Harm reduction in the home of the war on drugs: methadone and needle exchange in the USA

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Methadone in the USA—we risk snatching defeat from the jaws of victory

It is by now well understood in medicine that narcotic maintenance using methadone offers a powerful tool for reducing the harms of opiate addiction and the array of public health and social problems that can accompany it [1]. In America, apparently, this is not good enough. There has been virtually no change in methadone treatment in the United States throughout the entire period of the AIDS epidemic—which has already claimed the lives of over 100 000 US drug users and those infected by them [2]. As the populations of entire communities have been ravaged by AIDS related to drug use, there has been no expansion of methadone treatment, relentless opposition, especially in the Federal government, to needle exchange, and (despite recent support by the US drug czar) only the most modest and grudging accommodations to new models of methadone based on harm-reduction principles. For example, there has been no lowering of the threshold to program entry or softening of the punitive structure of services—the factors which determine its acceptability to the wide spectrum of potential patients and, ultimately, its penetration into the affected population.
How may we understand this monumental failure of public health in the country that pioneered the use of methadone in pharmacotherapy and first demonstrated its success with addiction and large scale implementation [3]? Ironically, this failure occurs at exactly the same moment that we are entering a golden era of scientific and clinical comprehension of drug actions and the nature of addiction—a scientifically grounded understanding that holds the promise of far more effective means of substance use management in the future. Are we so lumbered by the ideology and moral baggage of punitive drug prohibition that, despite our great need and capability for effective treatment in the United States, we are unable to take advantage of the wide range of models of methadone treatment that are emerging (and working well) all around the world [4]?

A brief political history of narcotic maintenance

The United States is a nation with long-established opposition to the fundamental approach of maintenance [5]. This is primarily because methadone, like all maintenance pharmacotherapies, involves the continued use of drugs, especially the opiates, that are the object of such morbid fears in so many societies. (One wonders what the reaction will be if cocaine agonist treatment ever becomes possible.) However, the opposition to drug maintenance is also a product of our social history, our demonization of drugs (the true "American disease") and the role played by the medical profession in that history [6]. Furthermore, despite some improvements in American consciousness about methadone treatment and addiction, due largely to AIDS, the hostility to and misunderstanding of this approach in the United States today is rapidly making heroin addiction 'resistant' to methadone. The hostility towards many of those in the treatment, ignorance of its benefits on the part of their families and of those who work with them, has never been more negative—culminating recently in a public attack on methadone by New York's Mayor, Rudolph Ginfani [7].

Whereas the British medical profession, under the leadership of Sir Humphrey Rolleston, President of the Royal College of Physicians, took pains to articulate a set of principles for the medical provision of opiates as a humane approach to ‘incurable’ addiction, American medicine has mainly avoided the problem of addiction. The British set up a Royal Commission (in 1926) which established the right of British practitioners to prescribe any and all drugs (including heroin in its injectable form) to their patients who were addicted and unable to cease all use on their own [8]. This ‘British System’ served well for over 40 years, until changes in the British drug scene of the 1960s led to its revision and the institution of greater controls. However, in the face of the AIDS epidemic, the Conservative government saw the wisdom in maintenance programs, and loosened the reigns on medical prescribing—leading to a three-fold increase in narcotic prescribing in Great Britain. This, and other public health...
measures such as needle exchange, may account for the low rate of HIV infection among heroin addicts in Britain for the last 10 years—probably less than 10% of the US rates [9].

In the United States, in contrast, the drug maintenance approach has had a troubled past, and the historical role of the American medical profession was less laudatory. American doctors (at the time) were members of a much lower prestige profession than we know today and were often held responsible for the problem of addiction in this country. Writing in 1856, Supreme Court Justice Oliver Wendell Holmes blamed the drug problem on the "constant prescription of opiates by certain doctors". While many American practitioners, out of a humane motive, quietly provided these drugs to their patients as needed, others often referred to as "dope doctors" (and regularly vilified in the press) exploited these same patients' dependency, reaped substantial profits and thoroughly discredited the approach. In the period 1914-24, some morphine maintenance programs were established in the United States in Shreveport, LA and Jacksonville, FL. In New York City, over 7000 patients were dispensed narcotic drugs under the auspices of the City's prestigious Department of Health [6]. But the medical control was poor and public reaction to this approach was negative. American medicine soon sought to distance the profession from narcotic maintenance and from the problem of addiction altogether. In 1910 the American Medical Association (still in its infancy) described the provision of drugs to the addict as "immoral" and declared the condition outside their responsibility. The US Harrison Act (passed in 1914 to regulate the manufacture and sale of narcotics) was soon interpreted as banning the medical prescription of opiates as addiction treatment. This view, when challenged by concerned practitioners, was upheld in the US Supreme Court throughout the 1920s. The effect was to outlaw this form of medical practice and to shut down the still young and inexperienced drug maintenance treatment programs that had begun to emerge in this country [6].

