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One of the most difficult subjects to understand and assess in the drug policy and practice field is harm reduction because of disputes about its intent and meaning. Issues 2, 3 and 4 will address the subject in depth with special attention to the history of the concept in a three part series.

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Edited by Eric A. Voth, MD, FACP and David A. Gross, MD, DFAPA, our intended readership includes clinicians, clinical researchers, policymakers, prevention specialists and the interested public.

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The Lure and the Loss of Harm Reduction in UK Drug Policy and Practice

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Abstract:

Since the late 1980s drug policy and practice within UK has been heavily influenced by the idea of reducing drug related harm. The paradigm of harm reduction, which has shaped drug treatment services grew out of the fear that HIV may spread rapidly and widely amongst injecting drug users. This article looks at the extent to which drug use or HIV have had the greater impact on individual and public health within UK and the extent to which it has been possible to reduce drug related harm in the face of continuing drug use. The article concludes that in the face of the growth in the prevalence of problem drug use over the last 10 years and the persistence of an array of drug related harms including: the extent of Hepatitis-C amongst injecting drug users, the extent of drug related crime and the impact of drugs on communities and families that it may be appropriate now to make drug prevention, rather than harm reduction, the key aim of drug policy and practice.

Introduction

In 1988, the Advisory Council on the Misuse of Drugs published the results of its enquiry into the growing problem of AIDS and HIV in the UK. Contained within the council's "AIDS and Drug Misuse: Pt 1" report (1988), was a sentence which proved to be more influential than any other in the history of UK drug policy. That sentence identified the need for a fundamental shift in drug policy and provision as a result of the belief that the "spread of HIV is a greater danger to individual and public health than drug misuse" (ACMD 1988: 17). In the wake of that statement, the principal priority for services working in the drugs field, as well as for drug policy more broadly, became one of reducing drug users' risks of acquiring and spreading HIV infection.

Whilst the ACMD's report was not the first to articulate the need for a "harm reduction" focus on the part of those working in the drug field, the report was a key step along the road to the development of harm reduction as a distinct area of professional practice. Stimson, writing in 1990, outlined what he saw as the development of a new paradigm on the part of those working within the drugs field. At the centre of the new paradigm was the focus on HIV:

> A key issue in shaping drug policies is the choice that has been posed between two targets, between the prevention of HIV transmission and the prevention of drug abuse. Preventing the physical disease of AIDS has now been given priority over concern with drug problems. In this paradigm prevention takes on a new meaning – the key prevention task is not the prevention of drug use, but the prevention of HIV infection and transmission. (Stimson 1990: 333–334)

Further aspects of this new paradigm involved the concentration on injectors and injecting drug use as opposed to those using illegal drugs by other means; a recognition that given the means (sterile injecting equipment, condoms) injecting drug users would seek to reduce their chances of becoming HIV positive; and the importance of ensuring that drug treatment services were as accessible and as user friendly as possible. This latter element contrasted markedly with the previous paradigm of drug abuse treatment in which the focus had been on addressing client's drug dependency needs. Challenging drug users about the impact of their drug use as well as testing individuals motivation for recovery (which were aspects of the prior paradigm focussed on meeting individuals drug dependency needs) was now seen as antithetical to the view that services should be doing all they could to attract clients and retain contact with clients as a way of reducing their HIV related risk behaviour.

It is difficult to overstate the impact of these ideas on the world of drug abuse treatment within the UK. In the period following the publication of the ACMD report there was the growth of an entirely new form of drug agency in the form of needle and syringe exchange clinics. There was also, at this time, a substantial growth in the use of methadone prescribed on a maintenance basis as a method of engaging and retaining drug users in contact with drug treatment services and reducing their HIV related risk behaviour.

Some 10 years, after the publication of the ACMD report the ideas and practices of harm reduction have become a key part of the "drug treatment establishment" within the UK. The UK drug strategy "Tackling

Drugs to Build a Better Britain," published in 1998, identified the importance of harm reduction within the treatment pillar of the strategy:

> There is growing evidence that treatment works. In particular, harm reduction work over the last 15 years has had a major impact on the rate of HIV and other drug related infections. (Tackling Drugs to Build a Better Britain 1998: Aim, iii)

Similarly, David Blunkett, the then Home Secretary, further endorsed the importance of harm minimization initiatives in his introduction to the Updated Drug Strategy published in 2002:

> All problematic users must have access to treatment and harm minimization services both within the community and through the criminal justice system. (Updated Drug Strategy 2002: 3)

So, central were the ideas of harm minimization to policy that the updated drug strategy even re-named the fourth pillar of the strategy "Treatment and Harm Minimization" in contrast to its previous designation simply as "Treatment". The updated strategy summarized how widespread the ideas and practices of harm reduction had become by 2002:

> Nearly all DAT area (97%) have harm reduction services and 87% provide access to drug prescribing services. (Updated Drug Strategy 2002: 52)

Within these terms, there can be little doubt that the ideas of harm reduction/harm minimization have had an enormous impact on the world of drug abuse policy and treatment within the UK. What I would like to do in the remainder of this article is to ask three related questions. First, was the ACMD right in asserting that AIDS and HIV represented a greater threat to individual and public health than drug misuse? Second, how successful have we been in reducing HIV and other drug related harms within the UK? Third, whether the time is right to shift the direction of policy and provision within the drugs field in the UK from reducing the harm of continued drug use to reducing the incidence and prevalence of drug use itself?

AIDS and HIV a greater threat than drug misuse?

At the time that the Advisory Council on the Misuse of Drugs "AIDS and Drug Misuse" report was produced, the thinking within the UK around the issue of drug users and HIV was influenced by one study more than any other, namely the results of research involving drug users attending a general practice surgery in Edinburgh. This research, carried out by Roy Robertson and colleagues, showed that a staggering 63% of injecting drug users attending the practice were HIV positive (Robertson et al. 1986). The results of this research sent a shock wave through those planning and delivering drug services in the UK as well as those working within the public health field more broadly. For the first time, there was real evidence that the UK might experience an epidemic of HIV amongst injecting drug users that was equal to, if not greater than, that experienced by sections of the gay community within parts of the USA. Moreover, the Edinburgh results opened up the possibility of widespread heterosexual transmission of HIV, first to the sexual partners of injecting drug users and then on to the wider heterosexual non-drug injecting population.

In the wake of these fears, research was rapidly commissioned to assess the extent of HIV infection amongst drug injectors across a broader range of locations. For example, on the basis of research carried out with drug injectors drawn from across Edinburgh (as opposed to the clients of a single general practice sample as was the case with the Robertson research) the prevalence of HIV infection amongst injecting drug users was found to be 19.7% (Davies et al. 1995). In Glasgow, similar research involving interviewing and drug testing citywide samples of drug users found that only 1.8% of injecting drug users were HIV positive (Rhodes et al. 1993). In London, research using the same methods identified 12.8% of injectors to be HIV positive (Rhodes et al. 1993). Finally, Haw and Higgins reported that 26.8% of injecting drug users in Dundee were HIV positive compared to 3.7% in the surrounding rural area (Haw and Higgins 1998). Further, research in Glasgow and London with female drug-using prostitutes – a group who at that time were seen as key in terms of spreading HIV beyond the injecting drug using population to the wider heterosexual non drug injecting population – identified low levels of HIV infection and high levels of condom use with commercial partners (McKeganey et al. 1992; Ward et al. 1993). Cumulatively, this research lowered the fears of an impending public health crisis involving drug users and HIV within the UK.

By December 2005, there were thought to be 21,898 AIDS cases in the UK. (of whom 1234 are thought to be as a result of injecting drug use) and 76,765 cases of HIV infection (of whom 4381 are thought to have acquired infection as a result of injecting drug use). The prevalence of HIV infection among injecting drug users attending drug treatment agencies and taking part in the Unlinked Anonymous Prevalence Monitoring Programme was 2.3% in London and 0.5% elsewhere in England (Health Protection Agency 2004). Despite these low levels of infection, very recent research has indicated that there may have been a small increase in the prevalence of HIV infections amongst injecting drug users in London, although the possible increase is still well short of the level of infection feared in the late 1980s (Hope et al. 2005).

The figures on the prevalence of HIV infection and AIDS amongst injecting drug users contrast markedly with the prevalence estimates for problematic drug use within the UK. Within England, Frischer and colleagues used the multiple indicator method to estimate a total problem and drug injecting population in 2001 of 287,670 (Frischer et al. 2004). From Scotland, Hay and colleagues used capture recapture

statistical methods to estimate the prevalence of problem drug use (defined as heroin and benzodiazepine use) in 2003 to be around 51,582 (Hay et al. 2004). From Northern Ireland McElrath estimated the prevalence of problem drug use to be of the order of 828 (McElrath 2002). On the assumption that the prevalence of problem drug use in Wales (where there is no current or recently equivalent estimate) is on a par with that in England, the overall prevalence of problem drug use in the UK as a whole may be in the region of 356,000, i.e. some 80 times greater than the number of HIV positive injecting drug users within the UK. On the basis of these figures alone it is difficult to avoid the conclusion that it is problematic drug use, not AIDS and HIV, which is having the greater impact on individual and public health within the UK.

In the next section I look at the degree to which it can be said that we have been successful in reducing drug related harm including that related to HIV amongst drug users in the UK.

Reducing drug related harm

There are a number of areas in which it is possible to consider how successful we have been in reducing drug related harm, some of these pertain to the individual whilst others relate more to the impact of drug use on families and communities.

HIV infection

It is evident from the foregoing that the UK has not witnessed anything like the rapid rise in HIV infection rates amongst injecting drug users that was feared in the initial "AIDS and Drug Misuse" report from the Advisory Council on the Misuse of Drugs. One reason for this may well have been the success of the very harm reduction measures (needle and syringe exchange, methadone maintenance programmes, and advice on safer injecting), which that report gave impetus to. This is the thrust of the submission from the UK Harm Reduction Alliance to the Home Affairs Select Committee's enquiry into drug policy:

> Between 1987 and 1997 Britain led the world in developing a harm reduction approach to drug use. The clearest achievement was in the prevention of HIV infection among people who inject drugs (by heeding the advice outlined in the report of Advisory Council on the Misuse of Drugs). UK has thus averted an epidemic of HIV infection associated with drug injecting and there is evidence that harm reduction has resulted in lower rates of Hepatitis -C virus (HCV) infection than found in comparable countries. (UKHRA 2001: 2)

Whilst HIV has certainly not spread to anything like the extent feared in the ACMD's report it should not be assumed that this was due solely to the development of a harm reduction approach on the part of drug services within the UK. It may have been the case, for example, that the number of cases of HIV infection amongst injecting drug users simply did not reach the critical threshold or "tipping point" to generate widespread transmission of HIV. However, having said this, it is unlikely that the development of such harm reduction initiatives as needle and syringe exchange had no impact on reducing the spread of HIV infection amongst injecting drug users. Setting this issue aside though, the claim that harm reduction initiatives within the UK have been effective in preventing the spread of Hepatitis-C is a good deal less convincing.

