

To Build a Bridge: The Use of Foreign Models by Domestic Critics of U.S. Drug Policy

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FROM THE BEGINNING OF THE U.S. POLICY DEBATE over narcotics control, drug use has been perceived as a significant domestic problem linked inextricably to international commerce. To gain influence over that traffic, the United States initiated the Shanghai Commission of 1909, the first multinational conference on the opium trade. Three years later, the U.S.-inspired Hague Opium Conference met to reconsider the possibility of controlling international commerce in drugs (Musto 1987). The conference, in its final convention, proposed that each signatory agree to strong domestic controls over the production and use of narcotics and cocaine (Musto 1987). Since those meetings, the United States has often used international conferences and agencies to attempt to police cross-national drug traffic, an important adjunct to its internal policy of narcotics prohibition and enforced drug abstinence.

Despite its involvement in international conferences and its recognition of the cross-national existence of drugs, drug traffic, and addiction, the U.S. government has shown almost no interest in how other countries treat their domestic drug problems. This is all the more remarkable when one considers that the United States has failed repeatedly to achieve the stated aims of its internal narcotics policy. Instead, it has been domestic critics of American policy who have historically looked to

other nations for answers to the U.S. drug problem. Why have they done so?

For domestic critics of U.S. narcotics policy, foreign models have served three related purposes. First, critics searching for alternatives to current policy have rarely been able to find them within the United States. Because the federal government has played such a dominant role in crafting drug policy and because it has supported a powerful, often intolerant, prohibitionist ideology, there have been few relevant social experiments, even at the state or local level. (By contrast, a problem like health care financing has generated a plethora of private and public initiatives.) Although critics could perhaps extract some few examples from the American past, the narcotics clinics of 1919–1923 specifically, foreign models proved richer in detail and experience.

Secondly, by introducing foreign models into political discourse on drug policy, domestic critics forced comparisons. Americans tended to see U.S. narcotics policy as standard, if not universal. Placing that policy into an international context, critics insisted on its “relativity” and on the empirical need to weigh the efficacy and efficiency of the American system against that of other nations. When critics found that foreign models performed better on selected measures, these data were used to support arguments for changes in U.S. policy. In sum, American critics used comparative studies to weaken U.S. ethnocentrism and to open the policy process to alternative approaches.

Finally, foreign models served as vehicles for the expression of political, moral, or ideological positions. The analysis of and elaboration upon foreign systems provided a social text from which arguments against the U.S. system or for reform could be mustered. Foreign models were appropriated as field experiments that validated one’s particular stance in American policy debates (Klein 1991). Those who used foreign experience in this manner were often guilty of “selective perception” (Klein 1991, 4), focusing on those dimensions of a multidimensional policy that best suited their needs.

In this essay, I will examine two periods in which American critics successfully introduced discussion of foreign models into the domestic discourse over drug policy. In the process, the foreign models came to represent important alternatives to contemporary U.S. approaches to drugs, narcotics in particular. During the first period, the post-World War II era, from the late 1940s to the early 1970s, critics suggested the possibility of adopting a British-style solution to the U.S. drug crisis.

During the second period, beginning in the mid-1980s, domestic policy critics found in Holland a response appropriate to drug use during the human immunodeficiency virus (HIV) pandemic.

Background: U.S. Narcotics Policy

In the postwar period, American critics attracted to British policy governing addiction wrote against a background of profound pessimism about the U.S. approach, seeing in the former a striking success, in contrast to domestic failure. As Edwin Schur, a sociologist who would emerge as a forceful proponent of the British system observed:

American efforts at controlling traffic in illicit drugs, as well as the various attempts to treat the addict, have not produced the desired results. Many large drug importers continue to evade enforcement officials; the number of addicts in this country is alarmingly high, and seems by many estimates to be increasing. . . . These discouraging facts might lead us to accept addiction as a permanent feature of our society. Yet another Western Country—Great Britain—reports a very small number of addicts and almost no market in illegal drugs. Why does this difference exist? (Schur 1962, 66)

The U.S. narcotics policy, the baleful effects of which Edwin Schur described, was quite different from that of Britain's. Central to the American policy is the 1914 Harrison Act, passed in part to comply with U.S. obligations under the Hague Opium Convention. The act required that physicians, dentists, pharmacists, and other "legitimate" drug handlers register with the Treasury Department, pay an annual tax, and maintain appropriate records. The implicit aims of the Harrison Act were disputed at the time of its enactment, and the dispute has continued (Musto 1987; Trebach 1982). Ultimately, the most important arbiter of the law's meaning was the Treasury Department's Bureau of Internal Revenue, administrator of the act, which held that, under the new legislation, the federal government could restrict physicians and pharmacists from dispensing narcotics for other than, in the words of the law, "legitimate medical purposes" (Terry and Pellens 1974, 984).

What that phrase denoted led to further disputes. Some, including physicians, believed that addiction was a disease and that drug maintenance therapy to prevent withdrawal symptoms constituted appropriate

treatment (Musto 1987). For a brief moment, between 1919 and 1920, the Treasury Department, fearing that addicts deprived of narcotics could threaten the public order, joined with maintenance forces to support public clinics where poor addicts might be prescribed narcotics (Lindesmith 1965; Musto 1987). Otherwise, the department supported elite medical, legal, and social groups opposed to therapeutic maintenance, arguing that it fed the vice of degenerate individuals while enriching dishonest doctors (Bayer 1976; Musto 1987). These groups held that appropriate medical therapy consisted of drug detoxification within an institutional setting where an addict could be treated for withdrawal, isolated from narcotics, and assisted in remaining abstinent.

Unfortunately, the cure of addiction remained elusive, and relapse rates were high (Musto 1987). Belief in cure for addicted persons began to diminish by 1920 and disappeared almost entirely by 1930 (Musto 1987). Presciently, the Public Health Service concluded in 1918 that all approaches that weaned addicts away from drugs were equally good; the answer to narcotics abstinence lay less in medicine, which could do very little, than in law enforcement (Musto 1987). Soon after the passage of the Harrison Act, therefore, "narcotic users were treated almost exclusively as criminals. . . . If the addict was to change, such change was to occur from behind prison bars, the principal agency of rehabilitation being punishment" (Bayer 1976, 76).

Consequently, the number of narcotics-associated prosecutions rose during the 1920s. The point prevalence of narcotic law violators in three federal penitentiaries on April 1, 1928 was approximately 30 percent (Musto 1987). The proportion in state and local prisons was also high, particularly with adoption by the states of the Uniform Narcotics Law in 1932, after which state laws tended to be patterned on, and to follow the trends in, federal narcotics legislation (King 1972).