Methadone - a new day

It was not until 40 years later that we would see a re-emergence of the old ideas of drug maintenance treatment within US medical practice and the rediscovery and legitimization of maintenance pharmacotherapy. Working in New York's Harlem, Dr Marie Nyswander (a young psychiatrist and jazz fan) was trying to help her addict patients, sometimes prescribing
(unorthodoxly) to help them gain control of their use of illicit heroin [10]. She was soon joined by Dr Vincent Dole, a much-respected metabolic researcher at the prestigious Rockefeller University and New York Hospital. Together they mounted a series of careful studies of methadone maintenance which demonstrated that it did not lead to escalating tolerance and could therefore be used to achieve a stable daily dose without the ups and downs of shorter acting opiates such as heroin or morphine—especially when these are taken in uncertain doses and on unpredictable schedules [11]. A single daily oral dose of an inexpensive medication could eliminate withdrawal, narcotic craving, and the destructive need for illegal heroin. Importantly, in the proper dose for an already-tolerant user, methadone did not produce intoxication. This permitted relatively normal functioning despite taking large daily doses of a narcotic as addicts with access to pure drugs (e.g. doctors) had demonstrated repeatedly.

The initial results were spectacular—over 90% retention in treatment and the virtual cessation of heroin use. Arrest rates dropped precipitously as there was no longer a need to engage in acquisitive crime to obtain money for illicit drugs. More critically, as they began to relocate their source of drugs from the street drug scene to the clinic and shift their dependency from illegal to prescribed drugs, addicts began to reorientate their lives away from drug seeking and back to the worlds of family, work and the community; that is, to `get a life'.

The landmark clinical trial of methadone maintenance, first published in the Journal of the American Medical Association in 1965 [12], captured wide public attention and led both to its rapid acceptance and a certain amount of oversell of methadone as a `miracle cure'. This success was recognized by the award of several prestigious prizes for its discovery. In the late 1960s the United States saw a rapid expansion of methadone maintenance treatment programs (MMTPs), with clinics opening in dozens of cities and over 75,000 patients in treatment by 1975 (115,000 by 1998). Today methadone is the preeminent and still most successful means available for the treatment for heroin addiction-ending, one would have thought, 40 years of therapeutic nihilism about the treatment of addiction.

Snatching defeat from the jaws of victory

However, while the United States was the pioneer in establishing methadone treatment, old attitudes hostile to maintenance approaches were never totally abandoned in America. For, in
addition to creating methadone treatment, the United States was also the birthplaces, and is still the spiritual centre and home, of the world-wide abstinence approach to drug treatment. In the face of great need and the vacuum in formal health and social services for addiction, drugfree therapeutic communities (TCs) such as Synanon, Phoenix sprang up in America. These `self-help' approaches draw on the 12-Step methods of Alcoholics Anonymous and are historically intolerant of all drug maintenance approaches.

In these programs, total abstinence from the use of all mind-altering drugs was the principal goal of treatment and the only acceptable terms for drug users participation. A sharp division between this philosophy and methadone maintenance increasingly took its toll on the conception and practice of drug treatment in this country [13]. Furthermore, due to the inordinate US influence in international narcotics matters, this polarization was also replicated abroad. The dominance of this drug-free, abstinence orientation grew further under the auspices of the US `war on drugs'. This moral crusade soon found a natural ally in the TCs and among recovering addicts-who often became the most articulate and persuasive spokesmen for the `Just Say No' approach. Its foundation principle was the evil of drugs and, with it, the inevitable demonization of drug users.