Hepatitis-C

By the end of 2003, there had been a total of 38,352 cases of Hepatitis-C diagnosed in England, over 90% of which are thought to have been acquired as a result of injecting drug use (HPA 2004). In Scotland, in 2003, there were a total of 18,109 cases of HCV infection; amongst the 12,166 cases where information was available on route of transmission 90% were known to have injected drugs (HPA 2004).

In 2003, 41% of injecting drug users taking part in the Unlinked Anonymous Prevalence Monitoring Programme of drug users in contact with drug treatment agencies were known to be HCV positive (HPA 2004). High, as these percentages are the extent of HCV infection amongst injecting drug users may be even higher in some cities. Bloor and colleagues, for example, have recently reported that as many as 60% of injecting drug users in contact with drug treatment services in Glasgow may be HCV positive (Bloor et al. 2006). The high prevalence of Hepatitis-C amongst injecting drug users within Glasgow is all the more striking when one considers that for much of the 1990s to the present day, Glasgow has had a well supported, city-wide network of needle and syringe exchange schemes (EIU 2003). It is difficult to see how the level of Hepatitis-C in Glasgow could be any higher even in the near total absence of such harm reduction measures or indeed how the provision of such services over many years have in any way reduced the spread of infection amongst injecting drug users.

Deaths

Data on drug related deaths in the UK are collated by the Office for National Statistics. In 2001, there were a total of 235 AIDS deaths in UK and 1192 deaths amongst drug users involving heroin, cocaine or methadone (Health Statistics Quarterly 13). Between 2000 and 2004 there were a total of 5551 deaths of drug users involving heroin, cocaine or methadone (Health Statistics Quarterly 29). On the basis of these figures there is little doubt that the level of drug related mortality within the UK attributable to HIV/AIDS is only a fraction of that associated with drug misuse more broadly. Whilst there has been a decline in the number of drug related deaths in England and Wales, with the number of heroin and morphine related

deaths falling from 926 in 2000 to 744 in 2004, that reduction is hardly commensurate with a successful harm reduction campaign that still leaves hundreds of drug users dying prematurely each year (ONS: 2006). Indeed, for the period 1993 to 2000 (a key period in the impact of harm reduction ideas within the UK) deaths from heroin and morphine in England and Wales actually increased from 187 in 1993 to 926 in 2000 (ONS: 2002).

Overdose and life problems

Over the last few years there has been a growing interest in the extent and the factors associated with non -fatal overdoses amongst drug users. This research has been initiated in part in an attempt to reduce drug related deaths amongst injecting drug users although the work itself has identified the extent of the problems which in many ways are characteristic of the life circumstances of long term drug users within the UK and elsewhere. The National Treatment Outcome Research Study found that 15% of respondents had overdosed in the three months before accessing treatment (Stewart et al. 2002). From Scotland, Neale and Robertson (2005), reporting on the results of the Drug Outcome Research in Scotland study, found that 11.5% of drug users initiating treatment had experienced an overdose in the last three months and 2.4% had experienced more than one overdose during that period (Neale and Robertson 2005). Within this Scottish study 32.9% of drug users had experienced a recent relationship breakdown, 34.4% had financial problems, 34.5% had accommodation problems, and 30.3% had experienced the death of a close relative or friend. This array of life problems was significantly associated with an increased risk of overdose on the part of drug users included in the DORIS research.

Homelessness

Whilst the extent of homelessness amongst those using illegal drugs has not been widely studied within the UK, previous research has shown that in many instances those who have developed a significant drug problem are also often living in very unstable conditions. For example, a study of 1000 homeless young people in London found that 88% were taking at least one drug and 35% were using heroin (Flemen 1997). Also, Downing-Orr found that 85% of homeless young people in London were using illegal drugs (Downing-Orr 1996). In a study of 200 drug users admitted to hospital following a non-fatal drug overdose Neale (2001) found that 32% were currently homeless and 68% had been homeless in the past. Of the 136 individuals in this study who had been homeless in the past, 82% had experienced a non-fatal drug overdose compared to 66% amongst those who had never been homeless. As Neale points out these findings suggest that the "combined experience of homelessness and drug use increased life threatening behaviour (Neale 2001: 363).

Dual diagnosis

Within the last few years there has been increasing attention focussed on the nature and extent of mental health problems experienced by dependent drug users. Marsden and colleagues, reporting on the sample of 1075 drug users included within the National Treatment Outcome Research Study, found that 32.3% of females and 17.5% of males had experienced anxiety symptoms, whilst 29.7% of females and 14.9% of males had experienced depression. Fully 26.9% of females had experienced paranoia compared to 17.1% of males (Marsden et al. 2000). From Scotland, McKeganey and colleagues have reported that 61% of female drug users contacting drug treatment services had experienced physical abuse and 35% reported having been sexually abused. In the case of male drug users contacting drug treatment services, 22% had experienced physical abuse and 7% had been sexually abused (McKeganey et al. 2005). On the basis of these figures, it is evident that a substantial proportion of drug users are experiencing serious mental health problems associated with past, and in some cases continuing abuse.

Prevalence of problem drug use

There has never been a series of drug misuse prevalence studies carried out within UK that would enable an assessment to be made of the increase in problem drug use over the period in which the ideas of HIV prevention and the reduction of drug related harm have been influential. Nevertheless, De-Angelis and colleagues have sought to analyse data on drug related deaths over the period 1968–2000 to estimate the possible growth in the incidence and the prevalence of problem drug use over that period. On the basis of this work De-Angelis and colleagues suggest that with regard to the incidence of opiate use/drug injecting there may have been a "threefold increase in the incidence between 1975 and 1979 and a five- to six-fold increase between 1987 and 1995". With regard to the prevalence of opiate use/drug injecting over this period De-Angelis and colleagues suggest that this has "continued to rise since the early 1970s doubling between 1977 and 1982 and rising more than fourfold from 1987 to 1996" (De-Angelis et al. 2004).

Identifying possible changes in the prevalence and the incidence of problem drug use in the absence of successive prevalence estimation studies is a complex and inexact science. However, the research from De-Angelis and colleagues does at least illustrate the very real possibility that during the period in which, in Stimson's words, attention was shifting from the prevention of drug abuse to the prevention of HIV that in fact problem drug use increased substantially within the UK.

Children of dependent drug users

Whilst the impact of problem drug use is most evident in terms of the individual drug user the harms of dependent drug use often extend well beyond the individual user to other members of his or her family.

The "Hidden Harm" report from the Advisory Council on the Misuse of Drugs estimates that there may be between 205,300 and 298,900 dependent children in England and Wales with a parent using illegal drugs. The figure for Scotland is thought to be between 40,800 and 58,700. Large as these figures are, the authors of the Hidden Harm report add the caveat that "in the light of the assumptions we have made we believe these are very conservative estimates and the true figure may well be higher" (ACMD: 2003: 25). The Hidden Harm report notes further that amongst 77,928 drug using parents on whom information was available, only 46% of parents were actually living with their dependent children. 54% of drug using parents had children living elsewhere most often with other family members. These figures give an indication of the continuing destructive impact of parental drug dependence upon families and of the harm to both adults and children associated with parental drug use.

Although not all of the children with drug dependent parents are likely to suffer serious adverse effects research has indicated that many of these children will experience a range of short-term and long-term problems arising from amongst other things: neglect, exposure to their parents drug use and associated criminality, disruption to their household routines (Hawley et al. 1995; Forrester 2000; Hogan and Higgins 2001; McKeganey et al. 2002; Kroll and Taylor 2003; Barnard 2007). To a large extent it is only with the publication of the Hidden Harm report in 2003 that drug treatment agencies have become aware of the importance of meeting the needs of children within drug dependent households.

The impact of drug use on communities

Whilst communities represent one of the four key pillars of UK drug strategy there has been remarkably little research that has charted the evolving impact of drug abuse on communities within the UK. Where research has been carried out, the picture that emerges is one of communities that have been profoundly influenced by their local drug problems. Qualitative research in one such community in Scotland identified that drug abuse had become a major fault line amongst local residents with many of those interviewed and surveyed identifying drug abuse as one of the worst aspects of their local area (McKeganey et al. 2004). Similar qualitative research carried out for the Joseph Rowntree Foundation in England has explored the development of drug dealing markets within local communities and has identified something of the complex relationships that exist between local drug markets and their surrounding community. In some instances the drug markets studied arose within a context of widespread social dissolution, in others the local drug market was sustained within the context of socially cohesive local relationships. Both types of drug markets though were to be found in circumstances of widespread local poverty and deprivation. One of the shocking findings of the research team undertaking this work was the involvement of young people within local drug markets:

> Young people's involvement in drug market activity caused concern among professionals in all our sites. In Byrne Valley, the market relied on young people to connect seller and buyers. In Sidwell Rise and Etherington young people actively tried to be part of the drug market but found it hard to gain acceptance from the more established sellers. It was reported to us that young people in these two sites often offered to work for free in an attempt to gain a foothold in the market. Just under a third of our professional interviewees and just under half of four police officers thought that young people were more likely to work as runners than any other position. (May et al. 2005: 23).

The researchers in this study sought to identify the views of local residents as to how their local drug problems should be tackled. Over a quarter of respondents stated that there needed to be more of a police presence on the streets with only 10% feeling that the police were doing all they could. However, three quarters of respondents felt that tackling the local drug problem was a responsibility that needed to be shared by the whole community. There are though likely to be certain requirements for communities to be able to tackle their local drug problem: for this to occur a local community needs to be cohesive and to have mutual trust and shared expectations. In short there needs to be a collective sense of efficacy if residents are to be able to exercise any form of informal social control over the areas in which they live. (May et al. 2005: 29). Other research carried out for the Joseph Rowntree Foundation is rather more pessimistic about what it sees as the prospects for successfully tackling local drug problems. On the basis of their own qualitative study of the impact of local drug problems on communities Shiner and colleagues concluded, for example, that:

> Widespread drug use has given rise to a seemingly intractable set of problems dating back to the middle of the last century and there is little sign that these problems are abating. Despite the best efforts of the police, and the medical establishment, illegal drugs continue to be readily available and widely used. Even when the police are able to identify and arrest major drug dealing operations this has little if any discernible impact on price and availability. (Shiner et al. 2004: 48)

On the basis of these studies one would have to conclude that we have had only limited success within UK over the last 10 to 15 years in tackling the impact of drug abuse on local communities.