This early trend toward a uniformly restrictive and punitive national narcotics policy was accelerated after World War II. An upsurge in heroin use spurred the passage of new, draconian federal laws—the Boggs Act of 1951 and the Narcotics Control Act of 1956—followed by similarly harsh state legislation. These laws significantly hiked minimum sentences and almost completely eliminated parole for those found guilty of selling or possessing narcotics (King 1972). In many states the status of addiction became unlawful (Lindesmith 1965). Yet such coercive measures in support of a prohibitionist narcotics policy failed, as

had earlier legislation with the same aims (Bayer 1976). They neither stemmed the rise in heroin use nor checked public fears, which at times during the 1960s approached panic levels.

Compounding the inefficacy of draconian legislation was the burden it placed on the criminal justice system, threatening to overwhelm courts and prisons (Bayer 1976). When, subsequently, a movement emerged in the 1950s against the failed policy of rigid, punitive law enforcement, it had two critical components: the medicalization of addiction and the creation of alternative mechanisms to free overburdened agencies of law enforcement (Bayer 1976).

Any reform had to face multiple barriers, not least an ideology that tended to be as rigid and inclusive as the policy itself. That ideology, which treated the addict as an insidious "other," had powerful racist and xenophobic roots, and contained a strong prohibitionism, which held that drugs led to immorality and, in the worst instances, to insanity (Musto 1987; Trebach 1982). Such elements—immorality, the dangerous outsider—came together in the association between addiction and crime. By the 1920s it was dogma, supported by federal authority, that addicts were thieves and thugs who took drugs (Anslinger and Tompkins 1953). During the 1950s and 1960s most urban crime was falsely attributed to addicts (Bayer 1976).

In brief, from 1914 through the early 1960s, narcotics, heroin in particular, were demonized, and drug users were caricatured to the point of dehumanization. Because their depredations were perceived as willful, however, addicts bore moral and legal responsibility for their acts. As a consequence, society was within its rights to prosecute addicts forcefully until they chose to give up addiction and drugs (a source of moral disorder and pathology). Legal repression was required to save "civilized society" (Bayer 1976, 3).

Nevertheless, during the 1960s, American policy broadened to include a therapeutic response to addiction. Supporters of that response were medical professionals, jurists, and politicians who believed a purely punitive approach had failed (or was undermining the judicial system), and urban residents who feared the spread of heroin into the middle class. Although many supporters of a therapeutic response continued to caricature addicts as dangerous deviants and heroin as a "demon's brew," they also argued that heroin addicts suffered from a chronic disease that was largely the outgrowth of psychosocial stressors beyond their con-

scious control (Bayer 1976). Most addicts, therefore, were not responsible for their condition, and consequently should not be subject to legal sanctions.

Yet many who supported a therapeutic response still held to a policy of abstinence, believing that, for the good of addicts and the social order, drug users required incarceration, albeit under medical auspices. Some public figures called for "maximum security hospitals," others for indefinite quarantine of chronic narcotics users (Bayer 1976; Gostin 1991). During the 1960s, state and national governments passed into law policies of civil commitment to, and compulsory treatment of addicts in, hospitals (Bayer 1976). When, in that decade, alternatives to prolonged hospitalization appeared—therapeutic communities and methadone maintenance clinics specifically—addicts were often "benevolently forced" into treatment by the diversion programs of the criminal justice system or by the threatened denial of public welfare payments (Bayer 1976). The existence of such compulsory, closed ward, or even outpatient care serves to underscore the continuation of a morally coercive policy in the United States—of penal incarceration by other means for many addicts. In the words of Alfred Lindesmith, the leading critic of U.S. drug policy, these programs of control offered liberals "a gesture toward a new and more humanitarian approach and a new vocabulary for old practices" (Lindesmith 1965).

Lindesmith was an important spokesperson for those who held the most appropriate therapeutic response to addiction was not mandatory abstinence, but rather narcotics maintenance. In his writings he reconstructed the history of the U.S. narcotics clinics of the 1920s, positing that they demonstrated the viability of maintenance therapy (Lindesmith 1965). His main arguments, however, rested upon his reading of the British experience; his ideal was to adopt a policy comparable to one Britain had evolved.

The British Approach

Prior to 1920, narcotics were freely available without prescription in Britain (Schur 1962). Parliament that year passed the Dangerous Drugs Act, which, like the Harrison Act, was in partial fulfillment of the Hague Convention of 1912. The act stringently restricted Britain's international commerce in narcotics and regulated their manufacture. Fur-

ther, it limited to physicians the right to dispense narcotics, specifying, much like the Harrison Act, that a doctor could do so "only as necessary for the practice of his profession" (Judson 1975). To clarify the meaning of that phrase, the Home Office, administrator of the new law, asked the Ministry of Health for an expert opinion of what constituted appropriate medical practice in this area. In response, the ministry convened a special investigatory committee of physicians under Sir Humphrey Rolleston, president of the Royal College of Physicians.

The Rolleston Committee, in its final report of 1926, developed a number of definitions and observations that deeply influenced British narcotics policy and radically distinguished it from U.S. policy. The committee concluded that narcotics addiction was not a vice but a disease, one in which drugs "relieve a morbid and overpowering craving" (Trebach 1982, 93). Unfortunately, the committee found that medical practice infrequently produced permanent cures. Therefore, while urging physicians to treat their patients strenuously in order to free them of addiction, the committee recognized also that some patients required indefinite maintenance on narcotics: "those in whom a complete withdrawal of morphine or heroin produces serious symptoms which cannot be treated satisfactorily under the ordinary conditions of private practice [and] those who are capable of leading a fairly normal and useful life so long as they take a certain quantity, usually small, of their drug of addiction, but not otherwise" (Trebach 1982, 94). The precise clinical needs of each addict should, however, be determined only by his or her physician, possibly in consultation with a specialist.

The Rolleston Committee did not so much create a new system to treat narcotics addiction as "simply codify the best of the common law of medical practice" (Trebach 1982, 90). A conservative body, the committee maintained what it felt was realistic therapy for drug-addicted patients. Yet the committee could afford to act compassionately because the problem of narcotics addiction was rare in Great Britain (Judson 1975). When the first government figures were compiled in 1936, they showed 616 known addicts, a number that declined thereafter, reaching 290 in 1953 (Spear 1969); in the United States, when the Harrison Act was passed and interpreted, estimates of the number of addicts ranged from a million to 110,000 (Musto 1987).

In 1958, after the number of addicts began to rise in Britain, the government empanelled a new medical commission headed by Sir Russell Brain. The Brain Commission, in its second report, issued in 1965,

noted a relatively sharp rise in narcotics use associated with a new type of addict. Whereas in the past addicts had largely been medical professionals or persons addicted in the course of medical treatment, there was now a growing number of younger, urban, "deviant" addicts who came to drugs through a black market. Because that market was supposedly linked to irresponsible prescribing practices of some private physicians, the committee recommended that only specialists working in drug-dependence clinics dispense narcotics to addicts, recommendations that passed into law in 1967. Despite these changes, addicts in Britain were treated, as before, as sick people with access to narcotics maintenance.

