

The New War on Drugs : How Biomedicine and Science Have Disguised the Value Conflict
Over Harm Reduction

Gabriel Halperin-Goldstein
24 April 2019
Haverford College Sociology Department
Advisor: Matthew McKeever

Acknowledgements

I would like to thank the following people for their assistance in completing this thesis:

Professor Matthew McKeever for his thoughtful feedback that was always constructive, and gave me the confidence and inspiration to develop my ideas. Professor Mark Gould for his classes that pushed me to think analytically and raised my standards for myself. Professor Shelly Ronen for her useful feedback and literature recommendations. Professor Anne Montgomery for introducing me to the Philadelphia harm reduction movement and the importance of community engaged studies.

All the people who participated in an interview for giving their time and for sharing their passions, beliefs, and knowledge with me.

Rebecca Chang and Vanessa Morales for inspiring me with their strength and kindness. Jordan Acker and Michael Weber for driving me to focus on another project outside of thesis. Joey Leroux for his thoughtfulness and honesty. Mark Rosenberg for helping me to make new academic insights when I least expected to.

My sisters, Hanna and Sofia for being my best friends and biggest role models.

My parents, who gave me the opportunity to study at Haverford and always being my biggest believers. As the child of two psychologists, my ideas for this paper did not always go over easy with my parents. However, their thoughtful feedback and discussions only pushed me to think more critically. I will never be able to express how much I appreciate their unwavering support.

Table of Contents

Introduction	4
Literature Review	6
History.....	7
Assessing Bureaucracy as a Form of Organizational Structure	13
Science and Expertise	20
Symptoms, Illness, Disease, and Diagnosis	24
Social Problems	28
Research Methods	30
Data Analysis	34
The Role of Scientific Evidence.....	34
The Removal of Morals from Drug Addiction	34
Relationship Between Natural and Social Sciences	37
Selecting Credible Evidence	39
The Role of Values in Constructing Social Problems and Policy Solutions	41
What do people mean by the “drug problem”?	42
Various Desired Policy Outcomes	44
Public Versus Private Problems	47
Public Problems and Political Voice	49
Conclusion and Policy Implications	53
Appendix	57
Words Cited	58

Introduction

Over the past 30 years, the United States has demonstrated a shift in its understanding of drug use and drug addiction. During the era known as the “War on Drugs” drug addiction was overtly framed as a moral problem. Drug addicts were considered to be responsible for destroying the moral fabric of society. Since that time, drug overdose deaths in the United States have climbed dramatically during the “opioid epidemic”, from 16,849 in 1999 to 70, 237 in 2017 (Center for Disease Control). Concurrently, the demographics of drug users have shifted from predominately low-income minorities in urban centers to both whites and non-whites across geographic regions and income brackets (Cicero 2014).

Governmental experts in medicine and public health (of all political parties) claim that this transition towards understanding drug addiction as a disease has been driven by increased scientific understanding of drug addiction, and that this development has removed moral considerations from how we respond to addiction. However, while addiction has come to be understood as a disease in the eyes of most Americans, significant controversy remains over how to best respond to people who use drugs. While other countries experiencing high rates of mortality from drug overdoses, such as Canada, Portugal, and Denmark, have implemented “safe injection facilities” (SIFs), sites where people can use drugs under the supervision of medical personnel to prevent overdose deaths, the United States has been resistant to this idea. SIF advocates have started to organize and lobby for the implementation of SIFs in many cities, including Philadelphia, New York, Denver, San Francisco, and Seattle. This raises an interesting question; why is it that as more scientific information on drug addiction is available – pertaining to both the biological study of addiction, and to the impact of SIFs in other countries – the United States has remained politically divided over how to respond to drug users? Why is it that

the evidence of the efficacy of SIFs has satisfied other countries, but has failed to convince many stakeholders in the United States? Do scientific developments drive changes in political responses, or can we account for other factors that might inspire policy?

In order to address this question, I contextualize my answer within Max Weber's theory of rationalization. Weber argues that the development of capitalism has been accompanied by a shift from substantive rationality, where means are selected based on value postulates, to formal rationality, where means are rationally calculated. I argue that Weber incorrectly assumes that the rise of formal rationality must correspond with the decline of substantive rationality. Instead, I argue that while formal rationality has grown as a source of justification for claims-making activity, it has not reduced the role of substantive rationality in legitimizing those claims. Science is used as a means of justifying claims, but science alone cannot rationalize an objectively ideal policy because different stakeholders hold different values.

In this study, I analyze how different interest groups, politicians, and community leaders collaborate to identify public problems and design the ideal policy solution, using the response to the opioid epidemic in Philadelphia as a case study. I examine the role of biological sciences, social sciences, and value commitments in justifying and legitimizing different policy ideas. Furthermore, I examine how professional "experts" collaborate with non-experts, or "lay people" to share knowledge, and how bureaucratic organizational structures influence this collaboration.

I argue that scientific advancements did not drive changes in understanding of addiction, nor did they remove moral considerations from drug use. Instead, biomedical science is used to justify a new mechanism of social control – the medical industry. Discussions over questions of medical treatment and health policy are driven by both values and knowledge. Both experts and lay people frequently cite science to justify their claims, but they are truly arguing over values.

Even though the sphere of social control has shifted from the criminal justice industry to the medical industry, the value conflict pertaining to drug use is still the same as it was during the War on Drugs. Those who value the protection of human rights and a welfare state tend to advocate for SIFs, while those who value individualism tend to resist. I argue that lay people do not necessarily accept bureaucratic organizations driven by experts as legitimate organizational structures. More important than science in establishing harm reduction as a mainstream response to drug addiction is the ability for drug users and harm reduction activists to institutionalize their value orientations.

This research will have implications for how public health experts advocate for policy change in current and future public health crises. If public health advocates can ground their findings in comprehensive theory that more overtly incorporates the role of social values in disease diagnosis and treatment, they can better complicate the dominant values surrounding drug use and addiction that have informed policy since the War on Drugs and through medicalization. Furthermore, my research indicates that the formation of a systemic method for the sick population to have political organization and representation within governmental bureaucracy would result in health policies that better reflect the values of that population.

Literature Review

In this section, I start by outlining the history of drug policy and harm reduction social movements since the start of the War on Drugs. This includes 1) the emergence of stricter enforcement of minor level drug crimes in response to increasing heroin and cocaine use amongst black populations in urban centers, 2) the rise of social movements advocating for harm reduction, 3) the partial adoption of these harm reduction practices by local municipalities, 4) the

rise of the opioid epidemic and shifting demographics of opioid users accompanied by a shift towards understanding drug addiction as a biomedical disease and 5) ongoing political disputes over the implementation of safe injection facilities.

Next, I discuss Max Weber's theory of rationalization and its implications for the governmental organizational structure and the role of science and morality in the policy-making process. I continue with a discussion of Gil Eyal's theory of expertise, and explain why experts in laboratory sciences hold more authority than experts in social sciences. In the next section, I argue that this rise in the influence of laboratory science has resulted in the appeal to biomedical studies as justification for sickness diagnoses. This augmented role of biomedicine hides the ongoing role of social values in determining disease classifications, allowing the medical industry to function as a veiled institution of social control. Finally, I conclude with a section on the formation of social problems, and contend that all claims-making activity pertaining to social problems is legitimated by social values. In the event that a social problem generates a value conflict between different stakeholders, policymakers can no longer appeal solely to formal rationality as a means of fixing the problem because stakeholders may aspire for different policy outcomes.

History

Past presidential administrations have taken various stances on how to respond to drug use. Their comments and policies reflect the dominant narratives surrounding drug use. The "War on Drugs" began when Richard Nixon coined the term in an address to Congress in 1971, stating his goals to stop the rise of injection heroin use in American cities. In 2009, the Obama administration announced that they would no longer use the term "War on Drugs" because it was

counterproductive to the administration's goal of recognizing drug addiction as a disease (Fields 2009). The War on Drugs is remembered for the United States' adoption of zero-tolerance drug policies, mass incarceration of racial minorities, and foreign intervention in drug trade. Despite the ineffectiveness of punitive drug control measures, federal policy surrounding drug use remained remarkably stagnant in the 30 years following Nixon's address (Reuter 2013).

Although the Obama administration's declaration of the end of the War on Drugs might indicate that a boundary shift concerning the morality of drug use had occurred in the United States, this is not actually the case. In fact, different administrations during the War on Drugs adopted different value stances towards drug use, demonstrating the moral tensions surrounding drug use that has existed for decades. I want to highlight that the shift towards classifying drug use as a "medical" issue does not necessarily mean it is a morally neutral issue.

For the most part, federal administrations have advocated for strict, punitive approaches to drug use, and dismissed harm reduction. President Nixon declared drug use "the public enemy number one" and directed efforts towards restricting foreign drug trade in hopes of eradicating drug use in the United States. Nixon attempted to frame his policies as a problem of "law and order" instead of a product of racial tensions (Newell 2013:15). However, evidence suggests his efforts were still racially charged. Criminal drug laws have disproportionately affected black populations. One 1969 poll indicated that 81% of Americans believed "law and order" had broken down and most blamed "Negroes who start riots", highlighting the ongoing racial tensions in response to the Civil Rights Movement (Mauer 2006:53). President Ronald Reagan instigated strict enforcement of drug law enforcement. Reagan passed the Anti-Drug Abuse Act in 1986, which allocated money towards prisons and drug education, and established mandatory

minimum sentencing laws for low-level drug crimes. Nancy Reagan initiated the “Just Say No” program, famous for its simplistic abstinence-based approach towards drug use.

In 1988 President George H. W. Bush appointed William Bennett to be the first director of the Office of National Drug Control Policy. Bennett claimed that the problem was not the consequences of drug use, but drug use itself. The measure of success was not rates of crime or disease, but the number of users (Reuter 2013:83). As anti-drug sentiment grew, levels of incarceration for drug-related crime rose. The number and length of drug sentences increased dramatically since Reagan’s policies: from 4,500 cell-years in 1980 to 85,000 cell years in 1992 to 135,000 cell-years in 2001 (Reuter 2013:83).

However, this era demonstrated contradicting political approaches towards drug use. As criminalization increased, there were simultaneously advocates for harm reduction and non-abstinence based treatments. The Nixon administration was responsible for the start of methadone clinics, marking the first time that the government supported an intervention that tolerated continued drug use. President Ford and President Carter distanced themselves from the drug issue, and did not advocate for strict enforcement of drug laws. In a message to Congress, Carter said, “Penalties against possession of a drug should not be more damaging to an individual than the use of the drug itself” (Reuter 81-82)

During this period, harm reduction social movements emerged at grassroots levels in urban centers. Although there is no universal definition of harm reduction, the term broadly refers to the public health ideas and interventions that reduce physical harms of drug use by giving drug users the tools to consume drugs safely. This includes, but is not limited to: clean needle and syringe exchange programs, distribution of overdose-reversal drugs like naloxone, Medically-Assisted Treatment (MAT), peer support groups, and supervised consumption

facilities. Many harm reduction proponents emphasize that harm reduction is more than a set of interventions. It is based upon ideology that people who use drugs deserve to have their rights, respect, and humanity protected.