Drug Related Crime

Information on the nature and the extent of drug related offending has been provided in the UK through a range of studies including work involving interviewing and drug testing arrestees. The ADAM and the New ADAM (Arrestee Drug Abuse Monitoring) programme in the UK has provided a means of systematically

measuring the proportion of arrestees using illegal drugs and the extent of the link between drug use and offending (at least that element which involves a police arrest). Holloway and colleagues have produced an overview of the results of having interviewed and drug tested over 3000 arrestees in England between 1999 and 2002. In year 1 of their research 25% of arrestees tested positive for opiates (n¼1434), by year 3 this figure had increased to 28%. Similarly in year 1 15% of arrestees tested positive for cocaine, whilst by 2002 this figure had increased to 23%. In terms of the link between drugs and crime the New ADAM research team were able to report a number of significant reductions in drug related offending over the study period. For example, the proportion of cocaine users reporting one or more property crimes in the last 12 months fell from 59% in year 1 to 51% in year 3, overall the proportion of arrestees reporting property crime in the last 12 months fell from 53% in year 1 to 48% in year 3. The link between drugs and crime was very evident in this research with, for example, 17% of non-drug using arrestees in year three reporting one or more property crime in the last 12 months compared to 85% of those who had used crack cocaine or heroin.

Similar research carried out in Scotland in 2000 found that fully 71% of arrestees tested positive for at least one controlled drug, 31% tested positive for opiates and 33% tested positive for benzodiazepines (McKeganey et al. 2000). Within this Scottish research 43% of injectors had shared needles within the last three days, 25% reported that they had been in receipt of an illegal income in the last 30 days. Amongst current injectors 61% reported having been in receipt of an illegal income in the last 30 days whilst amongst those arrestees who had not used any illegal drugs over the last 12 months only 5% reported having been in receipt of illegal income over the last 30 days. These figures confirm the close association between illegal drug use and crime and of the challenge, which we still face within UK of breaking the link between problematic drug use and offending. Crucially, within the Scottish research only 44% of female drug using arrestees and 19% of male drug using arrestees had prior contact with a drug treatment agency. These findings indicate the shortfall in access to treatment of a significant proportion of drug using arrestees at that time within Scotland (McKeganey et al. 2000).

Discussion

In the light of the previous section one would have to say that the harm reduction approach within the UK appears to have had only modest success in reducing the breadth of drug related harms. With approaching 15 years experience of harm reduction initiatives we have a situation in which around 40% of drug injectors within the UK are Hepatitis-C positive, in which thousands of drug users are dying from drug related causes, in which the number of problem drug users appears to have increased substantially; in which drug use continues to fuel high levels of offending and to undermine communities and families throughout the UK. It is worth considering in this section why we have not had more success in reducing these various drug related harms.

The level of harm reduced in the face of continuing drug use is less than it needs to be

The principle of reducing drug related harm has an immediate and almost unquestioned appeal. However, whilst the notion of reducing harm is very appealing this is not the same thing as saying that it is possible to reduce drug related harm to a sufficient degree, in the face of continuing drug use, to enable drug users and those around them to avoid a range of adverse outcomes. The effectiveness of harm reduction initiatives in this sphere then may lie not with the question of whether it is possible to reduce drug related risk behaviours per se, but by how much such behaviours can be reduced. Within the UK Unlinked, Anonymous Prevalence Monitoring Programme, 29% of a total of 1677 drug injectors studied in 2003 reported sharing injecting equipment within the last month. In Scotland in 2003/4, 34% of injecting drug users on the Drug Misuse Database reported sharing needles and syringes in the previous month. This figure compares to 32% to 36% during the period 1998 to 2002 (HPA 2004). These figures indicate that despite a plethora of initiatives aimed at increasing drug injector's awareness of the risks of needle and syringe sharing, and of providing drug users with access to sterile injecting equipment, that around a third of injectors are still sharing injecting equipment. Whilst the level of sharing identified in these studies may not be sufficient to generate epidemic spread of HIV infection the level of sharing identified may well be sufficient to generate further spread of Hepatitis-C infection given that it is already more prevalent than HIV amongst injecting drug users within the UK.

Existing initiatives aimed at reducing drug related risk behaviour are not able to exert sufficient control over injectors risk behaviour

Another reason why existing harm reduction measures may have had only modest success in reducing the level of drug related harm may have to do with the degree to which these initiatives have been able to exert control over individuals' injecting behaviour. A good illustration here may well be the provision of sterile injecting equipment to injecting drug users. This is an initiative, which, on the face of it, should reduce the risk of drug injectors acquiring HIV and other blood borne infections. However, if a sterile needle and syringe is used in a highly un-sterile environment (for example a toilet or derelict building) to inject highly toxic substances the drug user is likely to experience serious adverse health effects irrespective of the cleanliness of the injecting equipment used. For services to be successful in further reducing the risks of continued drug injecting it may be necessary to intervene much more directly in the injecting event, for example by providing advice on injecting technique, by supervising or administering injections to naive users, by providing drug users with a setting where they can use their street drugs under some level of medical supervision and ultimately by providing drug users with the drugs which they

are injecting or using by some other means. At the moment, there are no services within the UK that are developing such an intensive array of harm reduction measures although in fact anything short of such an array may well leave considerable areas of injecting risk behaviour intact and leave substantial numbers of injecting drug users experiencing a range of harms associated with their continued drug use.

Shortcomings in the quality of harm reduction work

There have been surprisingly few attempts to assess the quality of harm reduction initiatives within the UK. Recently, however, the National Treatment Agency has undertaken an assessment of needle and syringe exchange services. Whilst the results of this research have not yet been published, an early report provided by Abduldrahim and colleagues (Abduldrahim et al. 2005) gives considerable cause for concern at the quality of harm reduction work within at least some needle and syringe exchange schemes. On the basis of this survey of needle and syringe exchange clinics across the UK, the authors found that 16% of needle and syringe exchange clinics did not discuss issues to do with needle and syringe sharing in their assessments of clients, 30% did not discuss issues to do with safer injecting techniques, 35% did not discuss injecting hygiene, and 61% did not discuss issues to do with the clients possible registration with a general practitioner. These are all areas, which bear directly upon improving drug users health. The fact that substantial numbers of needle and syringe exchange clinics were not discussing these areas gives an indication that the quality of professional work within a significant number of clinics is falling below the level that would be needed to significantly reduce the array of drug related harms.

A lack in the quantity of harm reduction work

Another possible explanation for the persistence of serious adverse harms associated with illegal drug use may be the fact the level of investment in harm reduction initiatives is itself less than it would need to be for those initiatives to be successful in reducing drug related harm. It is difficult to weigh this explanation because of the lack of detailed information on the funding of harm reduction initiatives within the UK. However, on the basis of some of the statements made about harm reduction on the part of both advocates and commentators as well as official government policy it is difficult to accept that the level of investment within harm reduction has been so modest as to fall well short of that which would be required to bring about a major reduction in drug related harm. The updated UK drug strategy, for example, refers to the fact that "nearly all DAT area (97%) have harm reduction services and 87% provide access to drug prescribing services" (Updated Drug Strategy 2002: 52). With regard to substitute prescribing, although there is a lack of clear costing data with which to assess the level of funding for substitute prescribing services, Peter Martin has reported that approaching half of the total UK drug abuse treatment budget (itself estimated to be in the region of £500 m a year) is now being spent on providing substitute medication to dependent drug users (Martin 2004). Within Scotland, whilst there are no accurate data on the number of drug users being prescribed methadone, recent research undertaken by the Scottish Executive has estimated that as many as 19,000 drug users (more than a third of the total estimated addict population within Scotland) are now receiving methadone (ISD 2004). On the basis of these sorts of proportions it cannot be said that there has been a lack of support for harm reduction initiatives within England or Scotland.

The focus on reducing drug related harm has been directed too much at the individual drug user

Another possible reason why there has been the persistence of drug related harm within the UK may be that the harms which have been targeted in policy and practice have been too closely associated with the individual drug user. Again it is difficult to judge the degree to which this is the case. However, if one focuses on the children of drug dependent parents there are relatively few drug services oriented towards supporting the children within drug dependent households. Indeed it was not until the publication of the Hidden Harm report in 2003 that there was even significant official recognition that children living within drug dependent households were even in need of support. Further, whilst within the last few years there has been a growing awareness of the impact of parental drug use on children there remains hardly any official awareness of, or provision for, children affected by their siblings drug use despite the findings of recent research which has shown that the lives of children can be seriously adversely affected by their siblings' drug use (Barnard 2005). It may well be the case that in relation to reducing the harms experienced by family members our efforts have been impeded by the concentration within much harm reduction work on the individual drug user (Barnard 2007).

The impossibility of eliminating drug related harm

Finally, our limited success in reducing drug related harms might arise from the fact that illegal drug use, drug dependence, etc., are intrinsically harmful in and of themselves. Whilst one may reduce some of the harms of dependent drug use, it may well be the case that so long as the drug use itself continues that there will be a continuing element of harm arising as a consequence. For example, whilst it is possible through judicious prescribing of methadone to reduce individuals' needs to turn to crime to support their drug use, nevertheless, to the extent that some level of illegal drug use persists there may be a continuing involvement in criminal activities to support that drug use. Indeed it may only be with the complete cessation of illegal drug use that the harms of such drug use can themselves be eliminated.

Conclusions

Whilst in the late 1980s there were good grounds for fearing that AIDS and HIV might become a national epidemic amongst injecting drug users in the UK and for suggesting that HIV and AIDS represented a greater threat to individual and public health than drug use itself, in fact the reverse has been the case. HIV/AIDS has remained a relative rarity amongst injecting drug users whilst problematic drug use has become widespread in communities across the UK. Further, on the basis of the evidence assembled within this article, one would have to conclude that in the face of substantial support for harm reduction policies and practices within the UK nevertheless substantial drug related harms remain.

Writing in 1990 Gerry Stimson recognized that over time the shifts in policy and practice heralded by the AIDS and Drug Misuse Report from the Advisory Council on the Misuse of Drugs might themselves be vulnerable to challenge in the face of escalating levels of HIV infection and continuing drug related harm:

> For how long will agencies and their staff be able to sustain this new image of the drug user, when (to be realistically pessimistic) they will be faced with recalcitrant injectors many of who will not change their behaviour? How long will the doors remain open to all comers, and for how long will staff cope with the stress of such working conditions. For how will drug workers agree to give up on dependence and other chronic drug problems? How acceptable will these policies and practices appear when there are substantial numbers of HIV positive sick injectors? How much concern will there be for the injector when the epidemic becomes established in heterosexual populations?

Stimson further observed that in relation to the shift in drug policies and practices within the UK that "the stakes are high, if the paradigm turns out to be wrong or ineffectual, the consequences will be disastrous" (Stimson 1990: 338). Whilst for Stimson the key challenge to the harm reduction approach appeared to be the possible failure to curb the further spread of HIV infection, in fact it could be said that a greater challenge has come from the limited spread of HIV amongst injecting drug users combined with the persistence and escalation in drug related harms and prevalence. In the light of this it is possible to conclude that it is the prevention of drug use rather than the reduction of drug related harm, which now needs to become the central direction of policy and provision within the drugs field in the UK.