In contrast to the United States, therefore, the British neither demonized narcotics nor dehumanized the addict. Heroin and morphine remained therapeutic agents with powerful addictive properties, not sources of social and personal disorder. Regardless of how they came to be addicted, addicts were persons with a chronic disease who required medical care. Their responsibilities lay in seeking medical help and in attempting cure, that is, abstinence from drugs. Where that was impossible, they were expected to live as productively as possible, given their deficit.

Narcotics Maintenance Reform and the British Model

U.S. reformers in the 1950s and early 1960s who supported the British narcotics maintenance model might have found historical precedent in this country, particularly in the narcotics clinics of the early 1920s. Such clinics were of little practical interest to them, however; no contemporary country used a clinic system to treat its addicts (Lindesmith 1965). Instead, to define policy alternatives, the reformers looked abroad, using a comparative approach. Edwin Schur, for example, in the preface to *Narcotic Addiction in Britain and America*, wrote: "My purpose in this book is to indicate, more fully than has been done elsewhere, what the British approach to addiction is, how it works in practice, and whether it might be applicable to the drug problem in America" (Schur 1962).

A major reason U.S. domestic critics undertook comparative studies was to bolster their position at home. In studying policy in Britain and other countries, Lindesmith, Schur, Rufus King, and other reformers

hoped to disabuse Americans of their ethnocentric assumptions about the possibility of narcotic maintenance, arguing that the contrary was true: narcotics maintenance therapy was normative in many Western nations—and it led, cost effectively, to policy success.

Because they produced the most articulate and comprehensive arguments for the maintenance approach, the work of Alfred Lindesmith and Edwin Schur will be the central focus of this discussion. In addition, I will examine perhaps the most important instance of an effort to give institutional life to the maintenance position, the Vera Institute's proposal for a narcotics maintenance clinic in New York City.

In his books, *Opiate Addiction* (1947) and *The Addict and the Law* (1965), as well as numerous articles in journals of political opinion, Alfred Lindesmith trenchantly analyzed what he saw as shortfalls in American addiction policy. He sought alternative ways of framing the addiction problem and its solution. Like Schur and other supporters of narcotics maintenance, he was attracted to Britain's medical approach to addiction.

Lindesmith argued that addiction was essentially a physiological and cognitive process over which the individual had no willful control. Regardless of the original reason for coming to narcotics, the moment of "conversion" was universal: once a person recognized that his or her withdrawal symptoms were due to the absence of drugs, that person was "hooked," with little chance for permanent cure.

For Lindesmith, U.S. policy following the Harrison Act had failed in its objectives because it contradicted the physiological fact of addiction. Instead, that policy had produced undesirable, even dangerous, outcomes. These included a primitive, inhumane treatment of addicts, the development of an addict subculture that reenforced addictive behavior, an illicit traffic in needlessly expensive drugs, and a subsequent surge in urban crime. From these followed an escalation in the size of police agencies, police corruption, and the erosion of civil liberties in the service of drug eradication. Ultimately, American policy produced chaos: having criminalized a disease and driven the diseased underground, the United States had lost the capacity to control either narcotics or the addict.

Instead of perpetuating this ruinous policy, Americans, Lindesmith argued, should craft an alternative approach that conformed to the physiological requirements of addicts. The United States could find that alternative in Europe, where virtually all countries treated addicts as pa-

tients under the care of physicians (Lindesmith 1947). Instead of cruelly caricaturing addicts as moral monsters or social deviants, these nations defined them as patients with a debilitating disease. The exemplar of this approach was Britain, the model for most other countries (Lindesmith 1965).

The British program, Lindesmith held, had multiple advantages over the American model. The drug-dependent individual, under the treatment of a private physician, was free of the need to commit crime and the personal disgrace associated with criminality. He or she was exploited neither by the pusher nor the police, and in fact could lead a decent private and public life. The distribution of narcotics through medical professionals controlled the amount of drugs used by addicts under treatment. It also reduced the need for an illicit traffic in narcotics; consequently, drugs were rarely available to unaddicted susceptibles in the population (Lindesmith 1965). This accounted for the low rate of addiction in Britain and other nations with comparable narcotics policies. Finally, the private nature of the patient-doctor relationship, by isolating the addict, did not foster the emergence of an addict subculture, which might draw both "susceptibles" and illicit drugs.

Lindesmith bolstered his position in favor of a British-style system through a series of cross-national comparisons. Using United Nations documents, for example, he showed that, in each of 13 Western countries that permitted narcotic maintenance, the estimated number of addicts was exceedingly low. More interesting, perhaps, was his use of a "migratory study," the experiences of 50 expatriated Canadian addicts in London. In Canada, whose narcotics policies were comparable to those of the United States, 80 percent of that group fit the description of criminal addicts: "Few of these patients had ever worked steadily, all had been dependent on an illicit supply of drugs and none had been normal, gainfully employed members of society" (Lindesmith 1965, 185). Once cared for by the British system, a majority of the 50 was rehabilitated. Nineteen, maintained on heroin, held regular employment, while 18 were reportedly drug free (a proportion left unexplained by Lindesmith, for whom permanent cure of addiction was rare).

Finally, Lindesmith relied on comparative analysis to argue that U.S. drug policy consistently produced destructive effects. The United States, according to Lindesmith, with hegemony over its allies during World War II and over Japan thereafter, insisted on exporting its antimaintenance policy into Asia. What followed with monotonous regularity was

the transformation in each country of a limited opium-smoking problem within the Chinese community into a broad-based narcotics problem involving heroin, morphine, and other manufactured opiates. Along with these drugs, new practices appeared in Hong Kong, Formosa, Thailand, Indonesia, and Japan: the increased use of hypodermic needles, the growth of drug traffic and organized crime, and the spread of addiction to young, impoverished urban males who acquired narcotics through underworld contacts (Lindesmith 1965). Having introduced the American punitive-prohibition system of narcotics control, the Far East suffered an Americanized drug problem. The countries that followed the British example experienced significantly different results from countries that chose the U.S. policy. Thus Lindesmith could write: "There is a close relationship between the type of [narcotics] control program used and the characteristics and origins of the addicted population" (Lindesmith 1965, 188).

Edwin Schur, like Alfred Lindesmith, had little patience with causal theories of addiction (explanations based on psychodynamic or deviance theories), arguing that no definitive, unbiased research existed to support them. Like Lindesmith, he stressed the central role of addiction policy, portraying it as the crucial intervening variable between the raw physical fact of addiction and the characteristics or behavior of a country's addicts. Through its social policy, each nation crafted its addict population; to change the latter, one had to transform the former. A comparative study of two countries—the United States and Great Britain, similar in so many ways—supported the crucial role of addiction policy.