This view has steadily undermined the credibility of methadone in this country. Methadone treatment was commonly and publicly held in contempt, and an urban folklore of methadone's evil qualities (that it rots your teeth, penetrates the bones) soon became the conventional wisdom in the drug treatment world [14]. Anaemic funding of addiction treatment in the urban health centres which originally sponsored many of the first methadone treatment clinics, and its continued marginalization within mainstream medicine, all contributed to methadone's problems in the United States. While the worst examples of methadone treatment's failures were all too evident around the overly large and often conspicuous clinics in the midst of some of our nations most embattled communities, the very substantial number of successful methadone patients generally kept it a secret [15].
Predictably, the quality of methadone treatment began to suffer. This could be seen in the steady lowering of dosages, below therapeutically recommended levels, and in the increasingly punitive and controlling character of many MMTPs—often large clinics of the inner city which became associated with concentrations of unemployed and often still-active users of other illicit drugs. When the crack epidemic arrived, in the 1980s, it amplified the role of sex and drugs in the AIDS epidemic and produced a whole new group of drug users with particularly difficult-to-treat patterns of compulsive cocaine use. The crack trade and its associated violence also served to reinforce the strong anti-drug addict sentiments in the same communities already antagonistic to the use of methadone, and further distracted attention from the treatment needs of the large and much older cohort of heroin addicts.

The old prejudices and antagonisms towards drug maintenance are still evident in the regulation of methadone treatment, which is subject to many influences beyond the purely clinical responsibilities of medical care [13]. Thus a law enforcement agency, the DEA, rather than a health care authority, controls or has powerful influence over the most important aspects of the treatment program—dosages, schedules, admission and termination criteria, and overall access and availability of the treatment itself.

Harm reduction: AIDS and the ‘re-invention’ of methadone

In the early 1980s the AIDS epidemic appeared in the United States, Europe, Asia, and the Pacific—immeasurably changing the significance of drug use and addiction. While it had always been true that drug addiction and public health were linked, the appearance of AIDS set the stage for a reconsideration of injecting drug use and addiction, now seen as an engine of AIDS spread, and a reconsideration of drug treatment...
as a tool of AIDS prevention. This led to the birth of harm reduction—the modern public health model for dealing with addiction as a global public health problem. Harm reduction offers an alternative to abstinence as the sole objective of drug treatment. In harm reduction the goal 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. This includes AIDS and other infectious diseases (e.g. hepatitis) associated with sharing injection equipment, and other sexually transmitted diseases associated with prostitution. Methadone, properly managed and adequately available, has emerged as the ideal tool for harm reduction among this huge and growing population of American heroin addicts; but its future is in jeopardy here.

The new assault on methadone

In the summer of 1998, New York's Mayor and former Federal Prosecutor, Rudolph Guiliani, opened a campaign to end methadone maintenance treatment in this city [7]. He assailed the approach as ‘immoral’, merely perpetuating ‘enslavement’ to narcotics—a phrase reminiscent of the 1920s and Harry Anslinger. The Mayor ordered the five programs run by the City itself (with 2000 of New York's 36 000 patients) to begin plans to taper all their patients and to develop methadone to abstinence programs. In addition he ordered eviction notices to be sent to private and voluntary programs that occupy City-owned property affecting another 4-5000 patients.

In the face of a public uproar, the Mayor soon backed away from these threats. But given our history, the threat in New York echoes the persecution of narcotic prescribers in the 1920s. We have seen legislation in the United States restricting publicly funded methadone treatment to a few months to 2 years (in Alameda County, CA) and the continued intimidation by the DEA of practitioners wishing to use methadone treatment. However, despite this continued domination by non-medical government agencies there is a new spirit of resistance and innovation in the methadone treatment community, the patients and their families. In September 1998 the National Association of Methadone Advocates (NAMA), formed in 1980 to represent patients, rights and due process in treatment, had its first national meeting in New York City. There is also a growing awareness in medicine, mental health and substance abuse services of the importance of adequate levels and availability of such care. These developments have been
long in coming but
there is now an active consumers, group of methadone patients
and
their advocates who are fighting to normalize methadone treatment in
the United States. Even the US drug czar, General Barry McCaffery, has come out strongly for
methadone and the medical profession is slowly responding to the developments in methadone
treatment from abroad—especially the closer integration of methadone with primary care
medicine and AIDS care [16]. There is even a nascent move to office-based practice and the
expansion of medical maintenance where stable, long-term patients are dispensed methadone
monthly through their primary practitioner [17].