Given the current extent of problem drug use within the UK it would be inappropriate to entirely switch attention from reducing the harms of continuing drug use to preventing drug abuse itself – such a policy would seem to be a classic case of locking the stable door long after the horse has bolted. Nevertheless, high as drug user prevalence is within the UK the potential for further increases in prevalence remain. At the present time the estimated 350,000 problem drug users within the UK still only represents around one percent of the UK population aged 15–55. On this basis one would have to say that the potential for further spread of illegal drug use remains and the need for effective means of drug prevention is greater now than in the past. Within these terms, there needs to be a renewed focus upon drug prevention within the UK. In addition, however, there will be a need to continue our efforts directed at reducing the harms of continued drug use. Crucially though the notion of the harms that need to be reduced have to be extended well beyond the individual drug user.

Such an extension will present a substantial challenge to the harm reduction movement since it cannot be assumed that a commitment to reduce the harms experienced by those continuing to use illegal drugs will be equally applicable to those who are affected by others' drug use. The clearest example of this challenge lies in relation to the children affected by their parent's drug use/dependency where agencies may increasingly have to identify whose needs are paramount (those of the child or those of the parent) in seeking to reduce the impact of parental drug use on children. There is though a further reason why prevention rather than harm reduction may need now to become the major concern of drug policy and practice. At the current level of drug prevalence many of the drug related harms that we have become aware of over the last few years are already beyond the capacity of our existing services. Again the best example of this has to be children within addict households. It is currently estimated that there may be in excess of 350,000 children with one or both parents dependent upon illegal drugs (Hidden Harm 2003). If only a quarter of those children are in need of support then that is already well beyond the capacity of social work services within the UK. For many of these children then the only prospect of reducing the harm associated with parental drug use may actually be the reduction of parental drug use itself. Much the same case can be made in relation to many of the other drug related harms (Hepatitis-C, overdose, dual diagnosis etc.) such that it may well be only by reducing the extent of problem drug use that one can bring about a substantial reduction in the array of drug related harms within the UK.

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Professor Neil McKeganey is the founding director of the Centre for Drug Misuse Research which opened at the University of Glasgow in 1994. A sociologist by training, Neil McKeganey has carried out research on such topics as prostitution and HIV, drug injectors HIV related risk behaviour, young people and illegal drugs, the impact of parental drug use on children, the evaluation of drug treatment services and the recovery from dependent drug use.

Neil McKeganey has written widely on issues to do with drug policy and provision and is committed to stimulating public and professional debate on the nature, impact, and response to the problem of illegal drug use. In 2005 Professor McKeganey was asked by the UK Government Department of Trade and Industry to undertake an assessment of the likely impact of the UK drug problem in 20 years time. The report which Professor McKeganey produced raised fundamental questions about the direction of drug policy and the importance of successfully tackling the drug problem. Neil McKeganey is the author of over 150 articles on aspects of illegal drug use and is the author with James McIntosh of "Beating the Dragon: The Recovery from Dependent Drug Use."

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A Critique of Canada's INSITE Injection Site and its Parent Philosophy: Implications and Recommendations for Policy Planning

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Key Words: Injection Rooms; Harm Reduction; Program Effectiveness; Drug Policy; IV Drug Use; Canada

Abstract

This report provides a critical analysis of the evaluations done on INSITE, the drug injection site in operation in Vancouver, British Columbia, and billed as North America's first medically supervised injection facility. In doing so, it provides a documented historical discussion laying out INSITE's context within a national drug strategy that has been driven increasingly toward an ideology of harm reduction, as distinct from specific adjunct harm reduction strategies in support of a broader policy.

An informed critique is made of the specific published INSITE evaluations. Serious problems are noted in the evaluations' reporting and interpretation of findings. Specifically, the published evaluations and especially reports in the popular media overstate findings, downplay or ignore negative findings, report meaningless findings and overall, give an impression the facility is successful, when in fact the research clearly shows a lack of program impact and success. The published findings actually reveal little or no reductions in transmission of blood-borne diseases or public disorder, no impact on overdose deaths in Vancouver, very sporadic individual use of the facility by individual clients, a failure to reach persons earlier in their injecting careers and very little or no movement of drug users into long-term treatment and recovery. The fact that the evaluators and the funders of INSITE nonetheless have hailed the program as successful reveals a serious problem in drug policy today. It is argued that harm reduction has so permeated governments and the civil service and so politicized drug policy that evidence against the philosophy and its practice are being ignored, information is being managed in support of it, voices in opposition are decreasingly being included in drug policy dialogue and a culture of defensiveness has taken hold. This can only harm efforts to reduce drug problems and produce negative impacts on prevention and treatment, which are discussed along with other implications and recommendations for future policy directions.

This paper offers an independent critique of the evaluations of the INSITE supervised injection site in Vancouver, British Columbia and of the broader ideology of harm reduction that has given rise to such programs. To do so effectively, it provides first a historical context with an informed critique of harm reduction ideology as it has emerged in Canadian drug policy over the past decade. It then examines the published evaluations of INSITE, pointing out clear problems in how the findings have been reported and interpreted. Finally, it provides a discussion of the effects harm reduction ideology has dealt on treatment and prevention in British Columbia and in Canada and offers suggestions for reforms and rebalancing of drug policies to refocus on prevention and treatment.

INSITE refers to the supervised injection facility opened in Vancouver's Downtown Eastside, an area defined by high drug use, crime, public disorder and homelessness.

Background and Context: Harm Reduction Ideology

Certainly until the early 1990s and to a degree until five or so years ago, Canadian drug policy rested on an implicit understanding that drugs hurt individuals, families and communities. The primary policy focus at least on paper was reducing the number of new drug users through **prevention** and helping people hung up with drugs to get off of those drugs and to recover their lives through **treatment**. These two pillars together constitute what we have called **demand reduction**. A third policy pillar, **enforcement** or **supply reduction**, was intended to support the demand reduction pillar by reducing the physical, economic and social availability of drugs in society.

These pillars have varied in degree of emphasis. Prevention for example is always given lip service, but its story unfortunately remains one characterized by failure to implement on a substantial scale other than in the cases of tobacco and drinking driving. In both of these cases we have evidence of substantial impact.

Treatment has taken up much of public addictions budgets and has ranged in success. Larger scale studies suggest that, overall, 50 to 75% of illegal drug users entering substantive treatment (longer term - inpatient treatment and recovery) attain fairly stable abstinence.

As for supply reduction, contrary to popular criticism, evidence does suggest it has maintained a positive impact on drug use patterns. Current prevalence data in Canada shows current use of cannabis by the Canadian public over age 15 at 14%. For all other illegal drugs prevalence remains from 0.5 to 3%. These prevalence rates are very low compared to the 30% range of prevalence for tobacco use and about 80% prevalence rate for alcohol. (1,2) Clearly, our drug laws hold overall rates of illegal drug use at substantially lower levels than their legal counterparts. It stands to reason we benefit from these lower prevalence rates through lower public health and social costs. While we trade some of these savings for costs required to fight drug trafficking and other related crime, illegal drugs still produce substantially less costs than do tobacco and alcohol. The costs of tobacco and alcohol far outstrip the income they bring to governments.

Today, drug policy in Canada has taken a complete about face. Today, harm reduction has become the foundation of drug policy. How has harm reduction – the parent philosophy of INSITE and other initiatives to facilitate "safer" drug use – managed to overtake Canadian Drug Policy so substantially? Why do we now hear literally nothing about prevention or treatment and everything about the vital importance of such programs as INSITE? Is this an evolution, a progression or is it devolution, a regressing? What are the implications? This is a topic where complete objectivity is impossible for the very reason it involves values, worldviews and ideologies. It is the central topic of this section and constitutes a key theme of the whole report.

Harm Reduction: The Parent of INSITE

Harm reduction has no single, official definition. For purposes of this report harm reduction is defined as it manifests itself in Canadian drug policies today, as an ideology viewing drug use as **not only as inevitable, but as simply a lifestyle option, a pleasure to be pursued, even a human right**. In taking this view it purports to be "values-neutral." However, harm reduction is not values-neutral. The phrase "values-neutral" is in fact an oxymoron. The drugs issue is replete with values and the need to find and express values. Harm reduction simply represents a set of values summed up as, "There is no right or wrong choice, and your choice is your business. No one should tell you how to choose, and once you have chosen others should only be there to help reduce the consequences of your choice until if or when you choose to choose differently." This set of values is interwoven with libertarian ideology. It contrasts significantly with the values implicit in demand and supply reduction, which might be stated as, "Certain choices **are** better than others. The choice to get involved with drugs too often leads to trouble. Such choices affect not only the person but also his or her family, community and all of society. If people get into a trap with drugs, we will help them out of that trap and try to keep them alive while doing it. We as a society affirm this through our actions. And having a few drugs legal by tradition does not justify legalizing all drugs."

Harm reduction has moved from idea to ideology in a relatively short time. This transition has **not** come about through public demand or grass roots community involvement. On the contrary, it has followed a course of gradual infiltration – a fairly deliberate process laid out in the following excerpt from a text written by some of Canada's leading harm reduction ideologists:

> Although harm reduction is at odds with the dominant legal-sanction-based policy, the middle range and pragmatic nature of harm reduction measures makes it possible for certain harm reduction strategies to be tolerated, accepted, or even incorporated by legal authorities, without completely dismantling the counter-productive punitive policy. The support and cooperation of the police in needle-exchange programs for injection drug users is one of several examples of the diffusion of genuine harm reduction elements into the existing drug policy, enabling change to occur, and thereby bringing about gradual policy reforms. (3)

In Canada, we are past the first steps of needle exchanges and methadone maintenance, but not so far as Europe. INSITE represents a middle stage harm reduction initiative, requiring exceptions to drug laws but not outright changes to drug laws. But in order to expand and replicate themselves, such measures as INSITE ultimately require forms of drug legalization. Legalization and regulation of drugs are central in harm reduction ideology. The two things are interwoven, and Canadian drug policy has become vulnerable to the drug legalization movement.

As recently as 1996 in Canada, harm reduction was discussed publicly mainly as a "stopgap measure" to help keep people alive until they could get treatment. (4) Since that time it has increasingly been called a drug policy pillar, such as in the Vancouver Four Pillars Drug Strategy (www.vancouver.bc.ca/fourpillars).

However, by 2004, the Canadian Centre for Substance Abuse formally declared harm reduction as the first guiding principle of drug policy:

> One goal of substance abuse policy is to reduce the use of alcohol and drugs, but the first priority should be to decrease the negative consequences of substance misuse. The primary goal of harm reduction is to reduce the health and social problems associated with the use and control of alcohol and other drugs among individuals, families and communities. Abstinence from alcohol and other drug use is an important goal for some, but it is not necessarily the only acceptable or even the primary goal for all substance abusers.(5)

The Canadian Centre on Substance Abuse (CCSA) has had (and still has as acting associates) founding members of the Canadian Foundation For Drug Policy, an organization that presses for liberalizing drug laws and decriminalization of cannabis. CCSA has criticized international treaties and has blamed drug laws for much of the drug problem. CCSA today advocates a strong bias toward harm reduction ideology. Because CCSA presents itself as Canada's key agency in the area of substance abuse, was created by an Act of Parliament and receives substantial public funding, the overtaking of CCSA by harm reduction ideology carries serious implications.