In the late 1980s, cities such as New Haven, Chicago, and San Francisco implemented syringe exchange programs and naloxone distribution sites (Faulkner-Gurstein 2015:10). Harm reduction movements were especially prevalent in New York City, where there was a concentration of injection drug users and high rates of HIV. When the city did not embrace syringe exchange programs in the late 1980s, activist groups started their own underground exchange programs, and were often aided by city public health workers, who were frustrated by Mayor David Dinkins' unwillingness to help. Eventually, in 1992 Dinkins reversed his position on syringe exchange due to the rising activist movements. However, Dinkins did not fully commit to harm reduction. While he legalized syringe exchange, he did not authorize city funding for it, and most syringe exchange programs operated independently of the city, finding private funding sources instead (Faulkner-Gurstein 2015:12-13).

The Bloomberg administration also advanced harm reduction movements in New York City by providing funding for activist groups, making syringes more accessible, and supporting naloxone distribution (Faulkner-Gurstein 2015:14). The Bloomberg administration justified their actions as a commitment to pragmatic, data-driven policy that was "above politics" and "beyond ideology" (Faulkner-Gurstein 2015:14-15). This is emblematic of the way that harm reduction was justified as it became an institutionalized policy.¹ Faulkner-Gurstein comments on the tension between value rationality and instrumental rationality in harm reduction movements,

¹ By institutionalized, Gurstein means "the process by which harm reduction became a formalized, routinized, and generally accepted response to drug use". We can observe this process through the formation of organized groups at all levels of political change, as well as public and private grants made for this movement.

”Throughout American urban history, whenever representatives of public health departments, doctors, medical scientists, activists and others have debated public health measures, they have tried to adjust the boundary between the political - where we use the language of values, ethics and power to debate both process and ultimate ends - and that which is considered “nonpolitical” or “apolitical” and thus treated merely as matters of efficiency in means not the appropriate ends. These tensions - between value rationality and instrumental rationality, between the medical establishment and drug user mutual aid, between pragmatism and radicalism - are at the heart of harm reduction, both as a social movement and shorthand for a whole set of public health policies.” (Faulkner-Gurstein 2015:3)

This held consistent with the Bloomberg administration’s presentation as a data-driven government that would implement “policy beyond politics” in all fields, including health, education, and environment.

Today, most controversy around harm reduction in the United States is about supervised injection facilities (SIFs). SIFs are legally sanctioned facilities that allow people to use drugs under the supervision of medical staff. Staff members are responsible for providing sterile injection supplies, monitoring for drug overdoses, providing first-aid for other minor maladies, giving clients information about other treatment options, and being tolerant and accepting of clients’ choices to use drugs. Insite, located in Vancouver, became the first legalized SIF in North America when the Canadian government granted a special exemption for it to be legal in 2003 (PHS Community Services Society). In 2008, Federal Health Minister Tony Clement threatened to shut down Insite by refusing to renew the exemption. The court ruled in favor of Insite due to its success in reducing drug-related harm. Today, there are 120 SIFs that are operating in twelve countries around the world.²

There have been hundreds of studies on the efficacy of SIFs, analyzing their local impact on variables such as overdose-related deaths, rates of entry into substance use disorder treatment,

² Those countries are: Australia, Canada, Denmark, France, Germany, Luxembourg, the Netherlands, Norway, Spain and Switzerland

spread of infectious disease such as HIV and Hepatitis C, costs dedicated to emergency medical services, total client drug use, and rates of neighborhood crime. It is difficult to point to conclusive results of these studies because different stakeholders make different claims about the research findings. However, the majority of evidence suggests that SIFs have been largely effective in achieving their goals. Larson and Gogaczyk created a meta-analysis of all the research performed on SIFs, which is mostly based off Insite (Larson and Gogaczyk 2017). Their study indicates that SIFs have consistently lowered rates of overdose, spread of infectious disease, medical costs, and neighborhood crime and disorder, and that they have raised the rate of entry into addiction treatment services. Not all studies are so conclusive, as some new studies have indicated SIFs can increase neighborhood crime and total rates of drug use amongst clients.

Harm reduction movements started in Philadelphia in the early 1990s when Prevention Point Philadelphia (PPP) began an underground syringe exchange operation in cooperation with the HIV and AIDS activist group, AIDS Coalition to Unleash Power (Prevention Point). After lobbying efforts by members of PPP, Mayor Ed Rendell legalized possession of syringes in Philadelphia in 1992.

In recent years, overdose mortality in Philadelphia has grown at an even faster rate than the rest of the country. Overdose deaths have grown from 460 in 2013 to 702 in 2015 to 1,217 in 2017 (City of Philadelphia). Philadelphia County has the highest overdose rate of the ten most populous counties in the United States. Overdoses are prevalent throughout the city, but one neighborhood – Kensington – has gained a reputation as being a hub of heroin use and sales after a New York Times magazine article dubbed it the “Walmart of Heroin” (Percy 2018).

Over this time, local political controversy over SIFs has been escalating in Philadelphia. As activists have organized, they have pushed the city to provide funds for a SIF. Last year harm

reduction advocates Ronda Goldfein and Jose Benitez teamed up with former Mayor Ed Rendell to form a nonprofit corporation called Safehouse that they intend to be a SIF. Town-hall style community gatherings have exposed the controversy over the topic, as community members and members of City Council have taken strong positions on both sides. In the interviews that I conducted as part of this thesis project, participants emphasized the emotionally charged and intense nature of these gatherings.

Over this time, the mayor's office has maintained that addressing the opioid epidemic is a priority. CBOs that use other forms of harm reduction have been widely successful in obtaining city funding and support. Mayor Jim Kenney's administration started The Resiliency Project in October 2018, a unified city approach towards addressing the epidemic. The project claims to have long-term "progressive strategies focused on harm reduction and meeting those living with harm reduction where they are at" (Kruger 2018). Despite this, the mayor's office has not supported Safehouse financially or politically. On February 5, 2019 the U.S. Attorney for the Eastern District of Pennsylvania filed a civil lawsuit against Safehouse, and on April 3, 2019 Safe house responded to the lawsuit.

Assessing Bureaucracy as a Form of Organizational Structure

In this section, I explore the efficacy of governmental bureaucracy as an organizational structure to form policy. In order to do so, I will use Max Weber's ([1921] 1968) theory of rationalization as a basis for understanding the different forms of rationality that inspire political decision making. In his book *Economy and Society*, Weber argues that society has become increasingly rationalized since the rise of Protestantism in the West (Weber [1921] 1968). The shift from traditional legitimation to rational-legal legitimation, and substantive rationality to

formal rationality has resulted in the eradication of substantive values in favor of instrumental rationality. The rise of bureaucracies is emblematic of this change, and represents the most efficient organizational structure in the modern world.

I contend that Weber's distinction between substantive rationality and formal rationality is important, but that he is mistaken in claiming that there has been a decline in cultural values and substantive rationality as formal rationality has become more prevalent. Instead, I argue that the continued existence of a rational-egalitarian value system means that legitimate (and effective) policy outcomes cannot merely be contrived scientifically, but must also be "substantively rational" such that they are consistent with the values of people affected by the policies. I argue that the bureaucratic organizational structure where authority is determined solely by expertise still has the capacity to create poor policy because those bureaucrats are not experts in substantive rationality.

Weber outlines four distinct types of rationality; practical rationality, theoretical rationality, substantive rationality, and formal rationality (Weber [1921] 1986:293).

1. Practical rationality: found in mundane day-to-day activities, actors calculate all possible means available to them and choose alternative best allowing to reach their end
2. Theoretical rationality: "increasingly theoretical mastery of reality by means of increasingly precise and abstract concepts", involves logical deduction, attribution of causality, and arrangement of symbolic meanings. Practical rationality involves action, while theoretical rationality is cognitive process, province of intellectuals
3. Substantive rationality: involves "value postulates" that guide people in daily lives in choice of means to ends. The value clusters are rational when they are consistent with specific value postulates preferred by actors. Substantive rationality involves choice of means to ends guided by some larger system of human values.
4. Formal rationality: rational calculation of means to ends based on universally applied rules, regulations, and laws. Choice of means to ends is determined by these larger structures and their rules and laws.

Unlike the first three types of rationality, formal rationality has not existed across all times and places. Its rise is specific to the modern, Western, industrialized world.

Weber claims that in the past, substantive rationality guided people to choose means that result in ends that are consistent with larger value systems. However, according to Weber, this process of deliberation over substantive values is declining due to a rise in procedural laws and rules that function to empirically identify the best means possible to achieve a given end. This new approach guided by formal rationality is “incorporated into rules, regulations, and structures of our social institutions” so that actors never have to make value judgments (Ritzer 2011:43).

Weber viewed the adoption of formal rationality to mean that substantive rationality would lose importance. He anticipated that the conflict between these two modes of decision-making would result in the erosion of substantive rationality. Rather than orienting themselves to larger values, the world would be left to “people who simply followed the rules without regard to larger human values” (Ritzer 2011:43). Weber’s theory embodies an explanation of the past, but also a prediction of the future. The rise of formal rationality was inevitable, and will continue to grow.

Weber cites the rise of bureaucracy as emblematic of this shift in rationalization,

“Bureaucratic rationalization...revolutionizes with technical means, in principle, as does every economic reorganization, “from without”: It first changes the material and social orders, and through them the people, by changing the conditions of adaptation, and perhaps the opportunities for adaptation, through a rational determination of means to ends.” (Weber [1921] 1986: 1116)

Bureaucracy preserves “the development of ‘rational matter-of-factness’ and the personality type of the ‘professional expert’” (Weber 1946:240). In bureaucracy, the rights of authority are derived from expertise instead of lineage.

Weber suggests that two factors allow bureaucracies to function at unparalleled levels of efficiency: explicit rules and unique division of labor. Explicit rules are upheld by market jurisdictions between offices and permanent files documenting processing of cases. The division

of labor allows for experts to make decisions unencumbered by subjective influences.

Bureaucracy is structured in a way that top officials develop rules and regulations for lower-level officials to choose the best means to ends already chosen at highest levels. The goal is attained when each member has completed their required task. In this way, bureaucracies rely upon the methods that have been proven in the past to be optimum means of achieving ends in question.

Ideals of formal rationality occupy much of the modern discourse on policy formation. Deborah Stone (2002) tracks the ongoing mission to deduce policy formation to rational methods throughout American history. Stone writes, “The fields of political science, public administration, law, and policy analysis have a common mission of rescuing public policy from the irrationalities and indignities of politics, hoping to make policy instead with rational, analytical, and scientific methods” (Stone 2002:7). She calls this mission the “rationality project”.

This mission has been present across US history and adopted by people of different political ideologies. It began with James Madison’s “effort to ‘cure the mischiefs of faction’ with proper constitutional design, thereby assuring government policy would be protected from the self-interested motives of tyrannous majorities” (Stone 2002:7). In the 1870s, Christopher Columbus Langdell, dean of Harvard Law School, declared that law was a science to be studied by distilling set of common principles from past court cases. In the twentieth century, Progressive reformers removed policy-making authority from elected bodies and gave it to expert regulatory commissions and professional city managers to make policy more scientific and less political. In the twenty-first century, the rationality project persists in the discipline of political science under the banner of “rational choice” and in the field of “law and economics”, as well as in social movements like the science march. The common link between all of these

movements is the appeal towards the application of standardized, rational means to achieve an objectively ideal end.

