

Choose your poison? Moral, prudential, and political arguments about harm reduction

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A May 28, 2007 *New York Times* story profiled Ron Daniels, director of Prevention Works, a syringe exchange in Washington, DC. The front-page story depicted Daniels' journeys through low-income neighborhoods in his Winnebago van, as he distributed sterile syringes and other supplies to injection drug users. Himself infected with HIV from a contaminated syringe, Daniels now operates the District's only syringe exchange. Local health clinics had provided similar services until 1998, when Congress, which enjoys special authority over the nation's capital, blocked local government from financing these services. "We need to fight drugs, not show people they can be used in a safe manner," stated Representative Sam Groves, Republican of Missouri. (1)

Why is the United States so resistant to public health strategies that have found wide acceptance in many other industrial democracies? This is an old question, but it remains pressing. More important, given our history of missed opportunities to reduce the harms connected with HIV/AIDS, can we do better?

In part, American resistance reflects stringent views on foundational questions of drug policy. Federal sentencing guidelines consider a 5-gram sale of crack to merit greater penalty than attempted second-degree murder that results in serious injury to the victim.(2) In specific cases, nonviolent first-time offenders receive mandatory minimum sentences of 25 years or more that exceed penalties imposed for homicide, attempted hijacking, and other violent offenses.(3, 4)

The popularity of ballot initiatives that would allow medical marijuana or that would overturn harsh sentencing laws suggest a belief held by many voters that American drug policy has lost its way. Some critics go further. Mill's "harm principle" can be (but does not have to be) interpreted to support principled objection to government regulation of drug use.(5, 6) Most

academic researchers are critical of punitive policies, but nonetheless accept the right of government to stringently regulate some substances likely to cause severe and likely harm.(5, 7, 8)

Under any feasible set of policies, some citizens will harm themselves or others through the use of intoxicating substances. Whether or not such consumption occurs outside legal boundaries, societies have strong practical reasons to address accompanying harms. Striking the right balance between deterrence and compassion is an inherent tension in drug policy.

Harm reduction denotes the search for effective policies and interventions to address this tension. It provides an explicit framework for many nations' substance abuse policies, even, in some cases, law enforcement.(9, 10) Within the United States, harm reduction enjoys the endorsement of many medical and public health authorities, yet is politically embattled. A *New York Times* story, titled "Certain words can trip up AIDS grants," exemplified the depth of such resistance¹:

Scientists who study AIDS and other [sexually-transmitted infections] say federal health officials have warned them that their work may come under unusual scrutiny.... Speaking on condition of anonymity, the scientists say they have been advised they can avoid unfavorable attention by keeping certain "key words" out of grant applications to the National Institutes of Health and CDC. Those words include "sex worker," "men who sleep with men," "anal sex" and "needle exchange..." HHS spokesperson Bill Pierce said the department does not screen grant applications for politically delicate content. But an NIH official, speaking on condition of anonymity, said NIH project officers, who work with grant applicants and recipients, were telling researchers to avoid so-called sensitive language.(11)

Soon after, a congressional amendment to de-fund controversial HIV prevention studies came within two votes of passing; (12) while the Traditional Values Coalition (TVC) released a list of 157 scientists whose federally-funded studies concerned topics TVC deemed irrelevant or offensive.(13) HHS officials may have assisted TVC in preparing this list.(12)

Some projects are deemed objectionable because they concern populations TVC regards as immoral. TVC attracted widespread derision, in part because it challenged funding decisions made

¹ Such delicacy regarding sensitive behaviors calls to mind the joke, "Other than that Mrs. Lincoln, how did you like the play."

through scientific peer review. (14) Such views still held political currency. For example, a 2003 letter by Congressman Mark Souder to the National Institutes of Health begins:(15)

As you know, "harm reduction" is an ideological position that assumes individuals cannot or will not make healthy decisions. Advocates of this position hold that dangerous behaviors, such as drug abuse, should be accepted by society and those who choose such lifestyles -- or become trapped in them -- should be enabled to continue these behaviors in a less harmful manner. Often, however, these lifestyles are the result of addiction, mental illness or other conditions that should and can be treated rather than accepted as normative, healthy behaviors.

Other disputes, and then Democratic victories in the 2006 election, sidetracked Congressional efforts to curtail harm reduction interventions. Yet federal funding remains unavailable for syringe exchange, while policymakers studiously avoid harm reduction strategies and vocabulary in responding to social problems related to substance use.