The CCSA is not the only source of pressure for Canada to adopt harm reduction as the guiding ideology of drug policy. Both the Senate and the House Committees on Illegal Drugs sought and heard a preponderance of testimony from persons and organizations in favour of harm reduction ideology/drug legalization. In the case of the Senate Committee, the bias was evident from the beginning.

In the instance of the House Committee, witnesses were chosen by Committee vote, and the committee contained a majority of harm reduction ideologists. So, most witnesses chosen to appear were predisposed toward harm reduction. The result was a second, biased federal report calling for significant liberalization of drug policy.

The situation is not significantly different as we move to Vancouver, the location of INSITE. The sitting and previous two mayors of Vancouver are outspoken advocates of drug legalization. This document does not address the ethics of public officials making unsubstantiated statements that can have a profound impact on public perceptions of drugs that in turn can lead to increased use and subsequent problems. However, the Mayors' open advocacy for harm reduction, including INSITE, add to the overall pressure and expectation to implement those approaches.

It is within the context of harm reduction as guiding ideology that INSITE has come about. In fact, INSITE holds a showcase position in harm reduction ideology that inevitably places huge pressure on it to continue. Vancouver forms a testing ground. Quoting from the agenda of a 2000 Vancouver symposium on harm reduction: "Vancouver, in particular represents an important test case and centre for the implementation and evaluation of drug programmes and policies."(6)

This enormous pressure to push forward with harm reduction measures alone makes any evaluation of such measures the necessary target of the closest scrutiny. So many public figures have spoken out in favour of INSITE, before and without having evidence of its clear benefit, that any evaluation would be under huge pressure to affirm those statements. It is for this reason that I have provided such background before getting into the INSITE evaluations.

A Critique of INSITE Evaluations

The INSITE evaluations as reported in various research journals include considerable overstating of findings as well as underreporting or omission of negative findings, and in some cases the discussion can mislead readers. The reports show no impact on the key issues that would most warrant its existence: spread of HIV or other blood borne disease, getting clients into treatment and off of drugs, reducing overdose deaths. The reported impact on public disorder that is discussed is questionable and so limited in scope as to be misleading. "Straw horse" findings are reported that also can be misleading. These are findings that one would naturally expect but that lack any real meaning.

The most conclusive finding is not discussed to any extent in the reports. Data in all of the reports suggest that only a small percentage of IV drug users use INSITE for even a majority of their injections. Most drug users use it only some of the time or not at all. This finding illustrates a shortcoming of harm reduction measures that has recently been highlighted by Neil McKeganey in the UK: an inability to control a free moving population of IV drug users sufficiently to control disease in **the face of continued use of drugs.** (7)

The potential bias is so substantial in the evaluations and the findings so weak that any deep analysis of the research is risky, because suchinadvertently might lend validation to reports that demonstrate little or no impact of INSITE on key behaviours. The overall impression one gets from reviewing the research is that much more is made of the data than is warranted. The research by no means supports expansion of INSITE. Rather, it suggests alternative treatments need to be tried that may hold much more promise for not only reducing disease but also getting people away from and off of drugs.

Review of Individual Evaluation Reports

Wood E, Kerr T, Montaner JS, Strathdee SA, Wodak A, Hankins CA, et al. Rationale for evaluating North America's first medically supervised safer injecting facility. Lancet. 2004;4:301-6.

This editorial commentary by the lead INSITE researcher and others criticizes United States drug policy in response to a visit to Vancouver by the head of the Office of National Drug Policy. The article fails to acknowledge important distinctions between Canadian and US policy in the use of enforcement and incarceration. It displays a general disdain for supply reduction but does not recognize the role of laws in reducing the physical, economic and social availability of illegal substances. These effects in turn have contributed to the very low overall incidence and prevalence of illegal drug use in Canada – less than 2% of the population aged 15 and over compared to 79% for alcohol and 32% for tobacco. (8,9)

Most of the evaluation articles show indications of bias. The greatest indicator of this bias is that none show strong results or impacts on important outcomes, but all use terms such as "optimistic," "promising," etc. The potential for bias is so great that when it shows itself, as it does in the evaluations, it is even more difficult to trust anything coming forth from INSITE.

The article also makes a rather fatalistic assertion that people will "inevitably use drugs." This statement is an opinion and contradicts the potential of prevention.

Wood E, Kerr T, Lloyd-Smith E, Buchner C, Marsh D, Montaner J, Tyndall M. Methodology for evaluating Insite: Canada's first medically supervised safer injection facility for injection drug users. Harm Reduction J. 2004; 1-5.

This and the other published articles do not adequately acknowledge the potential for bias in the samples used. The progressive cohort design does not account for nor control for the fundamental potential of differences in control and treatment groups. The most significant difference is **motivation**. Attendees at the site demonstrate a level of motivation that those not attending INSITE do not. This can explain differences found, if any, and renders findings that make comparisons both weak and invalid.

Additionally, self-report is used at times in the study. The extreme pressure for INSITE to be seen to succeed brings self-report by clients and staff into question. In particular, INSITE staff members are heavily prone to the Hawthorne Effect, which refers to the tendency for groups who know they are being evaluated to act differently as a result. Even drug users have some potential for bias. The Vancouver Area Network of Drug Users (VANDU) displayed active bias in the media in the weeks leading up to the federal decision to extend INSITE on September 8, 2006.

The samples may be biased further by the presence of compensation for participation ($20 per follow-up visit). Together with the fact that the evaluations rely completely on correlational data, this risk of sampling area considerably weakens the evaluations.

A crucial omission in the INSITE evaluation is the lack of any comparison treatment. INSITE can only be compared to the status quo, which one can argue has been brought largely about through inaction in prevention and treatment. This is an important limitation given the cost of INSITE and the implications for future use of resources. In order to fairly access the worth of INSITE, it has to be compared to alternatives. One sample alternative would be the substantial and effective implementation of drug courts, accompanied by changes to make entry into long-term treatment easy and immediate. Without a comparison treatment, we have no way of knowing if any impact of INSITE, were it to occur, is more efficient and effective than that we could obtain in another way.

Wood E, Tyndall M, Li K, Lloyd-Smith E, Small W, Montaner J, Kerr T. Do supervised injecting facilities attract higher-risk injection drug users? Am J of Preventative Medicine. 2005; 29: 126-130.

The finding of this article illustrates the first of a number of "straw horse" findings that tend to inflate the overall significance of INSITE. A straw horse finding is one that is completely to be expected but that does not mean anything in and of itself. In this case the researchers fail to acknowledge, in saying INSITE reaches high risk drug users, that the population served is all high risk, particularly those using drugs regularly. Thus it is not a useful finding nor does it suggest success other than output (the number of people coming in). Output evaluations in treatment and prevention have been routinely criticized.

This article reveals that the facility fails to attract younger users where interventions would come earlier in their drug use career. It can be argued that the most potential for change exists among young users. It underscores the "after the fact" nature of harm reduction strategies in general.

The article includes data that show the relative infrequent use of INSITE by individual IV drug users. In this evaluation, 178 of 400 participating drug users utilized INSITE during the study period, leaving over 50% who did not use INSITE at all. Of the 178 who did use INSITE, over half used it for less than a quarter of their injections. These findings illustrate a trend that precludes INSITE effectively controlling injection drug behaviours.

Wood, E., Tyndall, M., Qui Z., Zhang, R., Montaner J., & Kerr T, Service Uptake and Characteristics of Injection Drug Users Utilizing North America's First Medically Supervised Safer Injecting Facility. Am J of Public Health. 2005; 5:770-73.

This article constitutes another version of the previous article. It largely describes demographics. The article makes the statement that "no adverse affects or harms were reported by INSITE staff." Given the powerful pressure for INSITE to be seen to succeed, staff self-report is not a valid method of data collection.

This article acknowledges that most clients live within a few blocks of INSITE. Neither this nor other articles offer an estimate of the number, size and cost of injection sites that would be needed to make it physically possible to accommodate even a significant portion of total drug injecting in the DTES, even if drug users utilized safe injection sites consistently, which the evaluations show clearly they do not.

Kerr T, Stoltz J, Tyndall M, Li K, Zhang R, Montaner J, Wood E. Impact of a medically supervised safer injection facility on community drug use patterns: a before and after study. BMJ. 2006; 332:220-222.

None of the published reports discusses the implications of the fact that 37% of DTES drug users inject cocaine. Cocaine injection is frequent – 10 or more times a day. They do not acknowledge the impracticality of attempting to capture a significant percentage of these injections at the site.

This article does acknowledge the possibility that INSITE may create some "risk compensation" based on the finding that there was an increase in incidence of cocaine use after INSITE started up. The possibility of such compensation (feeling safer because one uses INSITE, then engaging in other high risk behaviour) is overshadowed by the fact that a facility such as INSITE cannot, to a significant extent, accommodate cocaine injectors.

This article mentions that no overdose deaths occurred at the site. We do not know if any of the overdoses would have resulted in death outside the site. The number of overdose deaths in Vancouver and the DTES has increased since INSITE started up. This fact at least suggests that in its 3 years of operation, INSITE has produced no impact on overdose deaths.

This article reports that the facility does not keep people from quitting drug use or stop people from seeking treatment. While it is important to "first do no harm," this is not an adequate finding to use to continue a program of this scope. Moreover, the data collected are not adequate in scope to warrant these claims. We do not know what negative effects the facility may have had on the availability of treatment, given the preoccupation with INSITE. Neil McKeganey's research in the UK suggests such programs may actually have an adverse effect by drawing focus and efforts away from incidence reduction (prevention) and prevalence reduction (treatment).

Wood E, Kerr T, Stoltz J, Quia Z, Zhanga R, Montanera SG, & Tyndall MW. Prevalence and correlates of hepatitis C infection among users of North America's first medically supervised safer injection facility. Public Health. 2005; 119: 1111–1115.

This study only discusses correlates of having hepatitis C. Two of the factors - involvement in the sex trade and having been incarcerated – actually suggest that variables are at work over which INSITE has no control at all. A third factor, sharing needles, is one on which the evaluations suggest INSITE is having very little impact.

Wood E, Tyndall M, Stoltz J, Small W, Lloyd-Smith E, Zhang R, Montaner J, Kerr T. Factors associated with syringe sharing among users of a medically supervised safer injecting facility. Am J of Infectious Diseases. 2005: 50-54.

This report, if not read carefully, is misleading. It implies that use of INSITE is associated with reduced needle sharing. Actually, only **exclusive use** of INSITE correlates with reduced sharing - an example of a "straw horse" finding. If someone uses INSITE for all their injections, it goes without saying they would not share needles. Only about one in ten HIV negative participants reported using INSITE for all of their injections. Only four HIV positive participants reported using INSITE all the time. These are the most important findings in the study but are not reported.