Despite all of Weber's insights, he inadvertently contradicts himself in his discussion of evolutionary theory and comparative theory. Evolutionary theorists pose social development as one process that is "necessary", "continuous", and occurs in cumulative stages (Schlucter 1938:4). These theories suggest that the observed social outcome was an inevitable occurrence to which past stages have built. Comparative theorists, in contrast, focus on comparing different societies, and explaining the differential development of regions based upon their different circumstances. Weber claimed to be a comparative sociologist, and specifically denounced the utility of evolutionary theory. Within his studies of religion, he argued that ordering the world's religions sequentially is not a meaningful way to study their influence and development.

However, Weber himself incorporates elements of both evolutionary and comparative theory into his work on rationalization. Wolfgang Schlucter (1938) argues this same point in his book, *The Rise of Western Rationalism*. Stephen McNamee summarizes,

"Schlucter contends that Weber's developmental theory is evolutionary in the sense that Weber carefully specified a series of stages that gave rise to the unique expression of Western rationalism. But Weber's theory is also comparative in the sense that Weber identified this path as one of several possible cultural trajectories." (McNamee 1985:67)

Weber's postulation that formal rationality will continue to overtake substantive rationality implies that the internal logic of the rationality makes its persistence inevitable.

Schlucter's critique raises valid concerns, and begs the question: why are there elements of evolutionary theory within Weber's work even though Weber himself advocates for comparative theory? Weber sees the shift towards rational forms of domination in "strictly dichotomous terms". McNamee continues, "For Weber the modern state is moving toward a domination of means over ends, bureaucrats over politicians, and instrumental (formal)

rationality over substantive rationality” (McNamee 1985:68). Weber’s tendency to integrate evolutionary theory demonstrates a strange inconsistency in his sociological approach.

I suggest that Weber incorporates an evolutionary perspective into his theory to compensate for the shortcomings of his comparative theoretical argument. Mark Gould (1993) critiques Weber’s theory in his essay “Legitimation and Justification”. Gould contends that Weber’s analysis mistakenly traces the development of procedural justification without also tracing the development of moral value-commitments. Writes Gould,

“Instead of tracing the development of moral value-commitments (the collective conscience) and at the same time the development of the norms of procedural justification, both Weber and Durkheim created social theories that substitute the one for the other. Moral obligation appears to give way to procedural rationality, while rational values and non- or irrational procedures take a back place in their analyses.” (Gould 1993:206)

Instead of procedural justification replacing value commitments, both values and procedures have developed together.

The evolution of value commitments can be described by the rise of a “rational-egalitarian” value system. Gould continues,

“In failing to recognize that [traditional legitimation and rational-legal legitimation] fulfill qualitatively different functions, [Weber] implicitly sees (traditional) legitimation wane as (rational-legal) justification waxes. He ignores, at least within this context, the emergence of rational-egalitarian values, and, at best, slights the necessity of their legitimizing the emergent rational-legal procedures if order is to be stabilized.” (Gould 1993:215)

Without this distinction, Weber is unable to explain the growth of formal rationality as distinct from the logic of formal rationality itself. Weber cannot contextualize this form of procedural justification as a consequence of shifting value orientations, because his comparative theory does not acknowledge the changes in value orientation over time. Weber’s oversight in his comparative theory leads him to adopt elements of evolutionary theory to compensate for the

areas he cannot explain. However, with Gould's distinction between legitimation and justification, and the identification of the rise of "rational-egalitarian" values, it is plausible to recognize that the tendency to appeal to science-based policies is a product of the specific, non-universal value system of the emerging Western World – not one of destiny. Amending Weber's comparative theory to include the rise of rational-egalitarian values allows the possibility for formal and substantive rationality to develop simultaneously, without competing.

In the case of policy formation, formal rationality cannot achieve an ideal policy because the end goals of policies are subjectively determined by substantive values. Stone points out that the goals of a given policy are not necessarily the concrete goals they assert themselves to be. Those concrete goals are constitutive of broader values. Stone writes,

“...it is about goals – not the specific goals of particular policy issues, such as expanding health insurance coverage or lowering health care costs, but the enduring values of community life that give rise to controversy over particular policies: equity, efficiency, security, and liberty.” (Stone 2002:12)

The rationality project implies that there are objective standards to measure a policy. However, Stone claims that no standards can be objective because those values are understood subjectively, interpreted distinctly and prioritized to differing degrees by different people,

“One tenet of the rationality project is that there are objective and neutral standards of evaluation that can be applied to politics, but that come from a vantage point outside politics, untainted by the interests of political players...Behind every policy issue lurks a contest over conflicting, though equally plausible, conceptions of the same abstract goal or value. It may not be possible to get everyone to agree on the same interpretation, but the first task of the political analyst is to reveal and clarify the underlying value disputes so that people can see where they differ and move toward some reconciliation.” (Stone 2002:12)

Only once policymakers and interest groups recognize that an optimal policy cannot be derived scientifically can they overtly discuss the differential value commitments causing political

controversy, and systematically consider how those value commitments are being represented in the process of policy formation.

If both forms of rationality are needed to form good policy, then the legitimacy of a bureaucratic structure where authority arises solely from expertise is complicated. Those creating policy are not just using their knowledge to create policy, but are also using their value commitments. While both lay people and experts might agree that experts hold more knowledge, lay people may contest that the values of experts are no more legitimate than their own values. When policymakers and experts present their proposed plans, they often default to formal rationality as a means of justifying their proposed policy change. The procedures that justify how they came about their ideas are integral to their being taken seriously. The appeal to formal rationality may disguise the conflict over substantive rationality, especially in fields pertaining to medical sciences.

Science and Expertise

In this section, I draw upon Gil Eyal's (2013) writing on the Sociology of expertise and Ian Hacking's (2010) writing on the Philosophy of Science to explore the legitimacy of scientific findings in the eyes of lay people. I agree with Eyal's argument that experts are bounded by lay people when making claims, and expand to suggest that differential value commitments between experts and lay people are the source of that bound on the legitimation of experts. I further suggest that experts within the field of laboratory sciences are less susceptible to the critiques of lay people because the process of classification within the laboratory sciences appears less subjective.

Gil Eyal formalizes the Sociology of expertise in his book, “For a Sociology of Expertise: The Social Origins of the Autism Epidemic”. Eyal develops a theory of expertise that differs from previous studies of the sociology of professionalism, by differentiating between *experts* and *expertise* (Eyal 2013:869). Experts are the actors who make claims to jurisdiction over a task by “professing” their credibility. Expertise is the logic that enables experts to accomplish this task better and faster. Prior literature on the sociology of professions treated expertise as a given attribute of experts. All experts were considered to possess the expertise necessary to accomplish the tasks expected of them. However, sociologists of expertise recognize that the influence of expertise is not the same as expertise. A sociology of expertise begins from the recognition that,

“...the social consequences of psychology expertise are not the same as the social consequences of psychologists experts,’ that is, that experts and expertise are not reducible to one another and require two distinct, though combinable, modes of analysis.” (Rose 1992, as cited by Eyal 2013:870).

This distinction is important, because it recognizes the role that non-experts, or “lay people” hold in crafting classifications of and responses to conditions. The two fields have distinct analyses to power,

“In sociology of professions, power is analyzed as a set of mechanisms designed to control supply and demand for professionals services. It gets power through monopoly over its knowledge (leads to control supply of its services) and autonomy in defining significance and relevance of its knowledge (controls demand of its services)” (Eyal 2013:874)

This is to say that in Sociology of professionalism, power is firmly in the hands of the professionals because of the asymmetry of information.

In contrast, Sociology of expertise argues that experts are bounded by lay people in their claims and actions,

“When power is analyzed not from the point of view of the actors, the group of experts, but from the point of view of expertise, that is, the point of view of putting together a network that produces, reproduces, and disseminates expert statements or performances,

the focus shifts indeed to the mechanisms that secure the cooperation of the clients, as well as the other parties involved.” (Eyal 2013:875)

Lay people may challenge the expert without challenging the expertise if the experts’ findings are too inconsistent with the realities of the lay people.

Eyal’s argument is useful in distinguishing that it is not the experts that hold power; it is the expertise. However, he does not adequately address why this trend exists. Empirical examples suggest that lay people do not always take the claims of experts seriously. Why does this occur? If experts are using scientific methods that are deemed legitimate, what is the source of distrust? I argue that scientific findings are not necessarily legitimate because the system of classification within science depends upon the subjectivity of the expert performing the research.

When discussing science as a means of rationalization, there is a need to distinguish between the social and the biological sciences. Although the grounding theory of the process is the same for all sciences - all depend on the scientific method - there are profound differences in the way they are understood and interpreted. Science is a process of determining truths about determinant, causal relationships that explain aspects of the world. These truths depend on classifications. Different groupings, or variables, are defined by a certain set of criteria. Ian Hacking writes, “classification...is the essence of scientific reasoning” (Hacking 2010:5).

However, social sciences and natural sciences differ, in that natural sciences allow for the formation of laws and rules. In conducting “laboratory sciences”, researchers can concretely identify and separate variables. Although people can never prove a law, it is understood within natural sciences that we can come so close to proving a law that it can come to accepted it as truth. For example, Newton’s laws of motion are widely accepted as laws, not theories. In contrast, social sciences are (usually) presumed to be too variable, with methods that are too

imprecise, to arrive at any sort of law. Social scientists can only develop theories that are prone to being challenged, modified, and changed. The theories will never become laws.

Hacking supposes that the fundamental difference between natural sciences and social sciences is the role of classifications,

“They differ because there is a dynamical interaction between the classifications developed in the social sciences, and the individuals or behaviour classified. When we characterise a type of person or behaviour, it can affect some people so classified in a direct way, and may even change them...I have called that the looping effect of human kinds” (Hacking 2010:10).

The process of classifying a grouping of bacteria or a family of plants, which have no conception of self, has no impact on how those bacteria and plants will grow and behave. However, the process of classifying humans can moderate their behavior based on how they understand the classification. This understanding of biological and social sciences, however, puts medical sciences in an uncomfortable position. Hacking writes,

“They are not quite natural sciences, not quite social sciences. On the one hand, the thrust of medical sciences, including psychiatry, is to discover fundamental organic causes of illness. In the case of psychiatric disorders, these may be biochemical or neurological or both.” (Hacking 2010:10)

Harding also points out that the field of psychiatry strives to find hereditary antecedents for many illnesses. However, the ways in which we are ill - our actions, demeanor, and attitudes - are classified in very human ways. He continues,

“Thus the classification and diagnosis is constructed, and this very construction interacts with troubled people and helps to produce their behaviour, which in turn confirms the diagnosis.” (Hacking 2010:10)

I suggest that the key variable in determining the power of experts over lay people is the potential for experts' claims to be inadvertently impacted by their values. As previously mentioned, laboratory sciences come closer to discovering laws because they can distinctly separate variables and rely upon steady systems of classification. Therefore, laboratory sciences

are less prone to questioning by lay people. A sociologist who argues that depression is a social construct is likely to be taken less seriously than a neuroscientist who argues the same thing, because a neuroscientist uses biological data that appears to be absent of subjective values in a way that a sociologist cannot achieve. Medical science is often regarded as a value-free brand of science, but this is incorrect. Thus, claims grounded in biomedicine are less prone to pushback even when they provide classifications that are mutable and subjective.