"The content of behavior," wrote Schur, "is very largely determined by social definitions" (Schur 1962, 207). The United States had labeled addiction a crime and prohibited the use of drugs. Britain, following a nonpunitive course, had medicalized the problem. As a consequence, British addicts behaved differently from their American counterparts. In Britain, no strong correlation existed between addiction and criminal acts. With access to relatively inexpensive drugs, addicted individuals need not rob, burgle, or push narcotics, nor construct a protective subculture, to survive. Britain might well have had many individuals predisposed to addiction. However, because drugs were freely available, resulting in a dearth of illicit substances and the absence of an addict subculture, those susceptibles were precluded from readily obtaining drugs and, perhaps more important, from the opportunity of learning

how to use them. Certainly the effects of British policy served to contradict the American belief that narcotics maintenance could not curb addicts' criminality because addicts were never satisfied with a limited, legal dose.

British experience also contradicted American assumptions about who became an addict. In Britain, a large proportion of addicts were from the middle and upper classes, at least half were female, and most tended to be older rather than younger. In brief, British addicts were not from marginal or despised social groups or from the "dangerous classes." British policy, unlike American, did not produce addicts who were a threat to the social order. On a theoretical note, the cross-cultural differences between addicts undercut, according to Schur, much "scientific" discussion about universal psychological, or behavioral effects of opiates (Schur 1982, 115).

British policy worked; the U.S. policy did not and could not. Whenever a policy seeks to curtail the satisfaction of a strong demand, it encourages the development of a profit-oriented illicit market whose size and wealth creates a vested interest on the part of many for its survival. Alcohol and abortion prohibition were further examples of the failure of morally repressive laws. In Britain, where in contrast to its narcotics policy there were inadequate opportunities for legal abortions, illicit facilities existed that were similar to those in the United States. For Schur, policy was destiny.

Neither Schur nor Lindesmith expected the United States to adopt the British system in its entirety. According to Lindesmith:

What is suggested is that successful foreign programs, including the British, should be intensively studied and intelligently adapted to American needs and to the special conditions existing in this country. (Lindesmith 1965, 271)

Nonetheless, in broad outline, the proposals recommended were strikingly similar to the British approach. First, their programs would be under strict medical control. Addicts should, if possible, be treated by private physicians (not clinics, which would encourage the congregation of drug users and the social reinforcement of the drug subculture). Physicians should be able to tailor dosage to the needs of the patient and be permitted to maintain them on narcotics. Relatively few would be cured of drug addiction. Despite this therapeutic pessimism, however, the

proposed program would not rule out the possibility of abstinence. Lindesmith wrote that doctors should act as if maintenance therapy were a temporary expedient, keeping dosages as low as possible, while attempting to persuade their patients to undergo hospital-based detoxification (Lindesmith 1965).

Nevertheless, addicts should enter such programs voluntarily. Neither Lindesmith nor Schur held that most addicts should be coerced into treatment. On the one hand, mandatory therapy did not work. On the other, both reformers fervently believed that most addicts would use treatment if available:

Despite assertions to the contrary, there are very few addicts who do not desire to be freed of their habits. This is true also in countries where addiction is not a criminal matter. (Lindesmith 1965, 272)

Both reformers were interested in developing "humane and workable policies" (Schur 1962, 211). Humane policies and programs would make coercion and moral manipulation of most addicts superfluous. Their belief that coercion of addicts was generally unnecessary profoundly separated the reformers from most of their American contemporaries.

Lindesmith and Schur's advocacy of a narcotic maintenance approach based on the British example forced supporters of American prohibitionist policies to look abroad (or at least pretend to do so) in order to respond. Essentially four lines of argument were levied against the reformers. The first, used by the Federal Bureau of Narcotics (FBN) and its allies to discredit their opponents, was that the differences between the British and American systems were in fact spurious. The two systems were actually fairly similar—as they would be, given that both subscribed to the same international agreements (Harney 1960; Larimore and Brill 1960; Lindesmith 1965). The second rebutting argument was that the British system, far from being an efficacious alternative, had significant drug problems of its own. For example, Harry Anslinger, the U.S. Commissioner of Narcotics, wrote:

In England, the British government reports annually only 350 addicts known to authorities. . . . England during the past year has had a surge of hashish addiction among young people. A year ago they were looking at the United States with an "it can't happen here" attitude. (Anslinger and Tompkins 1953, 279)

His successor, Harry Giordano, made similar claims a decade later, as did others in the FBN (Harney 1960; Lindesmith 1965). The reformers, for their part, flatly rejected both arguments (Lindesmith 1965; Schur 1962).

In the remaining, more sophisticated rebuttals, the critics asserted that reformers had improperly reversed the causal associations between public policy and addiction rate and between addiction and crime. Opponents of narcotics maintenance argued that because Britain had always had a small number of drug abusers, it could support a maintenance approach, not the other way around. Larimore and Brill, for example, in a report to the governor of New York State, claimed that Britain, with a deep cultural abhorrence of narcotics, had few individuals in its population susceptible to narcotics addiction (Larimore and Brill 1960). Others attributed the relatively low rate of addiction less to susceptibility than to a far more efficient police and judicial system (Harney 1960).

Finally, those who criticized the reformers held that criminals became addicts, not the reverse. According to Harry Anslinger, in the United States, "the person is generally a criminal or on the road to criminality before he becomes addicted" (Anslinger and Tompkins 1953, 170). The absence of an addict-criminal "class" in Britain was a peculiarity of that country's culture and irrelevant to American policy.

To the extent that the British approach was a historical product of unique cultural and social conditions, how could it be transplanted successfully to another nation with a different set of historical experiences? The issue of "portability," raised by opponents of narcotic maintenance, was significant—and difficult to answer (Schur 1960, 1962). Lindesmith responded by denying the singularity of the British approach, claiming that other Western nations—the Netherlands and Argentina, for example—also had British-style systems (Lindesmith 1965). Schur, more tentative, asserted that the cultural relativists had produced no real arguments to support their claims (Schur 1962). For both sides, the issue, while powerful, remained academic, as it could not be solved empirically (except later, by analogy, using the methadone maintenance clinic experience).

In addition to these four arguments, opponents of the reformers, the federal authorities in particular, were not above shrill personal attacks on their critics. Commissioner Anslinger, when describing Alfred Lindesmith and others in a letter to the *Journal of the American Medical Association*, wrote:

Several years ago a professor of sociology at an American university who is a self-appointed expert on drug addiction, after interviewing a few drug addicts wrote an article in which he advocated that the United States adopt the British system of handling drug addicts. The professor followed the method used by dictators to "make it simple, say it often"; true or false the public will believe it. "Adopt the British system" is now urged by all self-appointed narcotics experts who conceal their ignorance of the problem by ostentation of seeming wisdom. (Anslinger 1954, 787)

Between the reformers like Lindesmith and Schur and their opponents, little substantive dialogue was possible. Each side represented alternative paradigms, with significantly different definitions of the addict, the roots of addiction, and the role of moral and legal coercion in rehabilitation. In appealing to foreign experience each side appropriated what it needed to support its claims, although the reformers appear to have done so with considerably more commitment to veracity and good faith.

