Op-ed/Editorials: Will Data-Proof Decision Making Prevail in New York City?

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Since 2006, the New York City Department of Health and Mental Hygiene has been distributing a science-based guide to safer injection drug use. *Take Charge, Take Care: 10 Tips for Safer Use* repeatedly urges readers to get help to stop using injection drugs. However, for people who have not yet stopped using, the guide also includes tips on injecting more safely. As a result, critics claim the guide reflects an implicit endorsement of intravenous drug use by a government-funded health agency.

_One of the guide's most vocal critics is New York City council member Peter Vallone Jr. Vallone calls the guide an "egregious misuse of taxpayer money" (Cho, 2010). His chief argument is that the city should unequivocally promote abstinence from drug use. Providing information about injecting drugs more safely, Vallone suggests, will send the message to teens and first-time users that there is a safe way to inject heroin and other drugs (Buxbaum, 2010; Cho, 2010).

If these arguments sound familiar, it is because critics have used the same line of reasoning over the past two decades to fight against needle exchange programs, methadone maintenance therapy, and, more recently, safe-injection facilities. The history of needle exchange programs in this country, in particular, has much to teach us about the tendency for U.S. politicians to use (or, more appropriately, fail to use) evidence-based judgment when it comes to drug control policies. In the mid-1980s, critics mounted a vigorous campaign to prohibit needle-exchange programs. As with *Take Charge, Take Care*, their central argument was that needle exchange programs would encourage substance abuse by sending a message that the government condones drug use (Drucker & Clear, 1999). In 1988, zero-tolerance policies triumphed when Congress established a ban on federal funding for needle exchange programs. And yet, about one hundred programs continued to operate in the next decade thanks to private, state, and local funding.

In 1997, after an extensive review of the available data, the National Institutes of Health concluded that not only did needle exchange programs fail to promote drug use or encourage non-users to use; they also dramatically reduced rates of HIV transmission (National Institutes of Health, 1997), all in a cost-effective manner. The NIH report summed up the state of the science in this way: “Can the opposition to needle exchange programs in the United States be justified on scientific grounds? Our answer is simple and emphatic: no” (National Institutes of Health, 1997). In response, the Secretary of Health and Human Services, the Surgeon General, the National Academy of Sciences, the American Medical Association, the U.S. Conference of Mayors and others all expressed their support for needle exchange programs. And yet, the ban on federal funding remained, as politicians continued to assert there was no evidence in favor of the programs’ effectiveness. As late as 2005, Rep. Mark Souter had this to say about the state of the science (2005):

> *“And when we find a strategy that reduces death in our community, and the best scientific minds in the United States—not in some developing country, in the United States—tell us this works, you betcha that's exactly what we ought to do. And when everybody from the CDC and NIH to the AMA and the Pharmaceutical Association of America tell me that, according to their studies, approaches like needle exchange reduce death in our country, that is who I am going to listen to.”*

Souter and others were apparently unaware that the jury had already returned its verdict on needle exchange.

The ban on federal funding was finally repealed in December of 2009, with the restriction that programs cannot operate within 1,000 feet of any area where children are likely to congregate. This restriction will effectively put many programs out of business (e.g., Ellis, 2009) .

We can situate the history of needle-exchange policies within a typology of public-health decisions advanced by Des Jarlais (2008). During the years of the ban, particularly after the first decade of data collection, the U.S. government made a “data-proof” decision to prohibit federal funds despite evidence of their effectiveness, not on the basis of scientific data, but on the potentially symbolic value of these programs. When the ban was lifted but with strict restrictions on where programs could operate, the government made a “data-compromise”

decision, which recognizes the available scientific evidence but retains a symbolic disapproval.

Of course, there is no comparable database on the effects of *Take Charge, Take Care*. So far, the science suggests that the benefits outweigh the potential costs. From 2006-2008, when *Take Charge, Take Care* was most widely available, rates of unintentional drug overdose and HIV infection among injection drug users declined in New York City (New York City Department of Health and Mental Hygiene, 2008, 2009, 2010a, 2010b). And contrary to the critics' warnings, providing tips on safer injection does not appear to encourage non-users to take up the habit. The rate of lifetime heroin use among New York City high school students slightly decreased from 2005 to 2007, from 1.8% to 1.3% (Centers for Disease Control and Prevention, 2006, 2008). This is consistent with other research indicating that when medical authorities provide a means of safer injection drug use, it is high-risk, long-time users—and not the uninitiated—who respond (Kerr et al., 2007; Wood et al., 2005).

Unfortunately, we might never get to find out whether *Take Charge, Take Care* helps to make injection drug use safer or encourages users to seek support to quit. In response to recent criticism, the Department of Health as removed the guide from its website, and City Council Member Peter Vallone is currently attempting to cutoff funding for the pamphlet's distribution. If Vallone succeeds, so to will "data-proof" decision-making.

–Heather Gray

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