Symptoms, Illnesses, Disease, and Diagnosis

In order to understand what factors determine legitimate from illegitimate policy proposals, it is necessary to analyze the nature of the specific field of policy. In this thesis, the stakeholders are those who are making claims about mental illness and medical responses. These include politicians, community leaders, medical experts and service providers, and people who are labeled as mentally ill. Diagnostic criteria and treatment methods are often considered to be deduced through formal rationality because conditions are recognized as diseases by the presence of biological deformities. However, the rise of medical sociology questions the social influences that shape what conditions are considered to be a disease, and what is considered to be useful medical treatment.

In this section, I will draw upon the work of past theorists in medical sociology to argue that even though health diagnoses are often made using standardized biological measurements, both social and biological mechanisms influence the boundaries of diagnosis. Technological and cultural advances have resulted in internal biological processes being a more legitimate source of evidence that a condition is a disease than experiential accounts. That said, experiential accounts are no less important in defining diagnostic boundaries, especially in the field of mental health,

even if they are not cited as so. The medical system can function as an institution of social control by using social values to delineate what deviant conditions embody sickness. Therefore, a study of health policy necessitates an analysis of the political and social processes that inspire policy formation, not only the biomedical advances.

Talcott Parsons is often considered to have initiated the field of medical sociology with his characterization of the “sick role” in *The Social System* (Parsons 1951:436). People who occupy the sick role enter a role of “sanctioned deviance” because they are unable to be functional members of society (Parsons 1951:440). Those who occupy the sick role hold certain responsibilities and privileges that are meant to ensure they are improving their health status as best they can. Parsons’ work was significant because he recognizes that sickness is not an objective medical condition, but is also dependent upon notions of values and the social responsibilities of the individual. Classifications of biological conditions as sicknesses depend upon the values of the culture and the social responsibilities of the individual. Sickness is identified using standardized measurements, however the boundaries that define those diagnoses are socially constituted.

The process of diagnosis depends on both standardized biological measurements and experiential accounts. For a long time, the terms illness and disease were used interchangeably. However, in the past fifty years medical sociologists have differentiated between the two terms. Kleinman, Eisenberg and Good (1978) describe illness as a personal experience of sickness, shaped by culture and influential for health outcomes. Illness is not something that can be determined using biomedical measurements because it is based on an individual’s experience and perception of their physical being. In contrast, disease is defined by biological measures. Kleinman et al. (1978) claim that western medicine considers disease a biological

psychophysiological dysfunction. The patient comes in with an illness, and their account of their experience allows the doctor to diagnose the patient with a disease.

This distinction is important, because it recognizes that not all experiences of illnesses are considered to be diseases, and not all diseases are experienced as an illness. There is a process by which a condition is either “medicalized” or “demedicalized”, and that process, even if it is justified by medical science, is driven by claims and legitimated by values. Therefore, medical experts cannot rely solely upon biological and neurological information to make useful classifications of disease.

When are claims of illness understood to be disease? Aronowitz (2004) examines how the mechanisms of justifying a condition as a disease have changed over time. Since the 1900s there has been a push to define diseases at a “deeper” level that incorporates a biological understanding of the disease and is less dependent on clinical criteria. This shift has accompanied a change in the understanding and importance of symptoms. Once regarded as a bodily phenomena that constituted part of the illness, symptoms have changed to be understood as a product of organs “deviating from their functions” (Aronowitz 2004:66).

Aronowitz finds that despite this shift towards defining disease in terms of biological malfunctions, there still remain large social factors influencing disease categories due to limitations in medical knowledge and “the imperfect match between individual suffering and medical categories” (Aronowitz 2004:70). This process of socially constructing diseases is not as apparent as it once was, because now it is not clinicians who hold authority but rather the “new agents and molecular mechanisms” (Aronowitz 2004:70).³ Despite this appeal to biomedicine, lay people and experts still engage in battles over what conditions are to be considered a disease. This argument highlights a paradoxical process; sickness is becoming more

³ Or in Eyal’s terms, it is not the experts who hold authority, but the expertise

commonly justified by biomedical evidence, a seemingly objective mechanism, but this shift has not been accompanied by a decline in political battles over the classification of disease.

The role of social values in constructing illness are even greater in the case of mental illness, where diagnoses are more often defined by symptoms rather than biomedical measurements. Thomas Szasz (2004) argues that mental illness is not “real” in a biological sense. Instead of conceptualizing mental illness as a product of physiochemical deformities that can be discovered with advanced medical research, Szasz suggests that mental illness arises from value conflicts. Szasz suggests two main misconceptions in defining mental illness: 1) mental illness can be explained by defects in the central nervous system, and 2) any errors that we make in diagnosis can be attributed to the way we organize and express our knowledge rather than to the manner of reasoning (Szasz 2004:44). Psychiatry attempts to remove itself from a discussion of ethics, however all mental illness diagnoses are influenced by the established values of society.

Traditionally, institutions of social control have used sanctions to punish deviant behavior, regulating norms and establishing social values within society. Past institutions of social control include the family, the church, and the criminal justice system. However, Conrad and Schneider (1992) argue that the past several decades have demonstrated a phenomenon they label “medicalization of deviance”. This means that many deviant behaviors that used to be considered moral problems are now considered medical problems. Throughout this change, the agent of social control has shifted to the field of medicine. They are not studying the deviant behaviors, but instead the changing means by which deviant behavior is defined and justified by social control mechanisms.

Conrad and Schneider argue that the rise in medical designations of deviance in the United States can be attributed to “the rise of rationalism, the development of determinist

theories of causation... and the growth and success of medicine in the 20th century” (Conrad and Schneider 1992:261). With the rise of determinist scientific reasoning, Americans began to regard treatment as a more humane form of social control than punishment. Furthermore, they point out, “In a world that views science as the ultimate arbiter of reality, deviance designations that can be supported by scientific research are more likely to gain credence” (Conrad and Schneider 1992:28). Medical designations of deviance are not predestined social processes, nor are they more accurate. Instead they result from shifting forms of rationalization in the United States. Therefore, Conrad & Schneider regard the transformation of deviance designations as “political achievements” rather than products of societal evolution and medical progress (Conrad and Schneider 1992:xi). This “shifting form of rationalization” might seem contradictory with my prior argument that formal rationalization is not eliminating substantive rationality. To clarify, the rise of formal rationality is inspiring a shift towards medicalization of deviance, but substantive values still define *what* behavior is deviant. The recognition of the medical system as a form of social control is crucial because it acknowledges that cultural values are influential in defining what behaviors constitute illness versus what behaviors are “normal”.

Social Problems

In this section, I explore how social problems are defined in order to argue why scientific findings might be interpreted differently depending on the context in which they are interpreted. Fuller and Myers’ suggest that it is value judgments that cause people to define conditions as problems. Every social problem consists of “an objective condition” and a “subjective definition” (Fuller and Myers 1941:320). The objective condition can be verified by an outside observer, and includes measurements such as trends in birth rate, unemployment, etc. The

subjective condition is the way that objective condition is labeled and it includes the awareness of certain people that the conditions are a threat to certain “cherished values”. Their definition of social problems contends that social problems are always borne out of a condition that threatens values.

Spector and Kitsuse (1987) contend that Fuller and Myers’ definition is too broad of a characterization, as it unnecessarily concerns itself with the determinants of social problems instead of conceptualizing the phenomenon itself. Spector and Kitsuse conceptualize social problems a type of *claims-making activity*. The formal definition of social problems that Spector and Kitsuse use is “the activities of individuals or groups making assertions or grievances and claims with respect to some putative conditions” (Spector and Kitsuse 1987:75). To demonstrate their point, they differentiate between value groups and interest groups. Value groups are driven by “moral indignation” about social conditions that do not affect them. Some examples of value groups include humanitarian reformers and animal-rights activists. Interest groups, in contrast, are the victims of the social problem, and are groups that advocate to protect their own interests independently of value commitments. It provides for the possibility that groups may “disingenuously espouse value positions and take pragmatic views to protect their interests” (Spector and Kitsuse 1987:89).

Can people engage claims-making activity pertaining to social problems that are independent of values? If so, we can imagine cases where science can systematically determine the optimal policy. However, I will argue that Fuller and Myers are correct in including value-orientation in their definition of social problems. What Fuller and Myers’ dub as an interest group could just as easily be a value group if their demands raise a value conflict with another stakeholder. All claims-making activity, even that by “interest groups” that are the “victims” of a

social problem, is legitimated by values. Even if not outwardly stated so, the proposed outcomes of a given policy are legitimated by values that are not necessarily universal.

Research Methods

This is a thesis about the factors that influence the formation of public health policies. Public health advocates often call for “evidence-based” policies even when the intervention might run counter to the beliefs of stakeholders. The current political controversy over safe injection sites in Philadelphia is a useful example of this trend. Philadelphia has experienced an exceptionally high rate of overdose deaths and stakeholders in the city hold access to vast amounts of scientific research on opioid addiction and SIFs. Despite this, the implementation of SIFs in Philadelphia has been more controversial than cities in other countries, such as Canada and Portugal.

In my research, I attempt to discover how different stakeholders in the opioid crisis justify their political beliefs on harm reduction. This research aims to support an argument about how stakeholders and politicians use formal and substantive rationality to deem which policy proposals are legitimate and which are not. My argument explains why political controversy over safe injection sites remains strong even in the presence of scientific knowledge. My findings have implications for future approaches to policy formation that seek to address the opioid epidemic and other public health crises.

In order to answer these questions, I conducted interviews of eleven individuals involved in the harm reduction debate. In Rachel Faulkner-Gurstein’s dissertation about the institutionalization of harm reduction, she divides the harm reduction political movement into three groups of stakeholders (Faulkner-Gurstein 2015:15-17):

- 1) The mayoral level includes city politicians and the city public health department, and is concerned with public policies, public discourse, and political appointments.
- 2) The middle level includes community based organizations (CBOs) that connect governmental bureaucracies and grassroots movements, and compete for resources and policy changes.
- 3) The grassroots level includes groups that contribute to harm reduction as a social movement, many of which are explicitly user-activist organizations and advocate for policy change.

However, Faulkner-Gurstein discusses how these levels have blended over the years as the harm reduction movement has become more institutionalized. Many early activists have continued on to adopt professional titles, and may identify as more than one of activist, health service provider, community organizer, or politician.

In my research, I observed a similar trend. I spoke with many people who have earned professional degrees and/or work at CBOs who also would call themselves activists, and are at the forefronts of many activist movements. Due to this development, I sort my subjects into two levels: 1) the mayoral level (analogous to Faulkner-Gurstein's mayoral level) and 2) the community level (includes community organizers, community healthcare and social service providers, and drug users). The community level holds a wider variety of interview subjects, as well as the largest number. I categorized three of my subjects into the mayoral level and seven into the community level. The last interview was with a population health researcher at an academic institution, and did not fall into either category. The mayoral level included two members of Philadelphia City Council and one staff member of a councilperson. The community level subjects included people involved with mental health services, legal services, social services, community organizing, and political organization. Subjects' work often spanned across multiple categories, so I did not further group members of the community level into these additional categories.

I used qualitative interviews as my central research method because it allowed me to gather data about how each stakeholder has formed their political beliefs and to contextualize their opinions within their field of work. Furthermore, in my interviews, I saw how subjects respond to viewpoints different than their own, giving a more honest assessment of how stakeholders balance their own beliefs and scientific evidence when formulating opinions.