In addition to individual reformers, prominent institutions also supported narcotics maintenance. During the early 1950s, both the Medical Society of Richmond County, in New York City, and the New York Academy of Medicine did so. More significantly, the Joint Committee on Narcotic Study of the American Medical Association and the American Bar Association, two organizations that had previously supported the prohibitionist policy, issued a report in 1959 recommending the creation of an experimental clinic to evaluate treatment protocols for narcotic addiction, drug maintenance among them. The report contained an appendix written by Rufus King, which praised narcotics maintenance policies in several European countries. Perhaps the most dramatic proposal, in that it came close to putting a limited heroin maintenance program into effect in the early 1970s, was that of the Vera Institute of Justice in New York City.

Up to that time, proposals for heroin maintenance had had little effect on policy. In fact, during the late 1960s, their thunder had been almost completely stolen by the successful proliferation of methadone clinics. Methadone, a synthetic narcotic, had been intensively studied between 1964 and 1966 by Vincent Dole and Marie Nyswander at Rockefeller University in New York. They found that patients, once "stabilized" on a sufficiently high dose of oral methadone, ceased to crave heroin and substantially attenuated their criminal behavior (Epstein

1974). Methadone maintenance was soon supported by municipal and state governments and, most crucially, by the federal authorities in Washington. It was, in fact, in the context of methadone maintenance that the Vera Institute proposed a new role for heroin maintenance.

A private foundation formed in 1961, the Vera Institute had created a number of innovative programs designed to reduce pressures on the criminal justice system (Bayer 1976; Robinson 1978). When, in the late 1960s and early 1970s, New York City committed itself to a large-scale program of methadone maintenance, it asked the Vera Institute to tailor a version for Bedford-Stuyvesant, a ghetto neighborhood with a high rate of addiction and associated crime (Robinson 1978). In 1971, even before the city's methadone program had expanded to the point of treatment on demand, the Vera Institute, with municipal support, embarked on a more radical venture: heroin maintenance to "lure" into treatment those hard-core addicts who had failed to stay in the program ("program failures") or who had rejected treatment in any form (Bayer 1976; Robinson 1978). In planning, the Vera Institute was influenced by the British approach to addiction, particularly the post-Brain Commission "clinic system," which the Institute "credit[ed] . . . with stabilizing the number of addicts at a level below that of 1968" (Judson 1975).

The final treatment model, as it emerged in a cautious proposal in May 1972, called for a research project consisting of 130 male methadone-maintenance "treatment failures"; they were to be maintained on heroin, dispensed intravenously in the clinic, for up to one year (the "lure period"). Over that time, bolstered by a range of rehabilitative services, addicts would establish a strong therapeutic bond with the clinic staff that would empower them to transfer from heroin maintenance to more orthodox forms of addiction treatment. Outcomes in addicts maintained on heroin would be compared with those of a control group composed of similar patients maintained from the beginning on oral methadone.

The Vera Institute's proposal found support among some high-ranking law enforcement officials in New York and many jurists, most of whom were concerned with lowering crime rates and reducing pressures on the overburdened criminal justice system (Bayer 1976). Among treatment professionals, the Vera proposal generated considerable debate; most professionals associated with therapeutic communities and the leadership of the methadone maintenance programs strongly opposed the heroin maintenance experiment (Bayer 1976). The black commu-

nity, with some exceptions, was hostile to the project, leveling charges against its proponents that ranged from genocide against, to indifference toward, black people. An example of the latter was the testimony of Harlem congressman Charles Rangel:

Heroin maintenance is the cry of some Americans who would like to sweep the addict under the rug. It is the call of those who are afraid to deal with the causes of addiction . . . that lead young men and women to narcotics. It is the instant solution of those who think that with free heroin will come—as if from heaven—an end to crime and violence. (Bayer 1976, 262)

Most damaging to the project was federal opposition that included an ad hoc Congressional alliance of conservative white and liberal black representatives from New York State, the director of the Bureau of Narcotics and Dangerous Drugs, and, ultimately, President Nixon, who attacked heroin maintenance in no uncertain terms (Bayer 1976).

The defeat of the Vera Institute's proposal raised a number of issues. First, despite the precedent of narcotic (methadone) maintenance in the United States—a new modality supported by the Nixon administration and by many members of the black community—heroin maintenance could not be freed from its earlier demonization, a striking example of the institutional and ideological rigidities of U.S. narcotics policy. In fact, methadone maintenance had been marketed less as an exception to America's prohibition policy than, paradoxically, as an "antinarcotic agent," which could effectively "eliminate heroin addiction and criminal behavior" (Epstein 1974, 6). Through this linguistic legerdemain, methadone maintenance prudishly retained the old taboos, thereby failing to extend the parameters of legitimacy sufficiently to allow for more radical policy changes.

Secondly, the rejection of heroin maintenance, even as a treatment lure, marked the end of therapeutic liberalism in the United States. By 1973, the number of treatment slots in most major U.S. cities exceeded demand; yet less than half the addicts in those cities had entered drug programs. (The estimated proportion ranged from 45 percent in New York City to 7 percent in Los Angeles [Bayer 1976].) The assumption of liberal reformers like Lindesmith that most addicts would voluntarily opt for treatment, if offered, proved incorrect (Lindesmith 1965). As a consequence, many who initially supported methadone maintenance and other modalities as a means of "capturing" addicts, and thereby

reducing crime, shifted back to more coercive enforcement, by calling again for compulsory quarantine and treatment of *all* addicts, or by supporting some form of old-fashioned “get tough” incarceration, stripped of any pretense to treatment (Bayer 1976).

On the federal level, support for demand reduction, that is, treatment and primary prevention, relative to law enforcement, as measured in share of total drug budget, declined after the mid-1970s (Falco 1989). Whereas under the Nixon administration, up to two thirds of the drug budget had gone to demand reduction, that proportion dropped to 43 percent under Jimmy Carter (Falco 1989; Trebach 1982). The Reagan administration initiated the most radical shift, allocating approximately 20 percent to prevention and treatment and 80 percent to law enforcement between 1982 and 1988 (Falco 1989; Moore 1991). Under President Reagan, drug policy was defined almost entirely as a law enforcement problem, much as it had been prior to the early 1960s (Falco 1989).

Drug Policy during the HIV Epidemic

The HIV epidemic produced a notable change in the debate over narcotics policy. In the past, one could dispute the extent to which drug addiction was a disease or simply a willful criminal act. Now the use of drugs, when taken intravenously, was clearly associated with a fatal infectious disorder, a “real” disease, one that threatened to spread into the “general” or respectable population.

In the early 1960s, the fear that heroin might further expand into the middle class mobilized the population and politicians to support a radical therapeutic response, methadone maintenance (Bayer 1976). Ten years later, the failure of narcotics maintenance to attract most of the urban addict population served to undercut the support of a public interested in a mechanism to “capture” and neutralize these antisocial “others.” With punitive legislation or treatment unsuccessful in absorbing the second largest risk group for AIDS, what alternatives were possible? How could one reach a group that remained, as Lindesmith had described it 20 years earlier, forced to live underground and beyond the control of medical or police authorities?

