] problems choose for some extended periods of their lives not to abstain or are incapable of sustained abstinence and that no viable intervention technology presently exists that can consistently alter this condition" [3]. In other words, some people are always going to use drugs and we should find better ways to manage their conditions.

This paper first outlines the history of American drug policy, questioning how it became and remains so punitive. The second half of this paper considers an especially controversial idea in harm reduction, needle exchanges, and outlines the arguments against wider implementation of these programs [4]. This proposition is especially relevant considering the ongoing opiate use epidemic. Independent clinics and public health advocates have occasionally carried out distribution ever since AIDS brought attention to the issue, but these often suffered legal consequences and social ridicule. A lack of empirical data, moral arguments, and the relatively hidden plight of opiate addicts will prevent any change in policy or public opinion for the foreseeable future.

2. Historical Context

Before considering the history of a particular idea in harm reduction, it is worth considering the broader history of American drug policy [5]. Drug use and regulation are by no means recent phenomenon. Interestingly, the two most consequential pieces of drug control legislation were passed in response to past opiate use epidemics. The first, the Harrison Narcotic Act of 1914, arrived in the fallout of an iatrogenic epidemic resulting from physicians' overuse of opiates (and, to a lesser extent, cocaine). Historian David Courtwright estimates that the rate of opiate addiction increased from not more than 0.72 addicts per thousand prior to 1842, to a maximum of 4.59 per thousand in the 1890s, or more than sixfold [6]. Scrupulous physicians noticed the "opium habit" developing in many patients and began withholding the drug by the turn of the century. Medical use subsequently declined but nonmedical use remained consistent although minor and confined to metropolitan vice districts. Social attitudes hardened against addicts, and the crimes associated with drug use (some real, some imagined) impelled individual states to pass drug control legislation before Congress instituted the Harrison Act.

The law required any business dispensing narcotics [7] to register with the government, pay a nominal tax, and keep detailed records of all transactions, but curiously did not specify how to deal with the existing addict population. The most contentious question became whether doctors could practice addiction "maintenance," or prescribe opiates simply to avoid withdrawal symptoms. Two consequential Supreme Court cases decided in 1919 answered in the negative. In *United States v. Doremus*, a physician had been charged with failing to complete forms required by the Harrison Act and distributing narcotics outside the bounds of professional practice. In *Webb et al. v. United States*, another physician had similarly dispensed morphine to numerous addicts and been convicted. The

charges against Doremus were ruled constitutional, Webb's prior conviction was upheld, and the antimaintenance approach was entrenched in Harrison Act enforcement.

The resulting “classic” era of narcotic control [8] lasted from the 1920s to the 1960s, until a dramatic increase in drug use prompted an overhaul of national drug policy. Marijuana and prescription barbiturate and amphetamine abuse were on the rise, but skyrocketing heroin prevalence was the most alarming trend. Courtwright identified an epidemic spanning from the mid-1960s to the mid-1970s, initiated and maintained by heroin’s “hip” status in jazz and beat culture, the established use of marijuana and other drugs in the experimental counterculture, the rebound of smuggling networks after World War II, and the deployment patterns of Vietnam veterans [9]. Nixon was thinking primarily of heroin when he declared drug use “public enemy number one” and pushed for passage of the Controlled Substances Act (CSA) in 1971.

This law allocated more money for treatment initiatives and dispensed with mandatory minimum sentences, but also introduced controversial measures such as “no-knock” search warrants. The CSA also instituted a framework of drug scheduling, promising flexibility in regulating access to psychoactive substances. In practice, however, regulation became rigid. After relevant federal agencies were combined into the Drug Enforcement Administration in 1973, Congress alleviated public concern over drug use by ratcheting up penalties for possession through CSA amendments, including the reintroduction of mandatory minimum sentences during the late 1980s crack epidemic. The CSA also affected many doctors, who, fearing legal oversight and fostering addiction, scaled back pain reliever prescription for decades [10]. Awareness of this trend, supplemented with huge campaigns by the pharmaceutical industry, led to more liberal prescription, a rise in “doctor shopping,” and the creation of “Oxycontin Superhighways” in the 1990s and 2000s. Recent legal and professional efforts to reign in opiate prescription are pushing many pain reliever addicts toward heroin. Increased street purity and falling prices (a result of higher productive output and competition) also continue to lure migratory users from other drugs.