Examining the scientific literature, one might wonder why harm reduction attracts such attention. Economists and public health researchers define the term in self-consciously apolitical terms. Stated blandly, harm reduction might be defined as follows: *choose policies that minimize the net harm associated with both substance use and with the policies used to dissuade, deter, treat, or punish individuals who use or distribute these substances.* For people trained in a certain technocratic strain of policy analysis, this definition is not subversive. It is nearly a vacuous restatement of how one weighs the costs and benefits of *any* intervention.

Yet like other many commonsense notions, harm reduction has unsettling implications. It frames the argument to privilege some approaches at the expense of others. The harm reduction calculus is a narrowing of focus. It directs attention towards particular outcomes and away from broader social and moral questions.

Several contributions to this special issue discuss specific interventions from a harm reductionist perspective. Following MacCoun and Reuter, such interventions are typically "micro"

harm reduction: measures which would reduce the harm associated with each unit of substance use, assuming that such measures have little tangible impact on the level and intensity of such use.(5)

Micro harm reduction typically reduces some harms while potentially increasing others. Because substance use brings many different benefits and harms to different people, citizens can reasonably disagree about specific harm reduction interventions. MacCoun and Reuter distinguish drug-related harms through the metaphorical equation:

$$\text{Overall harm} = (\text{Average harm per dose}) \times (\text{number of drug users}) \times (\text{Average dose per drug user})$$

One should not imply false precision, or even that one can directly measure everything in the above expression. It is surprisingly hard even to count drug users or to gauge the volume of drugs users consume.(16) This nonetheless provides a useful lens to scrutinize specific policies.

Somewhat egregiously, one can differentiate MacCoun and Reuter's equation. Thus, the change in social harm associated with a particular intervention is roughly:

$$\begin{aligned} \text{Change in overall harm} = & \\ & (\text{Change in average harm per dose}) \times (\text{number of drug users}) \times (\text{Average dose per drug user}) \\ & + (\text{Change in average dose per drug user}) \times (\text{Average harm per dose}) \times (\text{Number of drug users}) \\ & + (\text{Change in number of drug users}) \times (\text{Average harm per dose}) \times (\text{Average dose per drug user}). \end{aligned}$$

The "strong" harm reduction argument holds that micro harm reduction reduces overall, or *macro* social harm. Typically, one presumes that the impact of an intervention on average harm per dose consumed will dominate the impact of such an intervention on average doses or on the number of drug users.

This argument has troubling links. Designated driver programs reduce road fatalities. They may also encourage increased drinking among passengers, thereby aggravating other alcohol-related social problems.(17) Seat belts may improve safety among drivers but may thus increase reckless

driving, and hence increase pedestrian deaths.(18) Micro harm reduction can also backfire if it leads drug users to “push the envelope” by increasing average dosage.(19)

Tobacco provides striking examples of failed harm reduction. (20) During the 1960s, smoking prevalence declined due to heightened fear of the health risks. Public anxiety presented a marketing opportunity for two alleged safety innovations: filter and low-tar cigarettes. Readers may recall a myriad of advertisements, in which persuasive smokers would say, “Considering all I’d heard, I decided to either quit or smoke True. I smoke True.”² Unfortunately, as people actually smoke, filter and low-tar cigarettes proved no safer than prior models. Many smokers switched to these products when they might otherwise have quit or might never have smoked at all. (21, 22)

None of these examples demonstrate the general futility of micro harm reduction. In several debated cases, such as the alleged perverse incentives associated with seat belts, it is unclear that theoretically plausible increases in risk actually occurred. Moreover, micro harm reduction can bring favorable macro effects by promoting additional risk-reduction strategies or engaging individuals into systems of care.

The uniqueness of syringe exchange

Syringe exchange programs (SEP) are the paradigmatic example of micro harm reduction. SEP occasions some scientific disagreements. Nonetheless, there is consensus that these programs reduce HIV incidence. Many types of evidence—ethnographic and survey data, mathematical modeling based upon HIV testing of syringes(23-25)—indicates that SEP reduces behavioral risk and HIV incidence among participants.(26-31) Ostensibly so attuned to ways that political correctness trumps science, critics of the public health community appear strangely uninterested in these clear findings.(e.g. (32)) NIH consensus statements and several Institute of Medicine

² I owe this example to Kenneth Warner.