As before, policy alternatives were a function of one’s conception of the drug user (and, by extension, of addiction and narcotics). One of

the early reports on the epidemic, published under the auspices of the Institute of Medicine and the National Academy of Sciences, cited the many public health officials who believed that intravenous drug users were impervious to public health interventions because "the target population simply will not listen" (Institute of Medicine 1986a, 94). Addicts, by implication, were ignorant, hedonistic, and heedless of consequences, a view still expressed by Mirko Grmek, historian of the acquired immune deficiency syndrome (AIDS) epidemic, in 1990:

In contrast to homosexuals, who carefully heeded new data, the addicts were refractory to educational campaigns. . . . Too often the act of taking drugs is no more than acting out their desire to destroy themselves. . . . The uncaring victim becomes a peddler of death. (Grmek 1990, 168)

Researchers in the early 1980s demonstrated more positive possibilities. They found that by 1984 most addicts in New York City had heard of AIDS and its transmission through needle sharing; over half had changed their high-risk behaviors (Des Jarlais, Friedman, and Stoneburner 1988). The researchers therefore suggested that drug users might be open to public health interventions. The question remained, Which interventions were appropriate?

Because of the pandemic nature of AIDS, many U.S. public health and policy researchers, providers, and ethnographers engaged in working with intravenous drug users (IVDUs) began to exchange information with their European colleagues at meetings like the annual AIDS conferences and the 1985 International Conference on AIDS and Drug Injectors in Newark, New Jersey (S.R. Friedman of Narcotic and Drug Research, Inc., 1991, personal communication on July 15). Specifically, these workers began to learn of Holland's innovative programs for IVDUs. As a consequence, American researchers and policy analysts began to visit the Netherlands with the hope of finding appropriate strategies that might be applied to the United States.

Little of the Netherlands' narcotics policy originated with the HIV epidemic, but preceded it by a number of years. That policy developed slowly over the decade following the first significant rise in heroin addiction in the country in 1972 (van de Wijngaart 1988). The Dutch have adopted what they call a pragmatic and tolerant approach to drug addiction (Engelsman 1989). Their aim is to reintegrate the stigmatized addict into Dutch society by "normalizing" the addict and his or her

problems, primarily by using a public health model that provides treatment for addiction, while also offering services to attenuate the consequences of continued drug use.

In a public health model, legal rules play a diminished role. Prosecution of drug users is decidedly less stringent and more pragmatic in Holland than in most Western countries. Since 1976, the Dutch have distinguished between "drugs presenting unacceptable risks" (van de Wijngaart 1990, 668) like heroin and cocaine, and hashish or marijuana (which have been decriminalized *de facto*). Although users of the harder drugs may be prosecuted, the public prosecutor has considerable license in implementing the law. According to a statement by the Dutch Ministry of Welfare:

One of the basic premises of Dutch Criminal procedure is the expediency principle laid down in the Code of Criminal Procedure, whereby the Public Prosecutions department is empowered to refrain from bringing criminal procedures if there are weighty public interests to be considered. . . . The law thus steps aside, as it were, in cases where prosecution would have no beneficial effect in reducing the risks involved. (van de Wijngaart 1990, 668)

Central to the Dutch strategy is the concept of "harm reduction." For the individual addict who cannot or will not give up the addict lifestyle, harm reduction means learning to take responsibility for one's behavior; for society, the concept denotes providing assistance in various forms to improve the addicts' physical and social welfare (Buning 1986; Engelsman 1989; van de Wijngaart 1990). That assistance should encompass a spectrum of easily accessible and "user friendly" services.

Dutch harm reduction policy includes outreach work in streets and hospitals, medical assistance to addicts in jails, and low-threshold facilities that dispense methadone and health care while keeping "hassles" to a minimum (e.g., no mandatory urine checks) (Buning et al. 1986; Buning, van Brussel, and van Santen 1988). Perhaps the best known of the low-threshold projects are the methadone buses initiated by the Amsterdam Municipal Health Service in 1979. These mobile clinics, following a prescribed route, provide a daily dose of methadone to a client pool of narcotic addicts. (These clients have already undergone medical and social evaluation and agree to be listed in a central registry and to visit a physician quarterly.)

In 1981, the Municipal Health Service organized higher-threshold

methadone clinics for addicts willing to end their use of illegal drugs, submit to urine checks, and work with counselors (Buning, van Brussel, and van Santen 1988). For those committed to chemical abstinence, drug-free programs were also available. In the various programs, participants receive medical attention and a range of rehabilitative and social services intended to integrate addicts into society. By 1987, an estimated 70 percent of Amsterdam's 7,000 addicts had some contact with those programs (Buning, van Brussel, and van Santen 1988).

One of the most recent additions to Amsterdam's drug policy was the needle and syringe exchange program. Intrinsic to its development were the *Junkiebonden* (junky unions), which exist in Amsterdam, Rotterdam, and other major cities (Friedman, de Jong, and Des Jarlais 1990). Addicts created these unions in the early 1980s to promote their interests, including more services from the government and from health facilities (Friedman and Casriel 1988). The *Junkiebonden* demanded needle exchanges because they feared for addicts' health.

When an inner-city pharmacist refused to sell injection equipment in 1984, the Amsterdam junky union convinced a reluctant Municipal Health Service to underwrite a needle exchange to forestall a possible hepatitis B outbreak (Buning, van Brussel, and van Santen 1988). The next year, as public officials became alarmed over AIDS, Amsterdam expanded the exchange to enable a program that had traded 25,000 needles and syringes during the last half of 1984 to exchange approximately 820,000 in 1989 (Buning 1990; Buning, van Brussel, and van Santen 1988). By 1990, needle exchanges existed in 40 Dutch municipalities (Buning 1990).

A preliminary study of the Amsterdam needle exchange found that participants reported a lower rate of high-risk activities, like needle sharing or drug use, than nonparticipants (Buning, van Brussel, and van Santen 1988). Another investigation, which prospectively followed a group of exchange users for more than two years, observed a decline in needle sharing over that period (van den Hoek, van Haastrecht, and Coutinho 1989). During the years of the needle exchange, the number of narcotic addicts and of drug injectors has stabilized in Amsterdam, suggesting that the exchange has not been associated with an increase in the number of IVDUs in that city (Buning et al. 1986; Buning, van Brussel, and van Santen 1988).

By 1985, when the HIV epidemic became of major concern to Dutch authorities, they had in place a network of services to offer addicts and

a philosophy that emphasized accessibility. Although new policies had to be added, condom distribution for example, the Dutch, unlike other governments, did not suddenly have "to build bridges to addicts" (Engelsman 1989, 11). Having defined addiction as a public health problem, the Netherlands easily incorporated their drug policy into the larger public health effort against HIV infection.