While these are positive developments in the United States, we are not easily rid of the legacy
of encumbering regulations and outdated concepts about methadone treatment, especially the
distrust of the prescribing physician. The American Methadone Treatment Association (AMTA),
which represents the methadone treatment ‘industry’, has proposed referring stabilized patients
to office-based practice settings for all their care, including methadone. However, as proposed,
the criteria for patient and physician involvement are set at a very high threshold: for the patient,
36 consecutive months of stability and employment, with no positive urine toxicology or criminal
offences; for the physicians, Certification in Addiction Medicine or Psychiatry, or 3 years,
experience or 1500 hours in a licensed narcotic treatment program.

This is a marriage made in heaven and wholly appropriate for such deserving patients.
However, it does not begin to touch the more typical methadone patient or the huge reservoir of
active heroin users in America (a growing population, in our opinion) who need access to this
medication immediately. Until this public health view of the use of methadone is achieved, the
original and still essential vision of Drs Dole and Nyswander, we will never realize the full
harmreduction potential of this approach to treatment.
Needle exchange in the USA - attacked, underfunded, marginalized, but alive

Although needle exchange has been part of the American landscape of HIV prevention since at least 1986, when New York City's Commissioner of Health first proposed creating a program, it is an intervention that is more widely discussed and vilified than actually implemented. The United States stands almost alone in prioritizing its efforts to end drug use among its citizens over stopping preventable diseases. The reticence of city, county, state and federal governmental entities to support and fund needle exchange, because it conflicts with zero tolerance policies towards drug use, indicates an indifference to the scientific evidence supporting the efficacy of needle exchange [18-21], an abandonment of common sense and a callous disregard of human life.

Despite the negative climate in which programs necessarily function within the United States, a few programs have developed and flourished by creative use of limited funding and with the benefit of not having over regulated resources. However, these programs and organizations are the exception. Additionally, lacking institutional support, the focus has been on supplying syringes to drug users and to seeking an end to the Federal ban on the funding of needle exchange, rather than tackling legal barriers at the state level, or advocating for alternative means of needle provision (such as physician prescribing, vending machines, peer distribution and advocating for other organizations to be involved). Although this prioritizing is appropriate, it has led to neglect of other these other strategies to increase the number of sterile syringes in circulation.

As of 1998, the United States has had over 230 000 cumulative AIDS cases related to use of an HIV contaminated syringe [22]. This figure includes the HIV-infected sexual partners of injectors and their children. Nine states (New York, New Jersey, Pennsylvania, California, Massachusetts, Delaware, Illinois, New Hampshire, Rhode Island and the District of Columbia) prohibit the sale and possession of syringes without prescription and, not surprisingly, the HIV infection rates among injection drug users in those states far outstrip the remaining 41 states. Of the estimated 200 000 drug injectors located in New York City approximately 50% are HIV infected [23]. Cumulative AIDS cases among drug injectors in New York City total 43 564, with an additional 2770 cases among men who have sex with men and also inject drugs [24]. Of those drug injectors, 28 351 are dead [24].

New York City's charismatic and clairvoyant Mayor Edward Koch declared in 1986 that needle exchange was an 'idea whose time has not come and will not come' [25] in response to an
effort by Dr Stephen Joseph, then the City's Health Commissioner, to initiate a program. Tacoma, Washington became the United State's first public, above ground program. Even after celebrating its 10th anniversary the needle exchange in this relatively small northwestern, blue-collar city is still one of the largest exchange programs in the country in numbers of syringes dispensed. It is also an impressive example of how a city with a low HIV scro-incidence can remain so. In 1988, HIV prevalence was 3% for out-of-treatment injectors and in 1998 that prevalence has reduced to less than 2% [Dave Purchase, personal communication]. Close on the heels of the Tacoma exchange, which is named the Point Defiance AIDS Project, came Portland, Oregon and Hawaii.