committee reports conclude that SEP slows the spread of HIV. President Clinton declared as much when he edged up to the brink of certifying SEP according to Congress's two-part test, but then turned away.(33, 34) In 2004, Dr. Elias Zerhouni, Director of the National Institutes of Health, stated “A number of studies conducted in the U.S. have shown that SEPs do not increase drug use among participants or surrounding community members and are associated with reductions in the incidence of HIV, hepatitis B, and hepatitis C in the drug-using population.”(35)

Ironically, passionate supporters and opponents of SEP seem to agree on one thing: that a prospective randomized evaluation would be unethical. One side opposes such trials because they find SEP inherently objectionable. Meanwhile, many SEP supporters oppose such trials because, in their view, there is already sufficient evidence that SEP is effective that it is wrong to jeopardize the safety of a control or comparison group. (36, 37)

Critics of SEP also argue that these interventions encourage or facilitate continued injection drug use. Such diffuse concerns are difficult to directly refute. Available data suggest that exchanges have little measurable impact on drug use patterns in studied communities. They bring street users into contact with medical, public health, and social service systems, and so provide a vehicle to pursue other valued goals. (37, 38)

As this debate proceeds, the opposing sides spend so much time debating the basic idea of syringe exchange that surprisingly little attention is paid to how syringe exchange programs are best implemented, and for whom. There is a missing program evaluation and implementation literature which moves past foundational debates to improve what these interventions do. Equally important, syringe exchange for HIV prevention provides a powerful and emotive example that unavoidably frames our thinking regarding other, quite different interventions.

When one pauses to consider the unique aspects of syringe exchange, perhaps the most striking aspect is that the argument is so over-determined. It is surprising that there is any

disagreement at all. SEP may be the jewel in the harm reduction crown. For a variety of reasons, one cannot expect a similar extra-base hit every time.

Perhaps most important, the moral urgency of HIV prevention is so great, the neglect of IDUs so palpable, that these factors overwhelm much of the ambivalence one might otherwise feel about many harm reduction interventions. Those who have witnessed the ravages of AIDS are understandably impatient with moralizing objections to such programs.

SEP interventions are also quite cheap. Many of these programs cost on the order of \$10 per day for each participants. If one were distributing peanut butter sandwiches, it wouldn't be much cheaper. If SEP is any help at all, it is well worth doing.

SEP has the further advantage that users value clean, sharp free needles. SEP requires modest behavior change. The HIV virus is inefficiently transmitted. Rather small changes in individual risk are thus amplified to produce large reductions in population HIV prevalence.

In all of these respects, the arguments for SEP as HIV prevention are more compelling than those available for most prevention interventions that serve high-risk populations. Individuals—including SEP clients—appear markedly less enthusiastic about reliable use of condoms than about the use of clean needles to reduce sexual risk. People understand the need, but safer sex is less eagerly embraced.(39)

Syringe exchange's success in HIV prevention have not been replicated in addressing the more difficult challenge of hepatitis C. It remains unclear that SEP effectively protects IDUs against this disease.(40-43) Similarly problematic data have been reported for methadone maintenance. (42, 44-49) Some approaches, such as safer injecting rooms, may succeed at this, though these are even less politically feasible than SEP in the United States.

The current challenge of overdose prevention illustrates more complicated challenges to harm reduction interventions. U.S. opiate OD deaths have more than doubled since 1990. In

Chicago, opiate OD now rivals auto accidents as a source of death among working-age adults. In calendar year 2006, more than 300 fatal overdoses occurred from the drug fentanyl alone.

In response to rising OD fatalities, Chicago's largest SEP now distributes Naloxone to injection drug users. This complex intervention requires IDUs to shoot up with suitably trained peers. The intervention requires rescue breathing. It requires people to call 911 and not, at the margin, to try to handle medical emergency alone.(50) Although the intervention is promising

Fentanyl also underscores the voluntary nature of SEP as a harm reduction intervention. Just as epidemiology sometimes justifies quarantine, a harm reduction perspective sometimes justifies coercive interventions. Only seven fentanyl overdose fatalities occurred in Chicago during the first quarter of 2007. Much of this decline appears to have resulted from aggressive law enforcement efforts against particular illicit drug distributors who added fentanyl to their products.

The cultural politics of harm reduction

As noted above, the U.S. government does not fund syringe exchanges, although some states and localities do. The 1988 Helms Amendment forbids federal funding unless the Secretary of Health and Human Services certifies that SEP prevents HIV infection, and that SEP does not encourage increased drug use.