Dutch narcotics policy was a powerful lesson to American workers interested in reaching as many addicts as possible with HIV-related interventions, particularly the majority of IVDUs with no interest in drug treatment programs. Following harm reduction principles, these workers moved to introduce various preventive measures designed to reduce the probability of HIV transmission through shared, contaminated needles and syringes and through high-risk sex. Influenced by the Dutch example, they attempted, in particular, to introduce the concept of needle exchange into the United States.

Signaling that policy was a new report under the auspices of the Institute of Medicine and the National Academy of Science, written by the Committee on a National Strategy for AIDS (Institute of Medicine 1986b). The committee, while recommending expansion of the current methadone and drug-free treatment programs, added:

Clearly it will not be possible to persuade all IV drug users to abandon drugs or to switch to safer, noninjectable drugs. Many may wish to reduce their chances of exposure to HIV but will neither enter treatment nor refrain from all drug injection. (Institute of Medicine 1986b, 109-10)

Although the committee recognized that increasing access to licit sterile needles would be controversial, it pointed out that Amsterdam had already begun to distribute sterile injection equipment, and it called for similar policy experiments in the United States.

In New Jersey, at approximately the same time, the deputy commissioner of health, influenced by Dutch policy, proposed an experimental needle exchange program (Bayer 1989; Sullivan 1986). The governor blocked the experiment, despite his state's status as the first in which over half of AIDS cases were IVDUs. Elsewhere in the nation, elected officials, as well as the National Institute on Drug Abuse, rejected needle exchange as a threat to drug control programs (Bayer 1989).

In the absence of a public initiative, local activists began to press for needle exchange. In some instances, this meant ignoring the law. Eleven

states (New York, California, New Jersey, Connecticut, Pennsylvania, Delaware, Rhode Island, Massachusetts, New Hampshire, Maine, and Illinois) forbid the sale of needles and syringes without prescription. In the remaining 39, possession of needles is illegal when found with illicit drugs (Lambert 1991). Despite these restrictions, almost all U.S. needle exchanges were started or catalyzed by local activists who secured governmental approval at some point before or after initiating the exchange, or who continue to operate illegally (Joseph and Des Jarlais 1989).

As early as 1985, AIDS researchers who had studied IVDUs locally and visited the Netherlands asked the health commissioner of New York City to develop a needle exchange in that municipality. (New York, the epicenter of the HIV epidemic in the United States, has approximately 200,000 addicts, over half of whom are reportedly seropositive.) A small experimental program started only in November 1988, after protracted negotiations between the city and state departments of health, negotiations that were catalyzed earlier that year by threats from a private group, ADAPT (Association for Drug Abuse Prevention and Treatment), to distribute needles as an act of civil disobedience (Gillman 1989). In 1987, Outside In, a private organization offering medical services to street kids in Portland, Oregon, began organizing a needle exchange, influenced by discussions with Dutch officials and by American researchers who had visited Holland (S.R. Friedman 1991, personal communication; Oliver 1990). Because of difficulty obtaining insurance, the Outside In program began only in November 1989, with the state health department providing consultation.

The first functioning needle exchange program in the United States opened in August 1988 in Tacoma, Washington. (By that date, such programs existed not only in Holland, but also in other countries, including Britain, Australia, and Sweden.) Dave Purchase, an experienced drug counselor who had read of the Dutch experience, began the exchange without government approval, using private funds. By January 1989, however, the Tacoma-Pierce County Board of Health adopted the program and began supporting it (Davidson 1990).

Other legal needle exchange programs in the United States exist in a number of cities, among them Seattle, Washington; Boulder, Colorado; New Haven, Connecticut; and the state of Hawaii. Exchanges operate illicitly in a number of places, including San Francisco and Boston; in New York City, the exchanges were illicit from February 1990, when a

new mayor canceled the legal pilot program, until the end of 1991, when he endorsed a new needle exchange plan. Activists operating those programs have been arrested, but charges against defendants in those cases have been dropped or they have been acquitted by the courts (Health/PAC 1990).

Although each of these programs, developed under local initiative, have unique features, all share two basic purposes. The first is to exchange new, sterile hypodermic syringes for used injection equipment, almost invariably on a one-for-one basis. Secondly, the exchange functions as a "bridge" between street addicts and health workers, allowing the latter to offer risk reduction counseling, services like condom distribution, and referrals to other facilities, like drug treatment programs (Joseph and Des Jarlais 1989). Workers claim to build that bridge to IVDUs through frequent encounters, the sharing of a common language, and the slow establishment of mutual trust (Health/PAC 1990).

This low-threshold approach has been attacked severely as condoning drug use, or worse, leading to an increase in IVDUs (Davidson 1990; Lambert 1988). Critics question the scientific validity of studies in the United States and abroad that provide justification for the exchanges (Joseph and Des Jarlais 1989; Marriott 1988). Many African-American and Latino leaders in New York City have accused the authorities of cynically distributing needles to addicts who would prefer treatment if that option existed (Lambert 1988). In language reminiscent of the debate over heroin maintenance in 1972, some African-American officials have called the exchanges "genocidal" or a symbol of white indifference to minority lives (Lambert 1988); implicit in those charges is black distrust of public health "experiments," particularly since the 1972 revelations concerning the infamous Tuskegee syphilis study (Thomas and Quinn 1991).

However, supporters of needle exchange argue that the programs should not be used as substitutes for treatment but, as in Europe, a link to addicts who, rejecting treatment, remain isolated and underground. Moreover, the needle exchanges are not genocidal, but rather designed to reduce mortality in all affected populations through the use of harm reduction measures. Finally, although ethical and practical limitations prevent definitive evaluation of the syringe exchange programs, the results to date across many study sites prove remarkably consistent. No data presently available demonstrate that exchanges are associated with increased drug injection; instead, investigations have shown either

no change or lower rates of injection over the study period (Joseph and Des Jarlais 1989). In addition, preliminary data from Tacoma, New Haven, San Francisco, and other North American cities appear to show that participants, like those studied in Europe and Australia, have reduced AIDS risk behavior, with a concomitant decline in HIV infection (Altman 1989; Navarro 1991a; Watters, Cheng, and Prevention Point Research Group 1991; Hagan et al. 1991). Naturally, evaluators must continue monitoring all needle exchange programs before definitive conclusions can be drawn.

Although opposition led to temporary termination of the needle exchange in New York City, other programs continued, uncompromised by New York's decision. Contrary to the experience of the last half-century, localities are able to initiate and, to a degree, control drug policy options. In fact, for the first time since the narcotic maintenance clinics of the 1920s, states have become social laboratories in the area of drug policy. They will be able to accumulate a body of epidemiological data that can be used to test American experience against that of Europe, Canada, and Australia. What is perhaps more important is that localities and states will be able to use these specifically American data and experiences to learn from each other, and to influence the further development of U.S. drug policies and programs. In fact, such a learning process has already begun; deeply influenced by the success of the needle exchange in New Haven, the same New York City mayor who terminated the small pilot program in 1990 recommended in November 1991 that the city assist community groups to design and run needle exchanges (Navarro 1991b).