American drug policy is thus a reactive and largely punitive set of laws. The implications of their enforcement— an explosion in prison populations, budgetary strain, adverse public health consequences, and a failure to diminish drug use—require a reassessment of the status quo.

3. Harm Reduction and Needle Exchange

Excepting the apparently imminent legalization of marijuana, there appears to be little tolerance for easing tension in the drug war. In this context, harm reduction advocates are united in recognizing shortcomings, if not the abject failure, of existing drug policy. But there are also numerous divisions within the coalition, particularly regarding personal versus public interventions and the extent of policy change and user rights. Most efforts at instituting needle exchange programs have been carried out on a minor scale by individuals or small groups, with occasional support from local governments. Needle exchange is obviously more popular in harm reduction circles than in mainstream discourse, but opposition similarly comes from abstinence-oriented therapeutic communities, and researchers skeptical of scant data. This section first discusses the development and present state of the needle exchange proposition, followed by an overview of its criticisms.

Needle distribution began in the depths of the AIDS crisis, and stopping the spread of infectious diseases remains its primary appeal. The first notable case occurred in 1986 when Jon Parker, a Yale public health student, began handing out needles to users in New Haven, Connecticut, and Boston, Massachusetts. Parker was ultimately arrested in eight states for his defiance of laws restricting needle and syringe access. Others followed suit in major cities such as Chicago, New York,

Portland, San Francisco, and Seattle, and by 1992 more than twenty programs of various sizes were operating throughout the country. Many operated illegally, but some local health officials recognized the utility of clean needle distribution. Like early narcotics restriction, some states have moved to permit needle distribution while the federal government has been unwilling or unable to act. Federal funds cannot be used to support needle exchanges [11].

Proponents have some seemingly persuasive arguments on their side. Potentially reducing the spread of HIV, hepatitis, and other diseases is a particularly powerful incentive, as more than ten percent of yearly HIV infections result from injection drug users [12]. Some also believe that the distribution environment would attract users to recovery services, or that program workers could steer users toward recovery [13]. Skeptics are quick to point out words like “potentially” and “believe,” as little data exists on the efficacy of needle distribution. But the data that do exist often show that needle distribution reduces disease incidence among participating users, reduces the number of discarded needles in public places, and does not result in increased drug use [14]. Still, the lack of larger or nationwide trials may make these encouraging conclusions circumstantial [15].

Opponents of needle exchange also have more visceral appeals. Journalist Michael Massing considered the extreme example of a visibly pregnant woman taking free needles, which, Courtwright commented, “might give pause to anyone” [16]. Really, needle exchange is weighted with the same baggage as being “soft” on drugs. One-time Supreme Court nominee Robert Bork succinctly put his take on moral opposition to harm reduction: “Knowledge that an activity is taking place is a harm to those who find it profoundly immoral” [17]. Even in 2014, two years after California and Washington legalized and regulated marijuana use, and as polls show a slight majority of Americans favoring marijuana legalization and other de-escalations in the drug war, most politicians are afraid to voice liberal opinions on drug policy [18]. This political hesitancy demonstrates hardliners still retain an influential moral argument.

A final reason needle exchanges face such strenuous opposition is the perceived demographics of injection drug use. Poor urban dwellers are imagined to most often take advantage of programs like needle distribution [19]. But the typical user has in reality changed in recent years. “You don’t think of heroin as suburbia, as rural America, but that’s what we’re seeing,” said DEA spokesman Joseph Moses in early 2014 [20]. White males now make up the vast majority of heroin and pain reliever overdose deaths. Pain reliever deaths quadrupled from 1999 to 2010, and heroin deaths increased just under fifty percent in the same period [21]. Users were traditionally marginalized from public attention by the effects of gentrification, incarceration, and other forms of disfranchisement, but changing user demographics may rally more support for the harm reduction cause.

4. Conclusion

Researchers interested in shaping drug policy must learn from the present and past debates over its current form. Opposition to new ideas stems primarily from reasons presented here: potentially circumstantial data, moral arguments, and the marginalization of users. Too often, academics practice their own form of “reducing harm” by minimizing the consequences of policy on actual users. But these issues are ripe for critical interpretation by scholars and advocates in sociology, anthropology, public health, and even history [22].

Conflict of Interest

The author declares no conflict of interest.