My interviews lasted between 30-60 minutes, and were conducted in December of 2018 through February of 2019. I conducted semi-structured interviews, where I began a set of standard questions but also followed the conversation in the direction that subjects pushed.

I asked interview subjects about two main topics:

- 1) The role of scientific evidence in crafting policy. This involved asking about the limits of scientific evidence, the types of evidence that they find most convincing and useful, the role of science in forming their own stance, and their experience collaborating with other stakeholders.
- 2) Their understanding of why the drug problem is a “problem”. This involved asking about their own work, their motivation for getting involved with getting involved politically, their ideas of the ideal outcomes of policy change, and their opinions on who should be driving policy responses (experts, drug users, neighbors of drug users).

There was no systematic way to reach out to stakeholders in the harm reduction debate. I had no pool to select from, nor did I have a reliable way to recruit volunteers to participate in the study. I simply reached out to as many people as I could identify who were invested in the SIF controversy, and used the snowballing technique to get in contact with more individuals. I had one contact from a prior volunteering experience, but otherwise all of my subjects were acquired via snowballing technique.

This technique had pros and cons. I was able to interview a large variety of people who occupy different roles in the political struggle. This collection of subjects gave me insight into the various considerations that go into the formation of political thought on harm reduction. On the other hand, I was not able to reach a balanced selection of respondents in that most of the

people I spoke to advocate for harm reduction. My sense is that those advocating for harm reduction methods are more outspoken and more likely to work for a CBO. As a result, I have less data than I would prefer on the viewpoints of opponents to harm reduction. Furthermore, the wide array of professional industries meant that it was not always a clean fit to compare claims across subjects and make generalizable claims.

This study received IRB exemption because I never asked subjects about their own personal history with drug use. Before each interview the subject was promised that their identity would remain confidential, and that their comments would not be attached to their organization. Most subjects indicated that they would be comfortable speaking to me even without these measures of confidentiality, but several subjects specified that they would not want their words to be misconstrued as representative of organizational beliefs. I asked for consent to record the interview, and every subject consented to being recorded. There was a technical difficulty during one of my interviews preventing me from getting a recording, so I paraphrased as much as I could remember from the interview afterwards. Pseudonyms are used for the subjects' names and their organizations.

In addition to my interviews, I draw upon past drug control strategies released by the federal government. The first document was written by William Bennett during the George H.W. Bush administration. The second document was written by the National Institute on Drug Abuse during the Barack Obama administration. These documents provide useful information on the means by which federal bureaucracies have justified their drug control strategies, and they demonstrate the ways that the federal government has changed (or not changed) its approach towards drug control. It is worth noting that I focused my study on the political controversy

occurring in Philadelphia, but controversy over harm reduction has been escalating in other cities in the United States, such as San Francisco, Seattle, and New York.

Data Analysis

The Role of Scientific Evidence

A key question in this discussion involves the role of science in identifying legitimate policy response. To what extent is policy “science-driven”? How are natural and social sciences used differently to inform drug policy? Why might not all scientific studies be deemed useful? In this section, I outline how both governmental health agencies and many stakeholders attribute the recognition of addiction as a mental illness to the development of improved scientific technology, and how this process has resulted in the supposed elimination of moral considerations in the political response to drug use. I then examine subjects’ perspectives on the utility of science in justifying their political stances. I identify three significant trends in this section: 1) claims that biological advances are responsible for removing moral values from our understanding of drug addiction 2) an inability to explain why harm reduction is a useful intervention within the biomedical model of addiction and 3) selective use of credible scientific evidence depending on the purpose of the scientific investigations.

The Removal of Morals from Drug Addiction and the Rise of the Biomedical Model

We can trace the entangled history of drug use and morality within the United States through looking at past strategies to control drug use. In 1989, the National Criminal Justice Reference Service released a National Drug Control Strategy. This was written by William Bennett, who served as the Director of the Office of National Drug Control Policy under

President George H.W. Bush. Bennett overtly connects drugs to themes of morality. When addressing the question of why legalization of drugs could not be an effective response, Bennett writes,

“Exactly how under this scenario we could convincingly warn potential new users about the evils of drugs - having just made them legally acceptable - is not clear...Whatever else it does, drug use degrades human character” (The White House 1989:7).

Bennett’s claims suggest that drug use is directly related to the destruction of the moral fabric of society.

In 2014 the National Institute of Health released a report titled “Drugs, Brains, and Behavior: The Science of Addiction”. The report begins with a preface titled “How Science Has Revolutionized the Understanding of Drug Addiction”, written by Nora Volkow, the Director of the National Institute on Drug Abuse. Volkow writes that new scientific breakthroughs have allowed us to identify substance addiction as a disease,

“As a result of scientific research, we know that addiction is a disease that affects both the brain and behavior. We have identified many of the biological and environmental factors and are beginning to search for the genetic variations that contribute to the development and progression of the disease.” (NIDA 2014:1)

She continues,

“At the NIDA, we believe that increased understanding of the basics of addiction will empower people to make informed choices in their own lives, adopt science-based policies and programs that reduce drug abuse and addiction in their communities, and support scientific research that improves the Nation’s well-being.” (Volkow 2014:1)

Volkow claims that advances in biological science have driven the shift in treating drug use with treatment instead of punishment. This scientific knowledge allows us to implement policy based off science, which will systematically ensure that we implement the best responses. Volkow contrasts this to prior understandings of drug use,

“For much of the past century, scientists studying drug abuse labored in the shadows of powerful myths and misconceptions about the nature of addiction.” (NIDA 2014:1)

Those myths can now be dismantled with (biological) scientific evidence, Volkow writes.

This passage demonstrates the ability for science to legitimize what might otherwise be controversial viewpoints. Whether or not advanced scientific understanding was responsible for changes in response to drug use, it is evident that biological science is deemed a legitimate way for the claims of professionals to be understood as valid.

The NIDA report demonstrates that addiction is a disease by depicting the neurology of people who use drugs. The report says,

“It is considered a brain disease because drugs change the brain - they change its structure and how it works.” (NIDA 2014:5)

Figure A shows a series of brain scans that highlight the difference between a “healthy brain” and a “diseased brain” of a drug user. The diagram compares the brain scans to the discrepancy between the heart of someone with heart disease versus a healthy heart. The caption reads,

“Addiction is a lot like other diseases, such as heart disease. Both disrupt the normal, healthy functioning of the underlying organ, have serious harmful consequences, and are preventable and treatable, but if left untreated, can last a lifetime.” (NIDA 2014:5)

The diagram implies that the behavior of drug users can be explained by physical deformities.

Many of my interview subjects echoed a similar understanding of drug addiction that is rooted in brain biology. Bill, a philanthropist who has invested in governmental naloxone distribution programs in Philadelphia, explains his understanding of drug addiction,

“It rewires your brain. You know they’ll feed like mice in cages substances, and they’ll use the substances over the food, so they’ll starve themselves because it just takes over the brain.”

This sentiment, explained by Volkow and echoed by Bill and several other subjects, demonstrates the rise of the biomedical model of addiction. It is understood that the biomedical model provides diagnostic criteria of addiction that is not subject to individual biases but rather

to the rise of scientific technology. The introduction of this scientific technology is claimed to have removed moral considerations from medical and political responses to people who use drugs. However, the following sections will demonstrate that moral concerns still shape how people respond to the opioid epidemic.

Relationship between Natural and Social Sciences

There are two types of scientific evidence to which subjects referred. The first falls under the category of laboratory sciences. These include biological studies examining the neurological processes that accompany drug use. The second falls under social sciences. This includes studies on the relationship between the introduction of SIFs into a neighborhood and measurements such as overdose mortality rate, crime rate, and drug use rate. As articulated in the previous section, I find that biological sciences are used to legitimize the biomedical model of addiction, and are claimed to allow for an understanding of addiction that is independent of social values. Social sciences are used as evidence to advocate for harm reduction, but they are not able to explain why harm reduction is useful within a biomedical model of disease.

Claims that addiction is a disease are useful for legitimating the need for medical treatments. However, they are not necessarily useful for legitimating the need for harm reduction. Instead, SIF advocates often use social sciences to justify their position. Says Ryan, a medical student and harm reduction activist,

“So I don’t cite hard sciences because this is to me not a hard science issue. Unless we are talking about the need for medically assisted treatment, or the fact that addiction is disease. In terms of framing, and the fact that we want to actually emphasize that this is an evidence-based intervention, we just give the evidence base about the efficacy of overdose prevention sites internationally.”

Ryan does not clarify why “hard sciences” are relevant for advocating for medically assisted treatment, but not for SIFs. Furthermore, Ryan points to the efficacy of SIFs, but does not feel the need to explain *why* they are effective.

Rita, who works with Justice for AIDS, a public interest law firm for those living with HIV and AIDS, explains why the Federal Department of Justice’s arguments against SIFs have failed to convince her that their stance is right,

“If they had said, here is the volumes of credible evidence that say this doesn’t help. I always have an open mind, I’d look at that... But they are just saying the law says no, so it is no. We need more. Particularly in light of all the evidence that says it does work.”

Her comments reflect the appeal to policy that is deduced from evidence rather than morals.

Peter, a mental health counselor who specializes in addiction, deviates from other subjects when he claims that drug addiction is not a “disease” in the way that people describe it. He critiques the biomedical model of disease, claiming that it removes agency from the person who is addicted,

“Yeah sure, so it is a disease in the sense that there are symptoms, it can be recurrent, it can lay dormant and it can come back. But I don’t like the disease concept of the disease model, because it takes away the responsibility of the person that is labeled as having an addiction or a substance abuse disorder, it takes away the responsibility.”

He has observed that his patients who have not internalized their condition as a sickness tend to rebound well after relapses, while those who consider themselves to be “sick” tend to spiral out of control. He continues,

“And you see this a lot when you talk to people that are in active chaotic using, they’ll use the disease concept as like, this is a disease, I don’t have a choice.”

Peter speaks of his frustration with neuroscientists, who justify addiction’s status as a medical disease by explaining the neurological mechanisms that occur in the brain when drugs are consumed. He speaks about his interactions with addiction experts,

“A lot of the time when I am learning about the neurology behind addiction, and neurologists are talking about it, they like to use the term ‘hijack’. They say ‘your brain has been hijacked’. They talk about that with sugar as the analogy, sugar, they say hijacks your brain, especially that high fructose corn syrup. And you do see a portion of the population that is obese and they have succumbed to this hijacking. But you also see a large portion of the population that isn’t affected by it. And that is because of the social constructs that go into that.”

Peter indicates that the correlation between neurological deformities and experiences of addiction do not convince him that people addicted to drugs are without agency. Brain neurology is only one variable that impacts a drug user’s decision-making. Arguably more important is the person’s understanding of the illness and social/cultural understandings of the meaning of addiction. Peter mentions that the “disease” label is useful for securing funding, even if he does not view it as a useful tool for helping his patients.

In Peter’s eyes, the focus on addiction as a disease results in incorrectly attributing all of drug seeking behavior to neurological impairments, and fails to recognize that one’s understanding of their experience is instrumental in the motivation of their future behavior. Those labels of illness may actually take away agency from the patient, because their experiences are not reducible to their brain neurology.

Just like Ryan, the medical student and harm reduction activist, Peter appeals to social scientific evidence—referring to past studies like the “rat park”⁴ experiment among other pieces of evidence - to legitimize his claims. However, Peter’s understanding that substance addiction is a socially constructed disease allows him to more firmly explain when to use social versus natural sciences, and to theorize why SIFs have proven to be effective.