New York City commenced a City-run program in October 1988. After 2 years of wrangling it was agreed that no needle exchange could operate within 1000 feet of a school. This left the City no option but to locate the program at the City Department of Health building, which is situated within walking distance of Wall Street and adjacent to police headquarters, the city courts and city jail. Participants in the program were limited to one syringe per visit. Intake included blood drawing and testing for HIV, hepatitis B, tuberculosis and syphilis. Concomitant with intake was a referral into drug treatment. The program ran for 14 months on the principle of needle exchange as a bridge to treatment and attracted 318 participants [Charles Eaton, personal communication]. It was closed upon the election of New York City's first African-American Mayor, David Dinkins, who abandoned the initiative in response to the charge that needle exchange was tantamount to genocide—a cry that originated among prominent African-American drug treatment and AIDS providers. The modern experience of neglect and the legacy of slavery within minority communities has led to a natural suspicion of the intent of needle exchange. As of 1998, the Black Leadership Commission on AIDS has yet to endorse needle exchange as a way of preventing HIV infection and there is still no program located in Central Harlem. Upon the closing of the City-run program, activists solidified under ground programs located in the drug using commu nities of Motthaven in the South Bronx, Manhattan's East Harlem and Lower East Side and Williamsburg and Bushwick, Brooklyn. The original five Statefunded programs were located in four Latino communities.

San Francisco's Prevention Point commenced needle exchange in 1989, originally operating out of a baby carriage. Officially recognized as the HIV Prevention Project, Prevention Point, like most other quasi-legal programs in California, operates under a State of Emergency Proclamation. The State of California does not recognize the legitimacy of needle exchange. In order for the exchange to continue to operate under some legal authority this State of Emergency Proclamation has to be renewed as frequently as every 2 weeks.
In 1991 the US National Commission on the Twin Epidemics of HIV and Drug Abuse appointed by President George Bush issued a report strongly supporting the implementation of needle exchange [26]. That same year, probably the most important research to have a lasting impact upon needle exchange in the United States emerged from the Yale-conducted study of the New Haven, Connecticut program [27]. Operating the exchange out of vans, the New Haven Department of Health exchanged bar-coded syringes and polymerase-tested the returned syringes for HIV. The results indicated, through a process of mathematical modeling, that individuals enrolled in the program reduced their chances of contracting HIV by 33%. This research was enough for the Commissioner of Health for New York City to influence the Mayor not to object to a new needle exchange effort. A collaborative effort between the State Department of Health, the American Foundation for AIDS Research, two underground programs and three community-based organizations interested in implementing needle exchange culminated in an exemption waiver from State syringe paraphernalia laws and minimal funding for the organizations running the programs [28]. Simultaneously, the Chemical Dependency Institute of BethIsrael Medical Center studied the impact of these programs. The rationale was that if it could be proven that needle exchange was effective in New York City, the densest population of HIV-infected drug users in the United States then the government would have to provide support and leadership.

In 1993 the General Accounting Office, part of the Federal government, and the University of California, San Francisco funded by the Centers for Disease Control (CDC) both analyzed the current state of needle exchange in the United States. Both organizations reported favorably on the intervention and recommended expansion [19,29]. In 1995, the National Academy of Sciences reported that there was enough scientific evidence to allow the government to commence Federal funding for needle exchange. In 1996, after 4 years of research involving participants of needle exchange programs in New York City, it was demonstrated that HIV transmission was reduced by 66%, equivalent to lowering the HIV risk to a level below that of drug users enrolled in methadone programs [30]. In 1997, after the National Institutes of Health issued a consensus statement urging the lifting of the federal ban on the funding of needle exchange [31], the Secretary of Health and Human Services, Donna Shalalala, in whose power the rulings lay, determined that needle exchange was effective in reducing HIV transmission among injection drug users [32]. This met one of the two measures needed to free Federal funding. In the Fall of September 1997 more than 1000 protesters, organized by the National Coalition to Save Lives Now!, marched on Shalalala’s office to demand a lifting of the 9-year-old ban and 11 demonstrators were arrested in a protest action, which attempted to deliver a giant spine to a spineless Secretary for Health and Human Services. Finally, in the Spring of 1998 the Secretary determined that needle exchange...
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does not increase or encourage drug use, which was the second point necessary to lift the funding ban. Without a second pause, President Clinton lifted the ban but denied funding.