References and Notes

1. See "Table 5.2A – Substance Dependence or Abuse for Specific Substances in the Past Year, by Age Group: Numbers in Thousands, 2012 and 2013" under "Dependence, Abuse, and Treatment Tables" in the "Detailed Tables" section of *Results from the 2013 National Survey on Drug Abuse and Health*. http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabsPDFWHTML2013/Web/HTML/NSDUH-DetTabsSect5peTabs1to56-2013.htm. The table of contents, with links to items listed, can be found at http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabsPDFWHTML2013/Web/HTML/NSDUH-DetTabsTOC2013.htm.
2. I have also excluded some potentially crucial figures, namely those taking buprenorphine, methadone, or naltrexone and teetering on the edge of the addict population.
3. White, William L.; *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, 2nd ed.; Chestnut Health: Bloomington, IL, United States, 2014; pp. 447.
4. For narrative variety, I will be using "needle exchange" and "needle distribution" interchangeably.
5. For an excellent overview of American drug history, see Jonnes, Jill.; *Hep-Cats, Narcs, and Pipe Dreams: A History of America's Romance With Illegal Drugs*; Scribner: New York, United States, 1996.
6. Courtwright, David T.; *Dark Paradise: A History of Opiate Addiction in America,* 2nd ed.; Harvard University Press, Cambridge, United States, 2001; pp. 9.
7. Defined as opium, coca, and their derivatives.
8. Courtwright, Herman Joseph, and Don Des Jarlais define "classic" drug control policy as "strict and punitive… simple, consistent, and rigid." This characterized policy as enforced by the Federal Bureau of Narcotics in the mid-twentieth century. See *Addicts Who Survived: An Oral History of Narcotic Use in America before 1965*, 2nd ed.; University of Tennessee Press, Knoxville, United States, 2012; pp. 1.
9. Courtwright; *Dark Paradise*; pp. 166-169.
10. Jaffe, Jerome H. "Impact of Scheduling on Practice of Medical and Biomedical Research." *Drug and Alcohol Dependence* February 2007, *14*, 403-418.
11. White; *Slaying the Dragon*; pp. 447.
12. Centers for Disease Control and Prevention; "New HIV Infections in the United States, 2010"; http://www.cdc.gov/hiv/pdf/HIV_infographic_11X17_HR.pdf. This figure does not include HIV-positive children born to mothers infected from intravenous drug use.
13. White provides an overview of of arguments favoring needle exchanges in *Slaying the Dragon*; pp. 448.
14. See Tracey Hooker's report to the National Conference of State Legislatures, "Getting to the Point: HIV, Drug Abuse, and Syringe Exchange in the United States"; 1992. Cited in White; *Slaying the Dragon*; pp. 448; and *AIDS and the Law*; Wolters Kluwer Law & Business, New York, United States, 2014; pp. 2-81.
15. Findings from other countries which support exchanges might also be dismissed as circumstantial by domestic opponents.

16. Massing, Michael; *The Fix*; University of California Press, Berkeley, United States, 2000; pp. 11. Courtwright; *Dark Paradise: Drugs and the Making of the Modern World*; Harvard University Press, United States, 2001; pp. 201.
17. Quoted in Courtwright; *Forces of Habit*; 201.
18. Nagourney, Adam; "Despite Support in Party, Democratic governors Resist Legalizing Marijuana"; *The New York Times*, April 6, 2014; pp. A15.
19. Courtwright sums up affluent and middle-class opinions of hard drug policy: "The heaviest burdens fall on poor communities… the costs of which are absorbed by people who shouldn't be behaving like that anyway." *Forces of Habit*; 202.
20. Quotes in Sullivan, Laura; "Spike in Heroin Use Can Be Traced To Prescription Pads"; *NPR*, February 4, 2014; http://www.npr.org/2014/02/04/271591524/spike-in-heroin-use-can-be-traced-to-prescription-pads.
21. Centers for Disease Control and Prevention; "Increases in Heroin Overdose Deaths – 28 States, 2010 to 2012"; *Morbidity and Mortality Weekly Report* October 3, 2014, *63*; 849-854.
22. Historians, hardly known for their advocacy, have actually made a few forays into drug policy debates. See perhaps the most recent example in Joseph Spillane; "Historians and Harm: Toward a More Thoughtful Appraisal of Policy Consequences"; *London School of Economics Ideas* October 2012, *14*; 31-36.

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