Selecting Credible Science

⁴ “Rat Park” was a psychology experiment comparing consumption of opioid-laced water across two groups of rats. It was found that rats who live in a cage with rat toys and other forms of entertainment (the “rat park”) choose to drink normal water over opioid-laced water, while rats who live in an empty cage prefer the opioid-laced water.

Subjects consistently claim that policy should be driven by science. However, not all science is claimed to be valid. Subjects selectively choose research findings, discounting studies that they figure will result in interventions that are substantively irrational.

Peter, the mental health counselor, indicates that science is useful for determining treatment methods and policy responses. He states that all of the treatment methods he practices are “evidence-based”. Furthermore, he cites the studies on SIFs in other countries as indicators that they would be useful in Philadelphia.

Peter demonstrates his frustration when people rely on their personal beliefs instead of science to make policy interventions. Here, he refers to restrictions created by the Drug Enforcement Agency that restrict which drugs can be researched in biomedical setting. These restrictions are used for drugs that the DEA believes to be too dangerous for medical use,

“...it is interesting how they have classified all of these other drugs to not allow for scientific research about them, because they’ve classified them as no medical use, blah blah blah. So they can’t study them, they can’t find out about them.”

He is suggesting that there exist preconceived notions about the danger of certain drugs. This classification which divides drugs into medically useful versus medically useless, is not grounded in science. Peter is suggesting there is a hypocrisy that these restrictions exist, because scientific studies might help to identify how dangerous a drug truly is.

Interestingly, Peter also warns that science can be abused to justify unethical interventions. He comments on the use of forensic science by law-enforcement agencies,

“Of course, I mean the more information that we have is always useful, no matter what we can study, no matter what we can gather data about. Unless we are gathering data for law enforcement because that typically isn’t beneficial because they use that to further prosecute people. But that isn’t data that I support because I think there is a lot of negative that comes out of it.”

Peter suggests that scientific findings can be easily misconstrued to support negative initiatives. Stakeholders must decide which science is useful for upholding their values, and which is misleading.

Peter's reasoning, while sound, highlights a fundamental contradiction. He is frustrated that scientific research for the purpose of determining the medical utility of certain drugs is banned. However, he also does not support the use of science within the field of law enforcement, because that evidence can be used to justify law enforcement. This raises the question; why is it that sometimes science is deemed valid, and other times it is not? I find that subjects selectively choose science that advances their own political agenda and appears to be subjective.

The Role of Values in Constructing Social Problems and Policy Solutions

The prior discussion regarding the role of science in responding to social problems demonstrates that science is regarded as a legitimate procedure to determine the best policy response. However, despite this appeal to science, stakeholders disagree over how to respond to social problems. Furthermore, they disagree about what science is useful. In this section, I examine the differing value commitments that shape how stakeholders define social problems and advocate for ideal policy outcomes. I outline three key trends in this section. First, different stakeholders hold differential ideas of what the "drug problem" is, and their disparate value commitments drive this difference. Second, due to their differential definitions of the social problem, stakeholders hold different ideas of what the ideal policy outcome would be. Third, some elements of the drug problem can be classified as "private", while others are "public". The more private the problem is, the more likely it is that government bureaucracies will defer to

scientific findings in favor of their own beliefs. The more public is the problem, the more politicians have to make value judgments about whose voices to listen to.

In the aforementioned NIDA report from 2014, Volkow writes,

“When scientists began to study addictive behavior in the 1930s, people addicted to drugs were thought to be morally flawed and lacking in willpower...Today, thanks to science, our views and our response to addiction and substance use disorders have changed dramatically.” (NIDA 2014:1)

Volkow’s comments suggest that the development of science has removed moral considerations from our response to drug use. This raises the question, have moral boundaries surrounding drug use shifted since this time? Have scientific developments caused a shift in moral boundaries surrounding drug use, or have they changed the foundation of legitimation for mechanisms of social control? Is our response to drug users a morally neutral topic that is deduced entirely through science, or do value commitments still play a role in determining policy response? Earlier I discussed Peter’s selective use of scientific evidence. Why is it that sometimes he would like to appeal to science, while other times he finds that scientific evidence can be abused to result in suboptimal policies?

What do people mean by the drug “problem”?

It is widely acknowledged that the opioid epidemic is a problem, but rarely do people acknowledge that there are different reasons for why it might be considered to be problematic. All subjects acknowledge that there is some sort of drug “problem” happening in Philadelphia. However, their claims about that problem are extremely varied. Some are most concerned that people who use drugs are dying at a high rate, and that we are failing to take all the possible measures to prevent these overdose deaths. Ryan explains the original inspiration for advocating for SIFs,

“My patients were dying. I mean, when you have a large amount of people who you care for or love who are dying because of the overdose epidemic and fentanyl, that’s what pushed me to want to work with Stand Together, wanting to lobby and be an activist for overdose prevention sites.”

Ryan’s work in the medical system inspired him to see overdose deaths as a major social problem. However, other subjects did not view this condition as problematic. While troublesome, Councilman Wilson, serving his second term on the City Council, does not regard overdose mortalities to be a problem worth addressing. Councilman Wilson believes that the government doesn’t have a responsibility to save people using drugs because those individuals have free will,

“You are dealing with people that have free will, have self-determination, that are addicted, and want to be addicted. And they don’t want to be addicted, but they want to be addicted.”

Other subjects viewed the drug “problem” as problematic for its impact on neighbors, not drug users. Kim, who works for an organization that supports neighborhood revitalization in Kensington, claims that her organization does not support SIFs for fear of the “community impact” they would have. While they might help drug users, they might also stifle economic and social development by attracting drug-related crime.

Both advocates for and against SIFs perceive the drug problem to be related to issues of racial justice. Ryan supports SIFs because the War on Drugs was primarily an attack on people of color,

“...we can end up contextualizing it in the War on Drugs. Which, by criminalizing and by pushing substance use under the table we have led to more harm on communities of color, in general increased incarceration rates...”

Councilman Wilson also advocates for racial justice, but instead claims that implementing a SIF would be working against racial equity. He explains that by implementing SIFs, the government is further perpetuating inequitable policing strategies by relieving incarceration rates for white people who use drugs,

“If you are walking to a safe injection site, we know you are carrying heroin. If you are carrying a crack pipe, you are getting arrested...And oddly, a larger portion of white people will be doing heroin and opioids, and a larger portion of African-Americans will be doing the other drugs.”

Why is it that two people who value racial equity would come to different solutions involving SIFs? Different stakeholders hold different notions of the rights of drug users. Councilman Wilson suggests that drug users don't merit welfare support if they aren't actively attempting to get treatment, while Ryan suggests that the public has a responsibility to provide them with adequate resources for survival.

Various Desired Policy Outcomes

Stakeholders demonstrate different ideas of what the ideal end policy would achieve. In this section, I demonstrate how alternative definitions of the social problem result in disparate ideals for policy outcomes, and further relate to the varying value commitments across stakeholders.

Councilman Sheldon, serving his second term on City Council, explains that he is not satisfied with a policy solution that would result in people continuing to stay alive without making strides to get them to stop using drugs,

“What is our end goal? We as a city, as elected officials, is our end goal to keep people alive? Or is our end goal to keep people alive and get them off of this? And I think it's the latter. You want to do both, keep them alive and get them the help they need so they can become productive citizens again.”

For Councilman Sheldon, the social problem is that citizens are failing to be “productive”. This means that any successful policy solution must ensure that people are being functional, and thus are practicing abstinence.

In contrast, Peter, the mental health counselor, articulates a different standard for his end goal for his patients. He speaks about alternative understandings of the word “recovery”,

“It is just any positive change. And that could be a mental change, like I don’t want to be doing this for much longer but right now I am... It could also be, I learned that injecting into my neck is more dangerous than injecting into my groin, so I will start injecting in my groin instead.”

Peter is focused on the patient being educated about their actions and establishing their own boundaries of what behavior they would like to engage in. Peter continues,

“Not making it contingent on, well, did you know you can stop?...It’s like, no, I am approving of you because you are a person and you have rights, just like everybody else, you should be cared for just like everybody else. Just because you choose to alter consciousness does not change any of those things.”

For Peter, the problem is that patients are putting themselves at risk of hurting themselves. His perspective on recovery and harm reduction is contingent upon the basis that the choice to alter one’s consciousness should not result in a change in their basic human rights. His conception of what recovery looks like is contingent upon his morals, not a study. Evan, a leader of the Philadelphia Drug Users’ Union, says that people who speak out against MAT and propose abstinence-only approaches remind him of the Nancy Reagan “Just Say No” campaign.

When considering whether or not to implement a SIF, stakeholders are not just considering the people using drugs. Many people are concerned with how a SIF would impact the surrounding neighbors. Kim, who I brought up earlier, explains that she doesn’t support building a SIF in Kensington because she believes it would establish Kensington as the epicenter of the opioid epidemic.

In contrast, Councilman Sheldon’s resistance to SIFs arises from fear that one SIF would lead to the construction of more SIFs,

“Well you had one [safe injection site]. Then you had two. Then you had three. Now you have 20. When do you stop? Are you going to have 500? Every area will have one so everybody can just go in and get high? That’s not our goal.”

While Kim and Councilman Sheldon both oppose SIFs, they do so for very different reasons. For Kim, the problem is that putting one single SIF in Kensington would negatively affect Kensington residents. For Councilman Sheldon, the problem is that instituting multiple SIFs would normalize harm reduction (and non-medicinal drug use) such that it is a common practice throughout the city. What legitimizes Kim’s perspectives on SIFs? She mentions that her organization values equity,

“So everything we do at this point, we are trying to think of in the lens of taking a trauma informed approach with an equity lens.”

Kim explains that a SIF would perpetuate economic inequality for residents in a neighborhood comprised mostly of people of color and already experiences high unemployment rates, low educational achievement, high rates of crime, and poor infrastructure.

Councilman Sheldon does not articulate his values as clearly, but he does allude to values first-world supremacy and individualism as legitimation for his end goals. He says,

“You’re living in defecation and urination, needles everywhere, you know rape happening daily... To say it’s okay – we’re not a third-world country, it’s not okay for people to live in these type of conditions.”

He continues,

“Our job is not to house everybody. Our job is to get them to be functional, and to go back to their families.”

Respondents often claim science helps develop an understanding of the truth. Policy should be evidence-based. However, we also see that respondents distrust science when it is used to justify practices they believe are antithetical to their values. We do not always hear what those values are explicitly, or how they are derived. Scientific knowledge has not resulted in more

unified understanding of how to respond to the drug “problem” because people use substantive rationality to determine their idea of the best policy outcome. Science is more likely to persuade people in the absence of a value conflict.

Public versus Private Problems

While SIFs are the main point of controversy today, there are other forms of harm reduction that have also faced institutional barriers in attaining funding and political support. Why is it the case that the city has funded some CBOs that use harm reduction techniques but has refused to fund SIFs? In this section, I explore how CBOs that address “private” social problems, are more likely to get city funding given adequate evidence that the program will work. By private I mean that the claims-makers are outside the public sphere of vision and are not perceived to be affecting other interest groups.⁵

Mason works with Healing in a Home (HH), an agency that provides housing for the homeless population of Philadelphia. Mason explains that HH embraces a harm reduction model by being tolerant of their clients’ drug use, and instead encouraging them to use safely. Other homeless housing agencies are strict about forbidding their clients to use drugs.