After 10 years of needle exchange in the United States, the number of programs has reached 135. This number has increased from six in 1990 (the first year of the North American Syringe Exchange Convention) to 77 in 1995 to 113 in 1997. In a 1997 survey in which 100 needle exchange programs provided data, 17.5 million syringes were reported exchanged, an increase of 3.5 million, from the previous year [33]. However, the 10 largest volume programs exchanged 59% of syringes [33]. Of the 113 programs in existence in 1997, 14 were located in New York State (11 in New York City), 19 were spread throughout California and 11 existed in Washington State. Twenty States had no needle exchange program whatsoever. Programs often rely on volunteer staff, operate very limited hours (some for as little as 2 or 3 hours weekly) and under a wide range of legal restrictions. For example, the Chicago Recovery Alliance, one of the largest programs, operates under the auspices of a research waiver. Programs operating in New Mexico do so by forgoing asking for State operating funds. New York programs have State waivers and California programs have city and county support. Unfortunately, street-corner syringe dealers still provide more reliable access to equipment than large needle exchange programs, due to their 24-hour availability. In 1998 there have been more arrests of needle exchange workers than in many previous years, with workers being arrested in Denver, Cleveland, Fresno and San Francisco. Needle exchange in the United States manages to provide approximately three syringes per injector annually [Denise Paone, personal communication]. This lack of progress is not for the paucity of effort on the part of needle exchange activists or the ignorance of elected officials. Many of us advocating for needle exchange believe that it is the result of a long-term, calculated effort on the part of the conservative establishment, wholeheartedly tolerated by Democrats and Washington's AIDS advocates, who have constantly utilized needle exchange as a bargaining chip to assure continued support for funds for AIDS research and care.

The Federal ban on the funding for needle exchange was established in 1988 as the first programs were being launched. In fact, it was imposed twice that year. In the first case it could be removed if the Surgeon General (the Federal government's leading public health officer) determined that needle exchange reduced drug abuse and protected the public from HIV. In the second case the Comprehensive Alcohol Abuse and Mental Health Amendments Act of 1988 restricted states from using funds to distribute syringes or distribute bleach for cleaning syringes. Variations on these restrictions were applied to the Ryan White Care Act of 1990 and renewed in 1996, and to the Labor/Health and Human Services Appropriations Bills for 1990, 1991, 1993, 1995, 1997 and 1998 [34]. In 1998 not only were federal funds unavailable to the City of Washington, DC where the US Congress controls all financing, but
also local funds. Several attempts to pass legislation that would prevent any organization that conducts a needle exchange program from receiving any Federal funding were narrowly defeated for reasons other than the exchange restrictions. These limitations are not haphazard or routine rollovers from one year to the next, but are added deliberately. The ban on federal funding is far more than symbolic. Without significant government resources it is difficult, if not impossible, to plan for long-term development or even a sustainable effort to prevent HIV among injection drug users.

State, county and city funding is often reliant on the imprimatur of Federal leadership) and private foundations offer too little money with high expectations and an annual renewal process.

An attempt by Congress to make the funding ban irreversible produced the following comments on 12 September, 1997 [35] which reveal the depth of the distorted opposition to needle exchange among politicians at the Federal level:

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 ... Any person, whether they are five or fifty, can walk up to a vending machine on a street corner (in Zurich) put in $2.00 of coins and get back a box. Inside that box is death. Inside that box are three syringes, needles and instructions on how to inject deadly mind altering substances into your body (Barr, Republican from Georgia).