States and localities have introduced other initiatives that, based on the public health/harm reduction models, are designed to reduce HIV transmission. For example, because needle sharing remains fairly common among addicts, most of whom cannot afford a supply of sterile "works," and needle exchanges are rather rare, a number of outreach programs have taught addicts to disinfect their injecting equipment with household bleach before use. One of the earliest of these outreach programs was ADAPT, formed in 1985 in New York City by ex-users and health professionals. ADAPT negotiates with shooting-gallery owners to make bleach and sterile needles available and conducts AIDS-prevention education among drug users in the streets and among ex-addicts in treatment programs (Friedman, de Jong, and Des Jarlais 1990). In San Francisco, beginning in the mid-1980s, a five-agency consortium trained

community health outreach workers to teach addicts to clean their hypodermics with household bleach (Newmeyer et al. 1989). In Chicago, a program recruits drug users to teach harm reduction (bleach and condoms) to their peers (Friedman, Des Jarlais, and Goldsmith 1989). Similar "bleach and teach" programs exist in other municipalities.

An interesting and remarkable aspect of many of these programs is that they have appropriated the drug subculture—abhorred by an earlier generation of reformers—to reach out to and locate the target populations. To what extent will such appropriations—incorporation of the shooting gallery, the hypodermic, and the addict into the public health model—eventually lead to social tolerance, if not acceptance, of them as unavoidable social phenomena?

A more immediate question is the extent to which the HIV epidemic can galvanize addicts to organize. Some involved in the public health/harm reduction effort have been inspired by the examples of the *Junkiebonden* and the U.S. gay community to promote drug users' organizations (Friedman and Casriel 1988). With the probability of collective self-organization among current users rather low, these reformers have suggested that sympathetic outsiders work to empower addicts, helping them develop an internal leadership and a set of goals (Friedman and Casriel 1988). Consequently, sympathetic ex- or nonaddicts have used needle exchanges and other interventions to promote individual and group empowerment among IVDUs and their families (Friedman et al. 1991; Health/PAC 1990). Unfortunately, despite the HIV crisis and several attempts by outsiders to organize IVDUs, the early results were at best equivocal (Friedman et al. 1991). More recent experiences in Baltimore, St. Paul and New York City, however, appear to promise greater success (S.R. Friedman 1991, personal communication). Given the multiple barriers addicts must contend with—illegal status, the need to support their habits, illnesses and poverty—it still remains to be seen whether American addicts can develop a movement, even during a pandemic.

Over the last five years, those who advocate the public health model have appropriately focused almost entirely on the vectors (needles and syringes) and behaviors that are implicated in transmission of HIV. These interventions have successfully reached street addicts outside the prison and drug-treatment systems. Interestingly, preliminary results from Hawaii, Tacoma, New Haven, and elsewhere have found that once

needle exchanges are instituted, drug treatment referrals begin to rise, sometimes significantly (Davidson 1990; Lichty 1990; Navarro 1991a).

Unfortunately, treatment programs are often too full to accommodate new patients, particularly in larger municipalities (Navarro 1991a). In New York City, according to city and state sources, "there has been no expansion of drug treatment facilities . . . within the past 10 years, and slight expansion of treatment slots in light of the crisis" (Joseph and Des Jarlais 1989, 5). Yet current programs in the city accommodate 38,000 patients, approximately half the number who would enter treatment if it were available (Joseph and Des Jarlais 1989). The next addition to the public health model should therefore be increased availability of drug treatment facilities. Ideally, this would mean not only more treatment slots, but also low threshold programs that would attract a larger proportion of street addicts, and experimental ventures that could reach out to subgroups like addicted women and to persons on crack.

Conclusion

For at least half a century, critics of American drug policy have had occasion to turn to foreign models for answers to the questions they have raised. Three of their major purposes for looking abroad were adumbrated earlier: (1) to discover alternatives to current programs in the United States; (2) to undertake comparative, empirical studies that might weaken American ethnocentrism and open the policy process to alternative approaches; or (3) to appropriate foreign experience in order to bolster political or ideological positions at home.

To explain the attraction of foreign models to the postwar critics of U.S. policy, the first two reasons are probably the least important. The United States had had its own experience of maintenance, including narcotic clinics; the search for new approaches was not a prime motivation for looking abroad. A stronger reason to do so was an attempt to make empirical, cross-national comparisons (for example, of the number of addicts) and to undercut ethnocentric assumptions about addict behavior or characteristics; but these comparative studies were often subordinate to, or part of, political and moral arguments. Despite attempts at scholarly research and careful documentation, promaintenance reform-

ers, engaged in a struggle with an ascendant adversary with radically different beliefs, tended to use the British model to validate their posture, which was that change as they defined it was both possible and preferable.

Conversely, faced with a pandemic that is transmitted, in part, by intravenous drug use, contemporary critics are most strongly attracted to foreign experience for the first two reasons. Their aim is to build bridges to street addicts in order to encourage behavioral change, the only means available to stanch the spread of HIV. Knowing from past experience that neither punitive enforcement nor treatment facilities will reach more than a minority of users, they learned of and adopted alternative approaches already in place in the Netherlands.

Significantly, these alternative approaches have as their dependent variable, not drug use, now understood as a vital intermediate variable, but the rate of HIV, which theoretically affects the entire population. This change in variables ironically allows the critics to press for dramatic changes in drug policy (using techniques of civil disobedience where necessary), which the authorities accept or connive with for the sake of the public's health.

In the near future, critics and others may look abroad for a second reason. As part of the public health campaign against HIV, epidemiology has played a crucial role in measuring and evaluating AIDS-related phenomena, including intervention programs in the United States and elsewhere (Oppenheimer 1988). For example, relatively objective data from abroad have proved useful to advocates of needle exchange at home. The U.S. experience, currently being measured, will be part of the international pool of data. Soon, perhaps for the first time in the history of U.S. drug policy, objective cross-national empirical comparisons of specific drug-related programs will prove possible. As a consequence, we may discern to what degree the U.S. drug problem requires unique policy responses, and under what circumstances selected programs, like needle exchange, can be transferred from other countries and cultures.

Can the consensus for change in U.S. drug policy, where it exists, expand beyond the parameters fixed by the current public health emergency? It is possible that local initiatives, once institutionalized, could develop a logic and constituency of their own. (It is also conceivable that such a constituency might include active drug users.) Moreover, should needle exchanges prove successful in this country, they could generate

interest in other drug-related interventions developed elsewhere. AIDS has created a formal system of information exchange among nations—the International Working Group on Drug Users and AIDS, for example—which could provide communities in this country with relevant intelligence and expertise. However, the current consensus for change, supported by local officials and health workers (with the federal government maintaining an ominous silence), is fragile. Should attempts be made to push beyond the perceived needs of the epidemic, the result may be divisive moral and ideological debates, similar to the heroin maintenance experience of the postwar years. Predictably, both sides would turn to the accumulated pool of international data; they would do so, however, selectively, to validate and to bolster their particular political texts.

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