The first of these condition is widely accepted. The impacts of SEP on surrounding communities are difficult to measure. Citizens' diffuse anxieties on such matters are thus harder to address. SEP seems to have little positive or negative measurable impact on community drug use. For clients, SEP is associated with somewhat decreased frequency of drug use and modestly increased treatment entry.(51, 52) If heroin demand were strongly influenced by supply of sterile needles, we would expect large syringe black markets. We would expect bundling of sterile

syringes with street heroin. We do see black markets, but not on any significant scale. Researchers have published little specific evidence on these points.

It is hard to refute generalized concerns that SEP enables drug use. Fear is a powerful motivator to reduce risk. “Treatment optimism” regarding Highly Active Antiretroviral Therapy (HAART) may fuel increased sexual risk.⁽⁵³⁾ It is reasonable to ask similar questions about SEP.

SEP advocates tried to address these concerns from a self-consciously empirical “public health” perspective, trying hard to sidestep ideological disputes.

These attempts to bracket controversy might once have worked. Partisan debate has become so entrenched one might not realize that SEP almost escaped becoming a front in the culture wars. During the first Bush presidency, HHS Secretary Louis Sullivan quietly expressed interest in syringe exchanges. He did not support federal funding, but was curious and supportive of local efforts. He invited researchers to seek federal grants. He commented, "I don't subscribe to the view that needle exchange condones drug use."

Sullivan lost an internal debate to social conservatives.⁽⁵⁴⁾ Drug czar William Bennett, a more energetic and emphatic figure, emphasized the symbolism of giving needles to drug users. Bennett dismissed SEP's role in HIV prevention before any pertinent research was done. He made similar arguments against methadone maintenance and other prevention approaches.

Once Bennett placed SEP on the front burner in cultural politics, Republicans and moderate Democrats felt constrained to follow. Ironically, Dr. Sullivan now supports SEP—placing him to the left of President Clinton. ⁽⁵⁵⁾ Clinton's medical and public health leaders favored SEP. They were thwarted by another drug-czar, Barry McCaffrey, who convinced Clinton to back off. ⁽³⁴⁾

More interesting and troubling was the opposition from minority communities most affected by injection drug use. David Dinkins, New York's first African-American mayor, dismantled New York's nascent SEP upon his election as Mayor. Harlem Congressman Charles Rangel emerged as

an especially damaging opponent of SEP. (27, 56, 57) He instigated a General Accounting Office report on SEP—a report he subsequently disowned when it supported the intervention.(30, 58)

One might argue that Rangel and others acted badly. People with reason to know better allowed class, the general stigma surrounding AIDS, drug use, and homosexuality, to marginalize HIV-infected persons within their own communities. So they did. Yet it's ungenerous to apply retrospective judgments spotlight AIDS while blurring related social ills.

For years, leaders such as Dinkins and Rangel tried in vein to marshal resources to address a long list of drug-related problems in their communities. SEP accomplished conspicuously little to address many problems on that list; nor was SEP presented as an effort to address these difficulties. When people worry about drug-related child abuse, or about whether a loved one will be robbed by heroin users, it is unsurprising that they provide tepid support for SEP. One article described the cool reception with which communities of color greeted harm reduction problem with the statement: “There's a fire in my house and you're telling me to rearrange my furniture?”(59)

The public health community was a distant presence, and thus had earned little credibility in places at greatest HIV risk.(60) Community-based approaches, as currently conceived, were in infancy. Dissemination of basic information about condoms remained controversial. NGOs and some local health departments provided frank messages to men having sex with men, injection drug users, and commercial sex workers. These efforts largely occurred outside public view, often through groups such as Gay Men’s Health Crisis whose very names offended millions of people.

New York Police Commissioner Benjamin Ward, another African-American leader, compared SEP to the Tuskegee experiments. As detailed by Amy Fairchild and Ronald Bayer, the inflammatory analogy was misplaced. “Whereas in Tuskegee [researchers] used the social circumstances of poor African-American men to manipulate them into a study that would deprive

them of treatment, proposals to provide sterile injecting equipment seek to address the vulnerable situation of those exposed to HIV by offering a potentially life-saving intervention.”(36)

Analogies to Tuskegee, whether or not they were justified, resonated with deep community grievances. When drug treatment is inaccessible, when streets are unsafe, when drug users and sellers face few opportunities for legitimate employment, the offer a sterile needle becomes a powerful symbol of neglect. Representative Rangel commented, “I cannot condone my government telling communities ravaged by the twin epidemics of drugs and AIDS that clean needles are the best we can do.” Rangel went on to note:

I believe government has an obligation to do more than just help people use illegal drugs more safely.... [C]ontinuing debate over needle exchange programs only diverts us from the real issue...expanding our capacity to get drug users into effective, comprehensive treatment.(27)

Compounding these difficulties, existing HIV advocacy groups were dominated by middle-class professionals, often gay white men. Social, economic, and professional distance, along with differences in personal experience and culture, created clear obstacles to coalition-building.(56)

Under the best circumstances, SEP advocates faced a difficult job. They needed to explain why citizens should support unpalatable interventions. They needed to fight a generalized pessimistic sense that drug users can't protect themselves or change their behavior. They faced real anger directed towards drug users, an anger both understandable and leavened with misimpressions.

Faced with such unsettling opposition, advocates for harm reduction measures are tempted to provide a technocratic response: One can cite the cost-benefit studies. One can cite dozens of studies, saying quite truthfully, “Whatever your beliefs about drug use, your community is safer and more prosperous when we slow a dangerous (and by the way costly) disease.” Over a long period, such clear and consistent scientific findings influence public debate and likely influence public policy. These findings provided justification and cover for officials in different presidential administrations to embrace harm reduction arguments.(35)

Despite these beneficial effects, the overall political impact of harm reduction research is disappointingly small. This attenuated political impact frustrates public health advocates and researchers, but reflects two inherent constraints imposed on policy analysis in democratic societies. First, the key harm reduction debates concern morality and politics rather than the impact, effectiveness, or cost of specific programs. Drug dependence, like its stigmatized cousin welfare dependence, is not a technical problem to be managed. At least it is not only that. Scientific findings and specific program evaluations cannot directly resolve these moral and political disputes, though one hopes that empirical studies can discipline public discourse.

Second, public health researchers and practitioners bring their own moral and political commitments to these same debates. Demands for political authority based upon dispassionate expertise are always contested and are often ripe for deconstruction. These demands ring especially hollow in HIV prevention, where most researchers' policy views are fairly transparent and stem from basic commitments to protect life and health among those facing greatest HIV risk. Gliding over, or "bracketing," moral questions surrounding drug use and stigmatized sexual behaviors is thus unlikely to prove politically successful.

Ironically, efforts to take refuge in technocratic arguments lead harm reductionists to avoid their most compelling arguments. By openly engaging public misgivings, supporters can write a more persuasive brief, one rooted in the humanity of drug users. In making these arguments, advocates and researchers should acknowledge practical shortcomings of many interventions. Harm reduction proponents are often tempted to support such interventions in messianic fashion. As exemplified by filter cigarettes, particular harm reduction approaches don't always work. If specific strategies to provide sterile syringes prove ineffective or harmful, these strategies must be improved. The relative merits, for example, of street-based, center-based, and pharmacy-based approaches to syringe provision remains under-explored.

Some SEP critics present pragmatic claims about program effectiveness. However, the most powerful argument is broader, though equally utilitarian. Stripped bare, it goes something like this:

Injection drug use is destructive and wrong. Maybe exchanges "work" in preventing AIDS. That's the problem. Fear and stigma deter people from drug use. We oppose SEP because it would, by reducing the fear and the stigma, ultimately create more harm than it prevents.

Critics then add a second argument. Policies and interventions have stated goals. Their methods and procedures are also a powerful expression of social values, expectations, intentions, and priorities. When methadone clinics queue clients at sunrise for perfunctory conversation and a monitored gulp of medicated Kool-Aid, when welfare applicants are fingerprinted, these organizations send a different message from what one would if these services were dispensed in more respectful ways. We express our values by what we do, and by how we do it. A myriad of commentators note the importance of such "mixed messages." Yet with the exception of Robert MacCoun, (61) few researchers have examined how these messages are sent or how policymakers should weigh such messages in behavioral interventions.

Syringe exchanges can certainly send disturbing messages. Imagine a storefront in which staff members linger behind plexiglass shields, glancing up to wordlessly provide a pack of syringes before turning back to the newspaper. This intervention is better than nothing. After all, users would get their clean needles. Yet many citizens would recoil from such an intervention. Important things would be left unsaid. Key help would not be offered.