Wood E, Tyndall MW, Lai C, Montaner JG, & Kerr T. Impact of a medically supervised safer injecting facility on drug dealing and other drug-related crime. Substance Abuse Treatment, Prevention, and Policy. 2006; 1:13.

As with the previous report, this article makes only a "no harm" claim. It fails to acknowledge or discuss the impact of police activity. In fact, there was a substantial police presence during the period of the study. The following is a quote from the Vancouver Police when asked about police presence at and around INSITE:

> Yes, four officers per day, 22 hours per day, 7 days per week, for one year from Sept 03-Sep 04 in the block at all times with cell phone access directly to them by SIS staff. These officers were paid on overtime callout at double time for that whole year. The Vancouver

agreement paid for that. At the same time 60 other officers were deployed in a 5-block area and still are to this day. The police took care of public disorder.The SIS enhanced public disorder.

It is misleading for any inference to be made that INSITE had any impact on crime or on public disorder. Police presence more than accounts for any changes in either.

Wood E, Tyndall M, Stoltz J, Small W, Zhang R, O'Connell J, Montaner J, Kerr T. Safer injecting education for HIV prevention within a medically supervised safer injecting facility. Int J of Drug Policy. 2005; 281-284.

This article reports very little – that being involved in the sex trade or requiring help injecting correlates with receiving safe-injecting education at INSITE. The finding that a minority of clients studied receive any such education is itself a finding but is not mentioned. One would look for some evidence that INSITE was providing actual education regarding drug use and options available to clients. None of this type of education is described in any of the studies.

Kerr T, Tyndall M, Li K, Montaner J, Wood E. Safer injection facility use and syringe sharing in injection drug users. Lancet. 2005; 366:316-8.

This report ignores the significant negative implications of the fact that, of 431 drug users studied, only 90 used INSITE some, most or all the time. It does not recognize adequately that half of these persons still shared needles. Research showing modest changes in the amount of needle sharing among a small portion of users is not a positive finding.

Wood E, Kerr T, Small W, Li K, Marsh D, Montaner J, et al. Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users. Canadian Med Assoc J. 2004; 171:731-4.

This study is misleading in asserting changes in public order. First, the methodology is flawed. The risk of bias is far too great to use observation and counting by a single individual. This is especially true given the overwhelming threat of bias due to the expectations of success among all levels of government.

The number of discarded needles and wrapping really says nothing about public disorder; at best it is a crude index of injecting outside of the confines of INSITE. No assumptions can be made from the data described. When asked for indicators of public disorder, the Vancouver Police Department provided the following:

1) People (usually crack addicts/IV users) setting up flea market set-ups on sidewalks all over the DTES

2) People congregating in the lanes/on the sidewalks and fighting with each other over drug-related matters

3) Drug trafficking on the street by addicted/non-addicted individuals - creating public disorder problems with their activities

4) Violence and assaults related to the drug trade in the DTES

5) People urinating and defecating all over the place

6) Open drug use - both injecting and smoking of drugs

7) Psychoses after drug use

8) Mental Health issues

9) Movement of stolen property

10) Intoxicated individuals in the DTES - from both bars (although not many are open any more in the DTES) and consumption of intoxicants like rubbing alcohol and mouthwash

11) Garbage scattered from one end of the DTES to the other – generated by the addicted individuals in the DTES

The evaluations address none of these indicators of public disorder. Indeed, an injection site could do little about any of these problems unless it engaged actively in getting people into long-term treatment. These problems with public disorder can only be addressed by dealing with addiction itself.

Tyndall MW, Kerr T, Zhang R, King E, Montaner JG, Wood E. Attendance, drug use patterns, and referrals made from North America's first supervised injection facility. Drug and Alcohol Dependence. 2006; 83:193–198.

This report describes the demographic profile of INSITE clients. It is largely an assessment of output – the number of people served, etc. It also mentions that there were no overdose deaths in INSITE. Mentioning that there have been no overdose deaths in INSITE without qualifying it (acknowledging that overdose deaths in Vancouver actually have increased) is misleading.

Wood E et al. Attendance at Supervised Injecting Facilities and Use of Detoxification Services. N Engl J Med. 2006 June 8.

Of all the reports, this one best exemplifies the transformation of limited findings into something entirely different in the media. This report's only finding is that some INSITE users go to **detoxification** upon referral. It does not show that INSITE increases use of detoxification, nor, more importantly, does it show that INSITE produces any increase or effect on people proceeding to actual **treatment**. Detoxification is often called a "revolving door." Going to detoxification is by no means the same as going for treatment, and this is a well-understood fact. In the media, this finding was somehow transformed into statements that INSITE was getting people into treatment and off of drugs.

Impacts of INSITE on Other Aspects of Drug Policy

None of the evaluations of INSITE consider the effects it may have on other drug policy pillars, whether directly or indirectly. INSITE and any other harm reduction initiatives have to be considered in unison with treatment, prevention and enforcement. In this section the potential impacts of INSITE on these pillars is discussed.

Impacts on Prevention

The principal impact on prevention of harm reduction as a major focus of drug policy has been to produce a relative void in prevention development and activity. No incidence reducing (primary) prevention programs appears to have been named or supported by the Health Authority, provincial government, federal government (outside RCMP Drug and Organized Crime Awareness) or City of Vancouver for the duration of INSITE's operation. Federally, no Social Sciences and Humanities Research Council (SSHRC) funding was found to be going to prevention-related research.

One formal prevention activity found to occur in B.C. for the term of INSITE was *A Dialogue on the Prevention of Problematic Drug Use*, a federally and provincially funded symposium in Vancouver in 2004. As the name suggests, the focus was on what was termed problematic drug use. The proceedings show clearly that little or no interest was paid to reducing the incidence of drug use. This carries serious implications because the key means to prevent incidence of addiction is to prevent drug use onset, and early illegal drug use onset (i.e., cannabis) is linked to significant increase of risk for later addiction and other drug problems. (10,11)

We cannot explicitly blame INSITE for this void. The parent philosophy itself is at fault. However, it is alarming to know that many supporters of INSITE want to see even more money put to such programs. This too would be money not available for other drug pillars. Given the ineffectiveness and inefficiency INSITE has shown, such spending would be considered unwise.

Impacts on Treatment

Similar to prevention, no expansion or innovation has been evident in treatment in Vancouver or in B.C. for years. A portion of blame for this inactivity must be placed on the Vancouver Coastal Health Authority and on provincial and federal governments for focusing almost entirely on INSITE. In interviews with directors of five area treatment facilities in association with completing this report, all reported having neither any connection to INSITE nor any clients coming to them because of INSITE. All supported some form of compulsory treatment, and all indicated that treatment, not INSITE, was the key to reducing drug problems including addiction, crime, disease, mental health issues and public disorder. None were consulted by INSITE or its proponents, nor did they know of colleagues who were. All reported their facilities as being badly short of funding. Each receives only $40 per day for each client in residential care, and no change or increase in funding has been received from Vancouver Coastal Health Authority in the past 12 years. All reported waiting lists, from weeks to months. All but one reported going to a fee for service system, further placing treatment out of reach. All persons interviewed indicated that this creates a serious problem for addicted persons who may only briefly reach a point where, on their own, they will seek treatment.

Clearly, INSITE has not considered links to treatment in its planning. Even if INSITE staff actively worked with clients to get them into treatment, it appears such is not at all adequately available. Treatment as a policy pillar, like prevention, has been largely neglected in pursuit of harm reduction strategies.

Impacts on Enforcement

Little comment can be made here regarding the effect of INSITE and/or its underlying ideology on the

enforcement pillar. It is particularly difficult to obtain a full picture of because the Vancouver Police Department officially is on side with the project. Impacts INSITE and its parent philosophy may have on the enforcement drug strategy pillar likely will come through impediment of enforcement. In order for INSITE to operate, enforcement exemptions have already been necessary. More would be necessary in order to expand the project in scope. Over the longer term, if the project continues, it is entirely likely that some form of drug distribution will be requested.

The ideology underlying harm reduction as promoted today is on a collision course with enforcement. Proponents of drug policy reform in the form of legalization and regulation, which include many policy makers and advisors at the provincial and federal levels, leave little doubt they want to change Canada's drug laws. In some cases the lines are quite blurred between policy makers and law reform activists.

Recommendations for Future Action

The failure of INSITE to show, in three years of operation, impact on disease or on users achieving abstinence and recovery are not surprising. Two current examples are found in other countries: The UK and Australia.

In the UK very recently, the entire focus and preoccupation with harm reduction strategies has been called into question. Notwithstanding a strong harm reduction focus, HIV and hepatitis C levels remain high. And at least one researcher is questioning whether rises in drug use incidence may outmatch the system's ability to cope, expressing concern that prevention may have been overlooked with very negative consequences. (12) Raising such concerns is courageous in the current environment in which harm reduction seems sacrosanct.

In Australia, the King's Cross Injecting Room was also the subject of an extensive evaluation sponsored by the New South Wales government. However, a team of independent researchers and practitioners critiqued the evaluations (13) and found much the same pattern as this critique has of INSITE. They noted large differences between what was in the report and what was published in the media where the injection room was declared a success.

From this report, it appears at least that similar dynamics may be at play in Australia as in Canada. This process might be described as follows. A new ideology (harm reduction) takes over policymaking and develops a momentum all its own through self-selection (hiring, funding practices), management of information and progressively cutting off other options as it seeks justification to continue. More dangerously, it selectively seeks evidence supporting itself and runs the risk of ignoring anything and anyone that disputes it.

This and the UK case provide but two examples of "red flags" that, at the least, should warrant a careful stepping back and examination of drug policy, how it has evolved and what forces are driving it.

Harm reduction ideology is alive and well in Canada, and before any honest and open dialogue can be held about drug policy, some form of action to stop its momentum will be required. And unfortunately, harm reduction ideology has politicized drug issues, as evidenced by the sharp criticisms and even political threats directed at the federal government as it considered whether or not to continue funding INSITE. This politicization makes it even more difficult to step back and have an even-handed discussion of drug policy.

The infiltration of drug policy with harm reduction has involved co-opting organizations, selecting staff and funding practices that effectively cut off dissent. Today, having a room full of policy makers say they are all on board is not particularly meaningful. Any disagreement was taken care of long ago at all levels of government.

All of this has significant implications. How can INSITE, the further facilities it could lead to and other ideologically harm reductionist programs be stopped or slowed until we can back up and look openly and objectively at drug policies? How can we embark in a consultative process that is not selective and biased, as were the Senate and House Committees on Illegal Drugs?

Here are some recommendations for consideration as we move forward.