Another congressman's statement invoked worrying analogy and reflected misconceptions about needle exchange in Europe:

They (needle exchange programs) offer the addict anonymity so that the addict can hide their problem from their friends and family so that they can't get help ... It's wrong public policy to give needles out to kids the same as it is wrong to give clean guns out to kids ... Needle Park in Zurich ... increased heroin use. [Zurich became a] mecca for heroin users, Why? Because as well as free heroin, they give free needles ... Heroin giveaway programs started with needle exchange ... Needle exchange encourages the use of heroin among our youth and children (Hastert, Republican from Illinois). Referring to the House of Representatives, and not any of the incarceration chambers in Mississippi where the death penalty is administered, a member asked the following: Could anyone in this chamber actually stick a needle in another person's veins and fill them with deadly drugs? It will give them a slow but sure death (‘Chip’ Pickering, Republican from Mississippi).
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From another Mississippi member, where there are no needle exchange programs: an IVDU approaches the facility with a dirty needle used to commit a felony (Wicker, Republican from Mississippi).

Aside from misleading statements about European efforts to address drug use, invoking `protecting our children' and expressing the view that anyone who uses drugs is de facto a criminal and therefore forfeits all civil rights, some opponents of needle exchange have argued that it is imperative to keep drug use as unsafe as possible as a means of discouraging the behavior. Congressman Myrick of North Carolina (where there are no needle exchange programs) weighed into the debate with `We need to discourage drug use and not make it safer for the user' [35]. This sentiment was echoed late in 1997 as the Colorado legislature considered legalizing needle exchange. A District Attorney for Colorado's Larimer County opined: `It seems to me that giving someone a clean needle is a disincentive to stopping addiction. One of the deterrents is the fear of spread of disease. If you have clean needles, that fear is gone' [35].

More frightening are opinions held by some individuals and organizations who act as advisors to elected officials. The Family Research Council (FRC) is a Christian fundamentalist think-tank whose founder, Gary Bauer, was a high-level official in the George Bush administration. Bauer is expected to make a run for the Presidency in the year 2000, is a regular guest on political talk-shows and is a regular source for mainstream media. The following quotes come from materials produced by the FRC in 1997:

The growing needle exchange debate is really about drug legalization. Pro-drug forces have nurtured a cadre of scientists and others to give their fight the appearance of legitimacy [36].

Needle exchange programs won't stop a desperate drug addict to do anything to fulfill his craving. NEPs will scar urban areas, snuffing out hopes for crime reduction and development. Government-sponsored needle exchange programs will move America down a disastrous path towards drug legalization ... On April 2, 1995, Saudi Arabia beheaded three drug smugglers. A little earlier, Singapore did the same. There are no needle exchange programs in Riyadh and few addicts on Singapore's streets. Neither country has an AIDS epidemic [36].

Some drug treatment providers and `experts' have also expressed opinions that have clouded
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the issue or opposed needle exchange efforts. For example Dr James Curtis, who is Director of Psychiatry and Addiction Services at Harlem Hospital Center and a member of the Black Leadership Commission on AIDS, wrote in a New York Times 1998 Op-ed that `Needle exchange programs should be outlawed because they do far more harm than good. Class action lawsuits should be explored as a means of preventing the further government approval [sic] or funding of these programs which constitute reckless experiments with human subjects' [37].

Government officials appear to have shied away from debate and have preferred political expedience over science and public health. Drug czar General Barry McCaffrey is widely credited with derailing efforts to approve Federal funding. He also believes strongly that needle exchange and other harmreduction efforts are a Trojan horse for drug legalization [38].

This rhetoric reflects dominant political opinion. Any deviation from this line of thinking places the actor outside mainstream culture and into the realm of 'otherness', about whom anything can be said and to whom virtually anything can be done. It takes both authorized and unauthorized needle exchangers into a semi-parallel existence with the drug users they work with and for. This has led to a constant state of uncertainty about the future of individual exchange programs, and leaves little time for planning and development. The climate of intimidation has limited the national growth and expansion of needle exchange leaving large numbers of injectors unreached and ignored, as virtually any support or social service for drug users, including drug treatment, is considered undesirable and fringe.

As in any oligarchical society, fear-mongering based on race, economics and personal security are utilized effectively to maintain the status quo and this is epitomized by the moral rhetoric fueling much of the opposition to needle exchange. Part of this status quo is the assurance that drugs are allowed to cause as much damage as possible, healthcare is a privilege and the lives of the poor, in particular minorities, have little value. This mainstream discourse has left little room for addressing the complexities.
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of being a drug user in the United States and has propelled the tragic and unnecessary course of the American AIDS epidemic. References


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