Some interventions send sufficiently disturbing messages that a reasonable person might oppose them, even if these were otherwise justified in harm reduction terms. Consider the following:

Psychologist Jane Smith designs virtual reality interventions for pedophiles. She argues that offenders need an immediate harmless way to discharge compulsive behavior. Her team designs a realistic videogame that allows adults to engage in simulated sexual acts with children. The game is played in the privacy of one's home. No real photographs are used. The game's appeal is heightened by player fan clubs and discussion groups. Randomized trials indicate that the game reduces child molesting by 10 percent and reduces possession of

illegal child pornography by 20 percent among known offenders ($p < 0.001$). Buoyed by this success, Dr. Smith develops a second game that allows men to don virtual reality suits to realistically simulate domestic violence. The most popular scenario involves punching and kicking a pregnant, 25-year-old woman. Dr. Smith seeks federal funding to distribute her child sexual offense intervention. If randomized trials indicate that the second game reduces domestic violence, she will seek federal funding to distribute this, as well.

Most of us would have mixed emotions about her grant application. We care about the randomized trial. Yet the coefficients and p-values are not determinative. We might ask who would have access to these games, how the games are supervised and promoted, whether there are less coarsening alternatives to this game. Most citizens, not merely social conservatives, bring a moralized dimension to their policy views.

Robert MacCoun recently surveyed Berkeley students—possibly the ultimate liberal sample. These students strongly favored marijuana decriminalization and syringe exchange.⁽⁶²⁾ They strongly opposed proposed harm reduction responses to practices they viewed as deeply immoral, such as female genital mutilation. It's not obvious that they are wrong.

Benign pornography for pedophiles might provide useful alternatives to incarceration, but there is no moral urgency to providing these products. We would just as happily imprison pedophiles if this were marginally more effective in protecting children. Pedophiles suffer when they are sent to jail. Yet the punishment is justified and rooted in the specific crime. Heroin users might deserve punishment for specific crimes or for a more general pattern of behavior that runs a predictable risk of causing social harm. They do not deserve to get AIDS, even if they might deserve other punishments, even if their recklessness contributes to their own ills.

It can be hard to make such moral arguments for harm reduction against the backdrop of the drug war—a war that easily morphs into war against drug users and sellers. This martial metaphor is generally misplaced, but in one respect the metaphor is apt. In war, combatants are tempted to do bad things. Philosophers distinguish arguments about when war itself can be justly fought (*jus ad*

bellum) from arguments about how one may behave in fighting such wars (*jus in bello*). This is a useful distinction for drug policy.

If a drug war should be waged, it should be honorably prosecuted to respect the common humanity of all affected people. In a just war, one is entitled to kill enemy soldiers, not to mistreat third-parties or to employ disproportionately destructive or deliberately cruel tactics. Common arguments against syringe exchange, in failing to acknowledge drug users (and their partners and children) as people worthy of concern, violate these principles.

To illustrate why, I will again note an R-rated analogy, to prison rape. Our light-hearted national reaction to this widespread problem was exemplified by comedian Andy Borowitz's *Who Moved My Soap? The CEO's Guide to Surviving in Prison*. Comedic 7-Up advertisements mined similar seams of humor, until they were removed from the airwaves following viewer complaints. Prevention efforts such as *Scared Straight* provided blunt warning to teenagers that they will meet a nasty cellmate if they don't shape up.

Many of these rapes could can be prevented through effective administration.(63) Yet prison rape is not a top-drawer issue to citizens or policymakers. Our lethargic national reaction reflects specific management failures. It also reflects widespread, though unstated views. If crooked accountants are deterred by what might happen to them in prison, it's only human to be a little less concerned than we know we should be.

Public apathy reflects the revulsion most citizens feel towards people who have committed crimes—revulsion that lessens our sense of urgency in addressing their essential concerns. Prison rape also reveals the thin line between omission and commission in public policy. We would not flood the market with poisoned heroin. Yet when we say that SEP might encourage continued drug use, we use fear of a deadly disease (and secondary infections to others) to serve our purposes.

In suppressing otherwise feasible prevention efforts, we no more directly kill people than a prison warden commits rape. Drug users, some anyway, do it to themselves. Yet continued HIV infection is an intended consequence of what we do. We use HIV-infected people as stage extras in our own morality play about the evils of drug use.

Conclusion

I draw six main lessons from the harm reduction debate.

First, syringe exchange for HIV prevention is a powerful, but probably unique case. Perhaps its most useful lesson is that harm reduction are actually possible. Active drug users have protected themselves with the help of prevention interventions.