1. **Depoliticize drug policy** by making clear that harm reduction is not about compassion and caring for the marginalized and poor. A great deal of marginalization comes not before but after addiction has taken hold and begins to consume financial and personal resources. Some poverty and marginalization comes about through preexisting mental illness. There is no reason that, in a modern and advanced society, mentally ill people should be left to fend for themselves. The entire system of identifying mental illness and protocols for taking care of them needs to be strengthened. Otherwise, more and more mentally ill persons will drift into the hellhole that is life on the street in the DTES. Addiction needs to be recognized as a major cause and contributor to all other medical and social problems a person experiences. Policy must make clear that dealing with the addiction comes first.

2. Strengthen treatment and create mechanisms to get people into treatment. The road from street to treatment needs to be opened up widely. Presently, some policymakers place little priority on abstinence. These people need to be made to understand that getting off of drugs is the first, not last, step to recovery into a stable existence. If policymakers sit down with the people running long term care treatment facilities, certainly ways can be identified to get people off the street into treatment forthwith. We already know that treatment need not be voluntary to be effective. It is time to put into place mechanisms that direct people into treatment who, because of their addiction, either break the law or are putting themselves and others at significant risk. Sweden has accomplished significant success with compulsory treatment and has among Europe's lowest crime, disease, medical and social problems stemming from addiction. Recently, a UN report described Sweden's success with their restrictive drug policy supported by all national political parties:

> A compulsory care order in Sweden can only be issued if certain legal conditions are met. The two conditions are: (a) that the person is in need of care/treatment as a result of ongoing abuse of alcohol, narcotics and volatile solvents and that (b) the necessary care cannot be provided under the Social Services Act. The first option for the substance abuser is always voluntary treatment under the Social Services Act. The social welfare committee, which works on the prevention and countermeasures of abuse of alcohol and other addictive substances, acts in consensus with the individual. (14)

As a matter of fact, Canada would be well advised to examine Swedish drug policy carefully, so distinct are its relative successes compared to similar European countries pursuing harm reduction-focussed strategies. The research described in the report is most encouraging. Given that Sweden is not a conservative country, it may show a way to depoliticize drug policy in Canada. The only beneficiaries of politicized drug policy are the members of the drug legalization movement.

3. Examine national drug policy, how it has gotten where it is and take action to refocus it. Present drug policy is largely a "hijacked" policy that has become influenced by and susceptible to the movement to legalize and regulate drugs. Federal government support exists for creating a new drug strategy affirming demand and supply reduction as key pillars. This includes initiating and carrying out an open consultative process that includes many groups that have gone unheard for a long time such as recovering drug users, treatment and recovery workers, incidence-reducing prevention professionals, businesses, addiction medicine specialists who have not agreed with harm reduction but have not been heard, youth who do not use drugs and, very importantly, parents, youth organizations, and other institutions and organizations with a stake in Canada's youth and their future.

4. Rein in the civil service and other government created and funded bodies. This paper has pointed out examples of a civil service operating independently of elected governments in setting drug policy directions and has cited specific examples of conflict of interest arising from a mixing of drug reform activists in with and as policy makers. There is currently no check on civil servants and others. In a democracy, such things as drug policies must be transparent to and involve the voice of the people. Without significant checks and a balancing in the civil service, harm reduction ideology will continue to propagate and sink roots in policy and programs so as to become very difficult to reverse. The federal government got a taste of this recently as they considered the extension of INSITE.

5. Make drug policy permanently transparent and with balances. Drug policies and strategies must not be able to be constructed in back room committees, through self-selected coalitions and through information management. To the greatest extent possible within a general framework, local communities should be able to generate their own drug policies. If national policy is clear and built on sound principles, then communities can build on these sound principles.

6. Affirm a national commitment to reducing drug use and to getting people off of drugs. These principles have become lost in recent years, and we have paid a price in reduced public awareness and attention to drug issues and the risks attendant with drug use. If the government makes it clear that it wants to help families help their children and youth grow strong and free of the snare of drugs and that it cares for its citizens who are caught up in addiction and all the constellation of problems that go with it and will do all possible to help them off of drugs, then the families and communities of Canada become involved and have a rallying point. For some time now, drug policies have formed a rallying point mainly for drug legalization activists in and out of government.

7. Support and take action now in primary prevention. As we speak, a new cohort of Canadian children are growing up in an atmosphere void of positive prevention messages

except for what they might get at home or in a school program such as DARE. We know that when people start using cannabis in their teens, they are then more likely to go on to other drugs. It is some of these people who will, in a number of years, be in places like the Downtown Eastside. It makes sense then to work to address the factors that are causing young people to start using.

8. Support community partnering. Finally, communities are at the very root of action to address drug problems. Communities are where people live, raise children, work and play. Yet communities often are pulled apart, isolated and do not use nearly their potential in strengthening the ties that hold society together to buffer against crime, antisocial and self-serving behaviour. Drug use can often be merely a symptom. Anything we can do to increase cohesion, order, altruism, neighborliness, compassion and caring in communities as well as integrity and responsibility in youth will pay great dividends. Today, law enforcement plays an important role as one of the few institutions people can look to for leadership and a sign that things aren't yet "gone to hell in a handcart." Police can play a significant role today in helping pull a community together by providing a stable partner, offering leadership in prevention, lending authority and credibility to actions, and informally acting as an example and mentor in building up the community and its members, especially its young members.

Acting on recommendations such as these, governments and citizens can rebalance Canadian drug policy and ensure that we do not become locked in by ideology to strategies that miss the point in addressing drug problems but become unassailable because of political correctness.

Dr. Colin Mangham is recognized as one of Canada's foremost leaders in the theory and practice of prevention. He has taught, conducted research, trained, worked with the field, and developed, evaluated and implemented programs for governments and provincial and local community and school organizations in Canada since 1979. He is also the author of numerous prevention programs for youth and parents that are in use across the country today and that reflect evidence-based best practice in the field. Some of these include *Your Life Your Choice, Making Decisions I and II, Making Decisions: Classroom resources for Grades 8 and 9* and *By Parents for Parents*. A fervent advocate for primary prevention and healthy youth development, Dr. Mangham is Principal of Population Health Promotion Associates and serves on a volunteer basis as Director of Research for the Drug Prevention Network of Canada. He holds a PhD in School and Community Health from the University of Oregon.

I declare that I have no proprietary, financial, professional or other personal interest of any nature or kind in any product, service and/or company that could be construed as influencing the position presented in, or the review of, the manuscript entitled
except for the following:

II am affiliated in an unpaid capacity with the Drug Prevention Network of Canada. This information is based on a report produced for the Royal Canadian Mounted Police, a national partner with Insite.

Where views are expressed they are my own. The findings are based strictly on research conventions.

Colin Mangham

January 17, 2007

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Is It Harm Reduction-or Harm Continuation?

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Abstract:

From a long career in treatment services, this author has first-hand experience in the practice of harm reduction and the consequences of applying it – which are not always positive. This author suggests ways of bringing greater clarity to the whole arena. The abandonment of abstinence as a goal in UK treatment practice is scrutinised with the conclusion that it could best be described as 'harm continuation'. The interaction between national treatment bodies and 'Whitehall' (the UK government) and the enforced reconciliation of treatment needs and political interests is appraised and found wanting. Some hope is seen in scientific and pharmacotherapeutic current advances, whilst at the same time recognising the ongoing effectiveness of 12-step fellowships (albeit difficult to scientifically measure) and its ready correlation with the transtheoretical model. This author concludes that British practice facilitates continued drug/alcohol use – whether intentionally or consequentially – and that statistical smoke screens mask the process, a process which if not corrected is likely to increase rather than decrease society's problems.

Keywords: Harm Reduction, harm continuation, treatment, addiction, dependency.

In the beginning

It is more than likely that the concept of harm reduction has existed since shortly after we discovered substances that could change the way we were feeling. Ever since man first trod grapes and enjoyed the temporary euphoria that subsequently arose from their fermented juices, there has been the realisation that the effortless, sometimes euphoric, altered states of consciousness arising from using 'elixirs' could produce unpleasant side effects. Not surprisingly, some found these side effects so unpleasant they chose to ingest more of the potion/substance in an effort to cope with the mental and physical disturbances experienced. Thus they sought to 'reduce' the harm brought on by the substance with 'self medication'. The rest, as they say, is history, with those in less enlightened times who became addicted to alcohol held up to ridicule, scorn and disgust; in fact, it was only as short a time ago as the 1950s that alcoholics were classified by the British Government as 'vagrants'.

One of the most notable and possibly disastrous attempts at harm reduction (although that may not have been its original intention) was attempted back in the 1880s when a German scientist managed to isolate and extract the active ingredient of the coca plant and presented the world with cocaine. It was initially used for the medical purpose of local anaesthetic, the credit for which is attributed to the experiments carried out by William Halstead. Dr Halstead was a co-founder of the John Hopkins Medical School, a man frequently referred to as the 'Father of American Surgery'. It was he who in 1884 carried out the first nerve blocking operation using cocaine instead of a general anaesthetic. Dr. Halstead's enthusiasm for this 'wonderful substance' led him to self experimentation with a view to establishing if surgery could be carried out with its use. Unfortunately, these experiments led to his addiction to cocaine - an addiction that was to jeopardise his career and lead him to use morphine as a 'safer' alternative, a habit which remained for the rest of his life, but presumably, one that he felt was less harmful.

Conversely, in the same year, Sigmund Freud published his now infamous paper 'Uber Coca' (1) extolling the virtues of cocaine as a 'cure' for asthma, wasting diseases, syphilis, andalcohol and morphine addiction. Like Halstead, Freud succumbed to the addictive properties of cocaine, but not before he had persuaded a close friend that this 'elixir' would *cure* his morphine addiction. His friend subsequently became the first recorded European cocaine addict.

Neither Halstead nor Freud was alone in promoting the use of cocaine. On the contrary, the medical journals of the day were fulsome in their praise of cocaine as the answer to a variety of problems, with just a few voices of dissent and caution. Needless to say, the use of cocaine became widespread, and there is well documented history of the subsequent epidemic of addiction (2) and explosion in crime (3). The latter was due to the fact whilst at that time it was not a prohibited substance; it was not free. Addicts, both men and women, sold their bodies, robbed, and stole to fund their habit - facts that are conveniently overlooked or forgotten by pro-legislation drug groups. At least they have the courage of their convictions as compared to covert groups who masquerade as drug treatment agencies and tout so called harm

reduction techniques for the ostensible and 'compassionate' reasons that it will reduce crime, unnecessary suffering, degradation, and deaths. Utopia beckons!

Clarity, rather than confusion

Before proceeding with the pros and cons of harm reduction, it might help to make it clear that whenever and wherever the word addiction or addict appears, it is done so deliberately. Dependency is allegedly the less pejorative and preferred description and isconsidered less stigmatising. It is interesting to note that 'dependency' was substituted for addiction after much discussion among members of the American Psychiatric Association (APA) (4), and its use subsequently was voted on by a majority of one. There were no clinical or scientific reasons for this change, nor for that matter is there any now. From those perspectives, the use of 'dependency' is hopelessly inaccurate. The change was motivated entirely by the politically correct attitude that it was less pejorative.