HH has received government funding with this model for several years. However, there was a struggle initially to convince city officials that this approach was worthy of receiving city funds. Mason explains,

“One of the first challenges we faced was being a housing provider that is doing it from a harm reduction perspective. I think that some people really struggled with that side.”

⁵ I am using the terms “private” and “public” loosely here. Joseph Gusfield defines private problems as those which do not call for governmental intervention, i.e. if someone chooses to cheat on their spouse that would be a social problem but not a public problem. In my case, I am including public and private to refer to the level of visibility of the claims-makers.

However, over time city officials became more comfortable with HH because they recognized that it was accomplishing its goals. Mason explains,

“But I think that what we were able to demonstrate was that not only was it effective, but it is cost-effective. It saves money for the whole system. And there is great dignity in all of those things. And participants want to stay in the program.”

Some other harm reduction techniques have followed a similar path. Initially, pushes to implement syringe exchanges in Philadelphia were highly controversial. Now syringe exchange is a common practice.

When asked why city officials embraced some forms of harm reduction and not others, Mason points to the different levels of visibility between different forms of harm reduction. With housing, he mentions that it is not as visible to the public eye,

“So it is a little bit different with housing because one, it was a little bit out of sight, out of mind.”

In contrast, at SIFs drug use is more visible. He draws upon his experience at a SIF in Vancouver,

“It is kind of jarring. I mean I’ve spent a lot of time in Kensington, I’ve seen plenty of public injection and been around it. But just the level of- it is right there, that is just what we are doing, what we are watching.”

Furthermore, the geographic region of the proposed intervention impacts whether the city will grant funding to CBOs. Kim complains about the city’s unwillingness to consider implementing a SIF in neighborhoods other than Kensington. Although Kim opposes implementing a SIF in Kensington for fear it would perpetuate neighborhood inequity, she supports the idea of a harm reduction approach. Kim would prefer to place the SIF in a central location,

“So there have been questions of why does it have to be in Kensington? Why can’t we put this in Center City? Because that is what most places do. Toronto and all of these

other places. They didn't put it in some outside neighborhood. It was right smack-dab in the middle of everything."

According to Kim, however, the city is not ready to seriously consider putting a SIF into other neighborhoods. Kim thinks the city won't put a SIF in Center City because if it is going to implement such a boundary-pushing institution, it must at least *appear* to be addressing the problem.

"I think that it is mostly Kensington is where it has been so we need to have a visible impact in Kensington."

Arising from these discussions is the distinction between private and public drug use. In the case of Philadelphia, CBOs that use harm reduction methods report less resistance from city officials to implement harm reduction in situations where the initiative is more private. Furthermore, in those private situations, city officials are more likely to use scientific evidence reflecting the efficacy of the harm reduction intervention in reducing overdose mortality and city costs as a basis for their funding decisions. In initiatives that are more public, public value orientations play a larger role in determining funding.

Public Problems and Political Voice

In the case of social problems that can be classified as public, politicians must balance the voices of different stakeholders and professional experts who are all invested. In this case, they must fall back on their value commitments to decide whose "problems" are most worthy of being solved.

The city must choose to address some problems but not others, and some problems merit greater attention. Says Councilman Wilson,

"There are a lot of issues, like education, housing, jobs, healthcare, and to step in front of an issue like drug addiction means that you think that is an important topic, more so than other topics that don't get addressed, like potholes and roads. Historically drug addiction

has been not a popular topic with people, because we are talking about self-inflicted harm, and people don't see that their money should be spent too much dealing with people who are living the life of a drug addict."

Politicians must make decisions about who to listen to, and how to balance the scientific evidence they receive from experts in the event that the evidence doesn't correlate with their constituents' demands. Councilman Wilson describes his job as a balance between simply fulfilling the people's will, "which is basically to poll them", versus trying to "weed through the confusion" and decide when the public is too misinformed to make a decision, so he must override their opinion to act in their best interest. It is not a matter of majority rules, nor is it a matter of leaving decisions to the experts.

Subjects acknowledge that the identity of the constituent matters when considering the obligation to listen to their claims. Rita, from Justice for AIDS, is a staunch believer of SIFs because she believes the evidence to be favorable. However, she acknowledges the difficulty in fighting against single mothers who do not want a SIF in their neighborhood,

"We go to these community meetings, and there are moms- not exclusively, but a whole lot of single moms, who say nobody ever listens to me, nobody respects me, and I'm trying to raise my kids to do better. That is hard to argue with."

Subjects were generally in agreement that it is important for drug users to be involved with the process of creating drug policy. However, there are slight differences in their reasoning for consulting drug users, and in their thoughts about how prominent of a role drug users should have. Mainly, I distinguish between two viewpoints on why it is important that drug users be involved in drug policy. The first viewpoint focuses on the ability to implement more efficient policies using the knowledge of drug users, who understand the thought-processes of drug users better than city bureaucrats. The second viewpoint embraces this efficiency, but also highlights

that it is vital for drug users to have a political voice as a principle of social justice to ensure their values are institutionalized.

Councilman Sheldon falls into the first category as he explains that it is important to collaborate with people who use drugs because they can give information about the state of the system.

“People who use drugs are the ones who give you all the information of how your system works or doesn’t work. When you go down there, it’s amazing when I tell the clinics this, you go down there and talk to them. They tell you what they do.”

This type of sentiment was common among subjects. However, this is where the differences start. Councilman Sheldon described how drug users provide useful information,

“They tell you if your system is working. They tell you how they are abusing the system.”

His comment “abusing the system” suggests that the fundamental system is correct, and their deviant behavior is an “abuse” of that system. The system has the right orientation, but has some fundamental holes or flaws that are letting people slip through the cracks.

Councilman Wilson is more upfront about his belief in the limitations of political power that drug users deserve,

“Interviewer: What role do you think that drug users should have in determining policy in response to the opioid crisis?

Councilman Wilson: Hey listen, honestly they should have some but not as much as they think they should have. We live in a terrible world where we think that everyone should have a determining role. I’m sorry that is just a lot of patronizing. Drug users should have say because we are trying to help them. But they shouldn’t run the hospital and tell the doctors what to do, and that is kind of where we are...Doctors are doctors. They are experts in medical and healthcare.”

In contrast to Councilman Sheldon and Councilman Wilson, other subjects, typically subjects at the community level, suggest the system demands real collaboration between experts

and drug users in order to be effective. Rita describes the limitations of implementing a plan without collaborating with drug users,

“I think if you don’t have buy-in from the people you are trying to serve then whatever solution you come up with is going to fail.”

Evan of the Philadelphia Drug Users’ Union said he started the union because drug users deserve political voice. He was inspired by other drug user unions across the world that have been successful in creating positive change.

Peter, the mental health counselor, speaks to the lack of compensation that drug users get when they assist in efforts to address the epidemic,

“...if the people who use drugs want to be involved, then they should be offered an opportunity to be involved. They should be compensated as consultants, because trust and believe that every city official and every medical person, professional, social worker, or whatever, they are being compensated.”

Peter’s claims that drug users who help government bureaucracies merit payment suggest that he believes their political voice should be institutionalized and treated with a baseline level of respect. Peter does not dismiss the utility of professional expertise. He says,

“So there needs to be this common ground where professionals and people who use drugs can come together and are equally respected.”

People rely upon their values to identify whose problems are public problems. Kim believes in equity, Councilman Wilson believes in free will and individualism, and Ryan believes in racial justice. These values dictate how they balance the complaints of various stakeholders, and make decisions about whose problems are “public” problems. Furthermore, tensions over political voice arise. Detractors of drug users’ influence in policy cite drug users’ limitations in knowledge inability to be formally rational, and sick state of mind. Advocates for drug users’ intervention in policy cite drug users’ ethical right to have a political voice and their

understanding of the thought processes of other drug users. This allows for experts to create policy that is both formally rational *and* substantively rational.

Conclusion and Research Implications

This study examines why political controversy over SIFs has persisted more strongly in the United States than other countries, even though the United States has experienced a relatively high number of drug overdose deaths and holds a large wealth of scientific knowledge pertaining to drug use and harm reduction. In order to answer this question, I look at how different politicians and community leaders communicate to define and resolve public problems. I examine the interplay of science and morality in legitimizing the claims of stakeholders, and how notions of expertise and morality impact which stakeholders hold influence in defining and responding to social problems. I contend that the United States has not implemented SIFs because of persisting value conflicts over the morality of using drugs, not a dearth of scientific understanding on the issue.

As mentioned earlier, Weber argues that as the Western world has developed, there has been a substitution from substantive to formal rationality. However, I find that people making claims about SIFs demonstrate selective use of evidence based on the values that they hold. This finding complicates Weber's theory, where formal and substantive rationality are unable to coexist. I contend that the rise of formal rationality has not replaced the influence of substantive rationality. Formal rationality is more frequently cited as a means of justification for claims. However, substantive rationality influences what scientific evidence is deemed legitimate for deciding useful policy interventions.

Weber's theory suggests that the legitimacy of experts would go largely unquestioned in the modern world because they are experts in formal rationality. The rise of bureaucracies, where leaders are based upon expertise, would formalize this structure. Lay people would only question experts if they feared experts didn't have their best interests in mind. I argue that the introduction of substantive rationality into the field of health policy creates room for lay people to question the efficacy of bureaucratic structures. Instead of relying solely upon formal rationality, policy makers must act in ways that are both formally and substantively rational to create good policy. The stratification of decision-making to experts, intended to result in the best possible policy decisions, fails to achieve this goal because it does not allow for lay people's values to be integrated sufficiently. This explains why drug users, experts, and neighbors might arrive at different conclusions on the best course of action despite ample information about drug addiction and SIFs. Furthermore, it explains why many lay people see the optimal organizational structure incorporating the voices of both experts and lay people. While stakeholders may claim that their political opponents are not reading the evidence correctly, they are really disputing over arguments pertaining to substantive rationality, and how to interpret the meaning of the evidence in accordance with their values.

Medical experts and politicians have claimed that scientific breakthroughs are responsible for the transition to recognizing addiction as a disease. They claim that our response to drug addiction is no longer driven by morals, but instead is driven by science. The use of biomedical evidence to justify their claims presents this as a topic of laboratory sciences, not social sciences. However, I contend that diagnosis and treatment of mental illness does not fall neatly under the category of natural science, and is especially dependent on the value commitments of those making claims. The means of justification have shifted between the War on Drugs and now,

resulting in a change in the mechanism of social control from the criminal justice system to the medical system. Throughout this change, the central conflict has remained the same. Is the United States willing to accept drug use as a normalized behavior and provide social services that support people who have not committed to stop using drugs, therefore foregoing values of individualism? The political controversy over SIFs indicates that the same value conflicts that drove the War on Drugs have not been resolved, and are still being borne out today.

Moving forwards, I do not suggest a specific policy intervention regarding SIFs in Philadelphia. However, I do suggest a shift in perspective in the policy-making process. Rather than urging for more scientific evidence in order to resolve problems, policymakers and interest groups would benefit from recognizing the discussion as a conflict over values. Medicalization of drug addiction and resistance towards harm reduction should be acknowledged as forms of social control that are grounded in value commitments, not movements that were driven by objective science. The biomedical model of disease was a useful tool to initiate the decriminalization of opioid use, but it fails to allow room for a socially constructed understanding of substance addiction, and for the normalization of non-abstinence based approaches towards those who are attempting recovery.