Second, effective and politically credible drug control policies include both use reduction and harm reduction elements. Use reduction is required because one cannot gain a hearing in American drug policy without acknowledging the deep harms associated with continued drug use. Moreover, drug use brings many harms one cannot otherwise prevent. Harm reduction is equally essential, because the human costs of extreme prohibitionist policies are unacceptably high, and because drug users face many serious and avoidable threats to their well-being.(8)

Third, harm reduction occurs within the continuum of health and social service interventions for substance users. Harm reduction is not confined to a separate channel of services for those otherwise out of care. Services such as SEP provide outreach and referrals for other interventions. Meanwhile, best-practice substance abuse treatment therefore includes harm reduction elements such as instruction in safer injecting and education regarding detoxification and overdose risk.

Fourth, harm reduction interventions are most politically credible when they also serve use reduction goals. By engaging street users in a system of care, these interventions make possible subsequent interventions that might halt or reduce clients' drug use. As Albert Hirschman notes, not

all unintended consequences of controversial policies are unfavorable.(64) SEP's potential within a wider continuum of care make this intervention more beneficial than its original supporters foresaw or citizens currently understand.

Fifth, harm reduction interventions merit the same scrutiny and evaluation as other interventions. Much of the SEP debate concerns the basic propriety of providing sterile syringes to drug users. Current laws which restrict federal funding for SEP interventions limit opportunities for direct practice research. A great silence in the literature concerns best-practice and implementation, how these efforts can be implemented to best effect.

Sixth, one cannot seek refuge in expertise to avoid the moral dimension of public policy. Expertise cannot replace political and moral debate. Critics on the left have long feared the “hidden politics” of policy analysis in reinforcing the interests and ideology of established stakeholders.(65) These fears are far from realized in the arena of HIV prevention. Researchers' political preferences are not hidden; nor are research findings, or researchers, very influential in setting federal policy.

If we value democratic deliberation, we should embrace public discussion of the moral dimensions of HIV prevention and substance misuse. There is no guarantee that public deliberation will produce humane choices. There is also no guarantee that current coalitions would remain intact in other domains of HIV politics and public health. Scientific findings do not bring transparent political implications, and are not reliably congenial to any specific constituency. In key areas of HIV prevention, public health science and most public health scientists now align with left-of-center activists and civil libertarians. On other issues—perhaps named reporting of HIV-infected persons or aggressive HIV testing of pregnant women—current allies may diverge.

Even if such disagreements emerge, harm reductionists have a good story, rooted in both science and in shared public values. Does offering clean needles to heroin users send ambivalent messages? It does, because drug policy occurs in an unavoidably ambivalent domain of public

action, and because mixed messages are better than bluntly cruel ones. One message we send is a presumption for life, a willingness to act to prevent deadly disease.

Fifteen years ago, harm reduction advocates could not provide sufficient cover for potential allies. Objections to SEP were readily predictable, but hard to address. There was too little time for community outreach and coalition-building. While HIV was rapidly spreading among injection drug users, syringe exchange became a front in the culture wars. Moderates and conservatives found no safe place to embrace or tolerate such interventions. Communities of color, where most new infections occur, were not ready to address painful issues involving homosexuality and drug use.

Public sentiment is now more favorable. The limited polling data that exist suggest that citizens do not see stark tradeoffs between use reduction and harm reduction, and regard both as legitimate policy goals.(62) Given evidence that SEP can be helpful in referring drug users into treatment,(66) advocates have opportunities to implement and to explain such interventions to earn support from a broad range of constituencies. In a 1997 survey, a narrow majority of Americans supported SEP, once they were informed that the American Medical Association endorses it.(67) The Congressional Black Caucus is now a strong ally, as are leading Democratic Presidential candidates. California's Republican Governor Arnold Schwarzenegger signed a bill allowing pharmacies to sell syringes without prescription. The Governor cited research indicating that SEP "significantly decreased HIV and HCV, but did not increase drug use or crime rates."(68)

Drug users are part of our community. Some deserve to be jailed or to have their cars impounded. They do not deserve multiple cancers, bacterial infections that score through their retinas, or debilitating side-effects from anti-retroviral medications. As MacCoun and Reuter put it, *we must defend the propriety of helping drug users*. Drug users--despite many ways in which they conspire in their own misfortune--require protection against devastating threats to life and well-being. That is not terribly sophisticated, but it is enough.

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