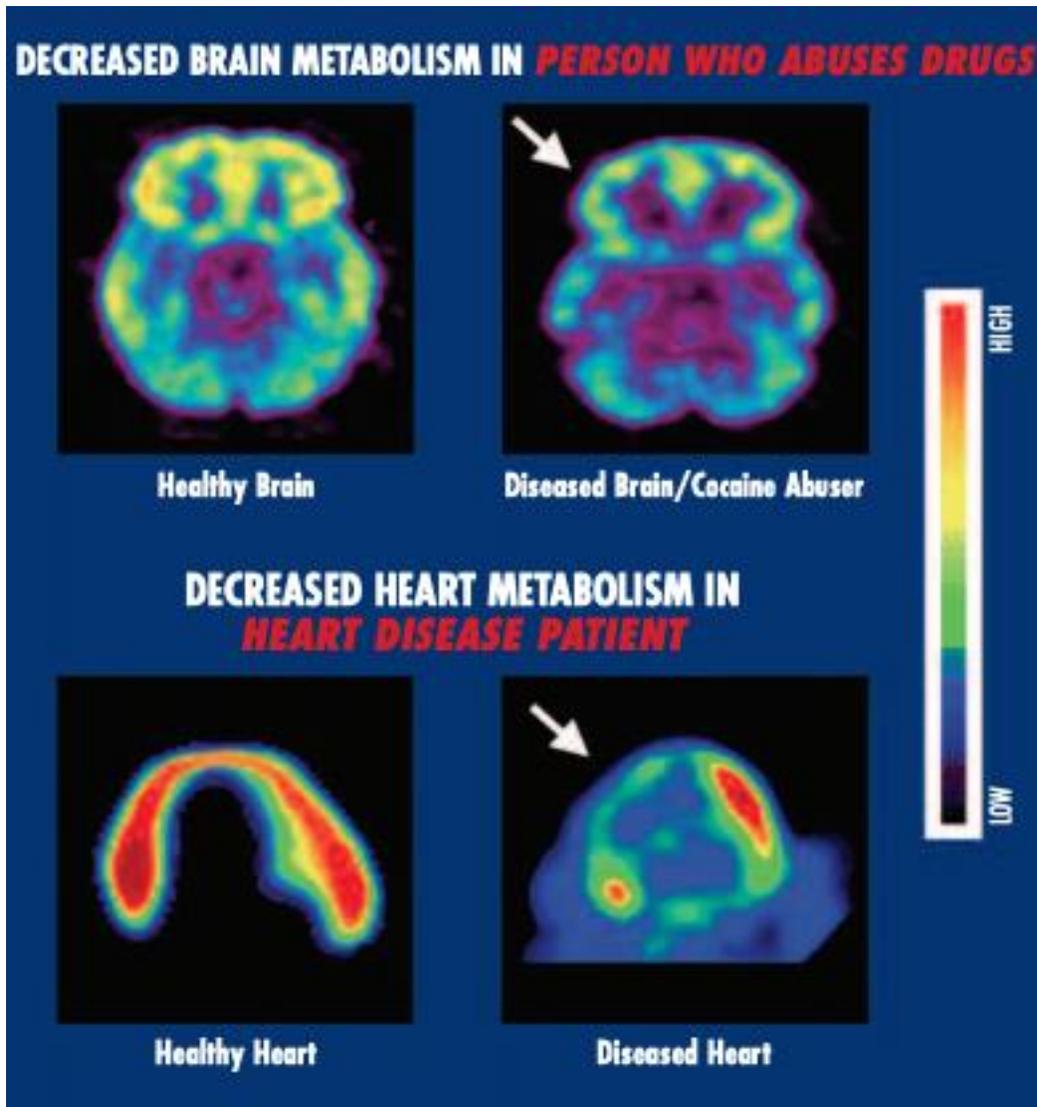
There would be differential effects for interest groups in the case that a SIF were implemented, depending on the location and number of SIFs. Policymakers must sort through a variety of potentially problematic consequences resulting from the creation (or lack of creation) of SIFs: the continued rise in overdose-related deaths of drug users, the establishment of Kensington as the drug epicenter of Philadelphia, the normalization of drug use in central locations, the investment of city tax dollars into SIFs, changing levels of racial disparities in incarceration rates, and many others. There is room for experts at the table, but policymakers

must also consult lay people in order to create legitimate policy. Policymakers must decide which of these policy consequences are problematic and which are not, and those judgments must depend on the value commitments of their constituents.

Harm reduction began as a social movement that was bound to moral principles of social justice. As governments have embraced it as a form of intervention, those moral principles have taken a background to scientific investigations as the primary source of justification. This appeal to science has veiled the moral value conflicts that persist, and the ongoing use of individualistic values to stigmatize drug use. This has resulted in hypocritical policies, where drug use is deemed a “morally neutral” issue, but people who use drugs are denied access to the ability to use safely, even as overdose mortality rates escalate. Politicians tend to waiver on their moral stance pertaining to the issue. They vow to support drug users, but are not outspoken about defending drug users’ rights. Therefore, I propose that government bureaucracies would benefit from more formally institutionalizing political roles for stakeholders who might otherwise lack political representation, such as drug users and neighborhood residents, in order to reestablish moral values as the integral source of debate.

Appendix

Figure A



Works Referenced

- Aronowitz, Robert A. 2004. "When do Symptoms become a disease." Pp. 65-75 in *Health Disease and Illness: Concepts in Medicine*, edited by Arthur L. Caplan, James J. McCartney, and Dominic A. Sisti. Washington D.C.: Georgetown University Press.
- Buchanan, David, Susan Shaw, Amy Ford, and Merrill Singer. 2003. "Empirical Science Meets Moral Panic: An Analysis of the Politics of Needle Exchange." *Journal of Public Health Policy* 24(3): 427-444.
- Center for Disease Control, "Drug Overdose Deaths".
<https://www.cdc.gov/drugoverdose/data/statedeaths.html>
- Cicero, Theodore J., Matthew S. Ellis, and Hillary L. Surratt. 2014. "The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years." *Jama Psychiatry* 71(7):821-26.
- City of Philadelphia. "Unintentional Drug Related Deaths."
<https://public.tableau.com/profile/pdph#!/vizhome/UnintentionalDrugRelatedDeaths/UnintentionalDrugRelatedDeaths>
- Conrad, Peter and Joseph W. Schneider. 1992. *Deviance and Medicalization*. Philadelphia: Temple University Press.
- Eyal, Gil. 2013. "For a Sociology of Expertise: The Social Origins of the Autism Epidemic 1." *American Journal of Sociology* 118(4): 863-907.
- Faulkner-Gurstein, Rachel. 2015. "Getting Out of the Ghetto: Harm Reduction, Drug User Health, and the Transformation of Social Policy in New York." Ph.D. dissertation, Department of Political Science, City University of New York.
- Fields, Gary. 2009. "White House Czar Calls for End to 'War on Drugs'." *The Wall Street Journal*. May 14.
- Fuller, Richard C. and Richard R. Myers. 1941. "The Natural History of a Social Problem." *American Sociological Review* 6(3): 320-329.
- Gould, Mark. 1993. "Legitimation and Justification: The Logic of Moral and Contractual Solidariry in Weber and Durkheim." *Current Perspectives in Social Theory*, edited by B. Agger Vol. 13: 205-25.
- Gusfield, Joseph. 1981. *The Culture of Public Problems: Drinking - Driving and the Symbolic Order*. Chicago: University of Chicago Press.
- Hacking, Ian. 2010. "Inaugural lecture: Chair of Philosophy and History of Scientific Concepts at the Collège de France, 16 January 2001". *Economy and Society* 31(1): 1-14.

- Jutel, Annemarie. 2009. "Sociology of diagnosis: a preliminary review." *Sociology of Health & Illness* 31(1): 278-99.
- Kleinman, Arthur, Leon Eisenberg, Byron and Good. 1978. "Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research." *Analysis of Internal Medicine* 88(2): 251-8.
- Kruger, Josh. 2018. "The Philadelphia Resilience Project: Our response to the opioid crisis." *City of Philadelphia*, October 19. Retrieved on April 20, 2019.
- Larson, Sharon, Norma Padron, Jennifer Mason, and Tyler Bogaczyk. 2017. "Supervised Consumption Facilities - Review of the Evidence". Main Line Health Center for Population Health Research at Lankenau Institute for Medical Research.
- Mauer, Marc. 2006. *Race to Incarcerate*. New York : New Press.
- McNamee, Steve. 1985. "The Rise of Western Rationalism: Max Weber's Developmental History." *Journal of the History of the Behavioral Sciences*, 21(1): 67-70.
- National Institute on Drug Abuse. 2014. "Drugs, Brain, and Behavior: The Science of Addiction."
- Newell, Walker. 2013. "The Legacy of Nixon, Reagan, and Horton: How the Tough on Crime Movement Enabled a New Regime of Race-Influenced Employment Discrimination." *Berkeley Journal of African-American Law & Policy* 15(1):1-36.
- Parsons, Talcott. 1051. *The Social System*. Glencoe: The Free Press.
- Percy, Jennifer. 2018. "Trapped by the 'Walmart of Heroin'." *The New York Times Magazine*, October 10.
- PHS Community Services Society. "The History of Insite". Retrieved April 16, 2019.
<https://www.phs.ca/project/the-history-of-insite/>
- Prevention Point. "History of PPP". Retrieved April 16, 2019.
<https://ppponline.org/about-us/history-ppp>
- Reuter, Peter. 2013. "Why Has US Drug Policy Changed So Little over 30 Years?" *Crime and Justice* 42(1):75-140.
- Ritzer, George. 2011. "Chapter 2: The Weberian Theory of Rationalization and the McDonaldization of Contemporary Society." Pp. 41-59 in *Illuminating Social Life: Classical and Contemporary Theory Revisited*, edited by Peter Kivisto. Thousand Oaks, CA: Pine Forge Press.

Rosenberg, Charles E. 2015. "Contested Boundaries: psychiatry, disease, and diagnosis." *Perspectives in Biology and Medicine* 58(1): 120-37.

Schluter, Wolfgang. 1938. *The Rise of Western Rationalism*, translated by Guenther Roth. Berkeley: University of California Press.

Spector, Malcolm and John I. Kitsuse. 1987. *Constructing Social Problems*. New York: Aldine de Gruyter.

Stone, Deborah. 2002. *Policy Paradox: The Art of Political Decision Making*. New York: W.W. Norton & Company.

Szasz, Thomas. 2004. "The Myth of Mental Illness". Pp. 43-50 in *Health Disease and Illness: Concepts in Medicine*, edited by Arthur L. Caplan, James J. McCartney, and Dominic A. Sisti. Washington D.C.: Georgetown University Press.

Weber, Max. 1946. *From Max Weber: Essays in Sociology*. Translated and Edited by H.H. Gerth & Cr. Wright Mills. New York: Oxford University Press.

Weber, Max. 1968. *Economy and Society*. Totwa, NJ: Bedminister Press. (Original work published 1921).

The White House. 1989. "National Drug Control Strategy".