A more realistic approach to changing the perception that addiction is a disease rather than a stigma is to increase, in lay terms, the awareness of the general public and the media of the evidence and facts:

- That addiction is a disease of the brain, body, and spirit.
- That no one sets out to become addicted.
- That anyone who includes in their lifestyle toxic and mind altering drugs, including alcohol, can quite easily develop what is referred to as Substance Abuse Disorder. (SAD)
- That some are more vulnerable than others.
- That there is a very fine line between SAD and addiction.

Surveys consistently show that the excellent 'awareness campaigns' run by the Partnership for a Drug Free America (PDFA) are helping the general public to understand that addiction is a disease and, of equal importance, to accept it as such (5). In addition, treatment agencies around the country report that whenever and wherever these campaigns are run, the numbers making enquiries about treatment services increase dramatically. Thus in seeking to minimise, if not entirely eradicate, through facts rather than semantics that addiction is a disease, PDFA is making a positive contribution to harm reduction. They are not only removing the stigma concept, which not infrequently prevents people from seeking treatment, they are also bringing more into treatment.

SAD is presented in *DSM-1V* as 'a condition'. This author suggests that it is more accurately described as 'a process, leading to dependency'. Dependency is a condition which applies to anyone on any form of medication, inasmuch as they are 'dependent' on their medication to alleviate their presenting symptoms. Toxic, mind altering substances, temporarily achieve a similar end for those seeking an altered state of consciousness without effort. The resulting transient, 'switching off' effect is discovered to be highly desirable; so, not unnaturally, the process is repeated as a perceived antidote to stress, worry, anxiety, and depression. In many cases it is a process that is indulged in to enhance feelings of euphoria and sexual desires, and so a dependency is formed upon the drug(s) of choice. Addiction, on the other hand, includes the fact that there is loss of control over the use of the drug(s) of choice. A very interesting debate has developed with the *American Journal of Psychiatry* (6), submitting a very strong argument for reverting back to the correct description in future *DSM* issues. This author would add that he has yet to meet an alcoholic or addict who did not have an aversion to reality and therefore believes that the use of euphemisms to describe their condition subliminally encourages and facilitates that aversion. For that reason alone, euphemisms are more likely to delay addicts from coming to terms with the reality of their condition and delay seeking treatment, thus hindering their chances of successful recovery. Such euphemisms could be regarded as permitting harm to continue rather than reduce it.

What is harm reduction?

Harm reduction is defined by the British-born, Australian based International Harm Reduction Association (IHRA) as follows (where italics appear, they have been chosen by the author):

> Policies and programmes aimed at reducing the adverse health, social and economic consequences of drugs. It can include (a) abstinence or reduction in consumption of drugs; (b) prevention of transmission of HIV diseases among injecting drug users; (c) use of less harmful drugs in place of more damaging ones. Based on evidence from many countries around the world, harm reduction programmes have proven to be effective in preventing HIV infection among injecting drug users. Effective harm reductions are not limited to the provision of sterile injecting equipment but must also include other components such as AIDS awareness raising and education among drug users and their sex partners, provision of barrier methods to prevent sexual transmitted diseases, drug dependence treatment and rehabilitation, treatment of sexually transmitted diseases and other health services: and access to voluntary and confidential counselling and testing. Moreover local communities, including the drug using community itself, must be mobilised and participate fully for such package of measures to work. *No single element of this package will be fully effective if practised on its own. Harm reduction programmes do not promote drug use and can be implemented in countries alongside programmes on primary prevention of drug use and demand reduction* (7).

The above could be described as entirely holistic and an acknowledgement that there is no cure for addiction, whilst recognising that the majority of those afflicted, notwithstanding the ongoing mental, physical, and spiritual damage they are inflicting on themselves and others, are likely to continue using. On that understanding it would be hard to reject such an all-encompassing vision if it were adhered to in its entirety, which includes the goal of abstinence and subsequent recovery for those who are addicted and, as the originators point out, not in a 'pick and mix' combination.

However, in the UK, in accordance with the politically expedient, convenient, and revised policies and strategies of the National Treatment Association (NTA), the goal of abstinence has been abandoned. In its place there is 'educating' of addicts (who by definition have lost control over their consumption) to reduce it. This policy has permitted the introduction of programmes that not only contradict the spirit of the IHRA definition but seek to fragment the component parts, whilst simultaneously ignoring the wealth of scientific and medical evidence. The research clearly shows that in the cases of addiction, any reduction in use is purely transient and that sooner or later the original pattern of consumption is reinstated. As such, the UK approach is more worthy of being described as 'harm continuation '. Running parallel with this travesty, we have NTA funded 'drug treatment agencies' promoting with local councils the establishment of Drug Consumption Rooms (DCRs). These have been described by one prominent agency as 'offering a warm and welcoming environment where clients under medical supervision can safely ingest drugs.' By any definition that has to be regarded as facilitating if not actually promoting drug use, a further contravention of the IHRA definition.

Notwithstanding their failure to adhere to the fundamental IHRA concept of harm reduction, NTA claims to advance harm reduction, by their methods, via the following statements:

> National and international evidence consistently shows that good-quality drug treatment is highly effective in reducing illegal drug misuse, improving the health of drug misusers, reducing drug-related offending (8).

The above is then reinforced by the following:

> Effective, well delivered treatment improves the health and social functioning of individual drug misusers, reduces the risk to public health resulting from the spread of blood-born viruses and improves the safety of community by reducing re-offending amongst drug-misusing offenders. (9)

Note the total absence of any reference to abstinence.

Success for the strategy is claimed on a number of issues, the first of which is the increased number of addicts in treatment. The statistic is a somewhat simplistic measure, unaccompanied as it is by the numbers who are 'maintained' on methadone, do not re-offend or indeed any other meaningful statistics, such as numbers discharged drug free (DDF). Nor is there any independent monitoring of sustained reduction in use, all of which would give a clear indication of how either or both the above statements translates into reality. However, the report does include the following claim: 'Overall drug related crime is reducing as treatment increases.' That claim is considerably at odds with Home Office statistics, which for the final quarter of 2005 showed an increase of 21% in such offences. Nor, unfortunately, is that alarming increase a blip or one off since increases were also recorded in the previous two quarters of that year, resulting in an overall increase for 2005 at 16% (10).

Written enquires to the NTA by this author, also dated June 2006, about this apparent anomaly together with enquiries as to the 'favourable effects' on blood borne diseases, Hepatitis C, and HIV etc. remain unanswered to date.

Anomalies seem to feature strongly in reports of claimed success of the Harm Reduction strategies promoted by the NTA - strategies which they continue to insist are 'evidence based'. A more recent statistical report issued by the National Drug Treatment Monitoring Service (NDTMS) (11) and publicly claimed in both the national and industry press by Health Minister Caroline Flint and Chief Executive of the NTA, Paul Hayes, as evidence of how successful the strategies are is a case in point.

The NDTMS report highlights 4 primary objectives for the strategies, none of which include abstinence; however, they do include 'reduction in harm'. There are also secondary goals which include the laudable objective of getting drug users into employment. Unfortunately, there is no explanation of how employers are to be persuaded to employ habitual drug users. Further, there is no explanation of how this tacit sanctioning of continuing illicit drug use can help addicts into employment. Nor, for that matter, are we offered any statistics as to numbers or percentage of clients who have achieved either a sustainable reduction in harm and/or are gainfully employed, or both.

The statistics we are offered and on which claims for success are based are, as might be anticipated, the numbers 'in treatment' (apparently these have exceeded targets), the number who have been discharged, and the numbers who have completed 12 weeks treatment and also discharged. We are advised that the latter 'is the point when sustainable change begins to become achievable'. The nature of these changes are not disclosed nor are we advised if or what 'sustainable changes' have actually been achieved, but it seems that they too have exceeded targets.

Apart from those omissions, one would have thought that as the majority of evidence indicates that it is at this time that changes become achievable, there is an increased need for support, in order to avoid relapse. Rather than discharging clients, a work oriented programme of recovery would be beneficial. Notwithstanding their claim to use only 'evidence based practice', this somewhat important part is not utilised.

Close perusal of the creative accounting criteria used to establish the numbers in treatment reveals that if someone turns up just once, they are counted as being 'in treatment'. If nothing more is heard from them during the year in question, they are considered as 'discharged' - an interesting use of semantics for those who are normally referred to as 'drop outs'.

The most significant anomaly from this report comes with the omission of the statistics for the North West of England, a major area which separate research shows contains no less than 8% of all clients in structured drug treatment services in England. We are informed that the reasons for such an important and substantial number being omitted are 'that details of drug use are missing for a large portion of clients registered in this region'. We are also informed that 'where such details have been collected they may be subject to systematic bias'. (Sic.)

In itself the foregoing might be understandable were it not for the fact that in the preceding August a report by researchers at John Moores University of Liverpool (12) appears to take a completely polarised view, inasmuch as the researchers quite categorically stated that their reasons for selecting the area omitted by NDTMS was influenced by the fact that the North West is the only area in England that has consistently collected treatment outcome data between 1996 and 2004/5.

The above study, rather than suggesting that 'numbers in treatment' is a measure of success, concludes that increasing such numbers is associated with an increased number of 'drop outs', a fact, which together with its realistic phrasing, is omitted from the NDTMS report (presumably because drops outs are classified as 'discharged'). It also brings into question the validity of using 'numbers in treatment' as a legitimate basis for claiming success. A further highly significant statistic in the John Moores study referred to the number DDF, which for the year in question was an abysmal 3.5%. It is apparent that this report offers a far clearer assessment of outcome treatments for the 'Harm Reduction' strategies than that published by the NDTMS. Whether that is by accident or design is speculative. What is crystal clear is that 'Harm Reduction' drug treatment, Whitehall style, is not working despite the ever increasing amount of taxpayers' money being invested and notwithstanding facile and disingenuous claims to the contrary.

One can only conclude that the architects of this particular corruption of the IRHA definition of Harm Reduction are not familiar with Einstein's definition of insanity, but they appear to have a strong familiarity with 'Alice in Wonderland's 'what I tell you three times is true'. Nor for that matter have they encountered the works of William James, psychologist and philosopher (1842-1910) who said: 'Truth may be defined as 'that which is ultimately satisfying to believe'.

The author was so incensed by the widely publicised misleading claims made for the 'success' of the current strategies and the sanitised NDTMS report that he was moved to put his concerns in writing, wherein he concluded that had the NDTMS published the numbers DDF and included 'drop outs', the result would have been more a more realistic but politically unacceptable report. Whilst some satisfaction came from having these concerns and comments subsequently published in the 'Featured Spot' in the comments section of the UK publication *Drink and Drug News* (13), the NTA, NDTMS, and the DoH have not sought to challenge his comments or conclusions, nor those of John Moores research.

The insistence on continued use of strategies that are clearly not working is all the more disturbing when Home Office statistics show that a high percentage of those on Drug Treatment Orders (DTOs) continue to re-offend. Year on year, these appear to be increasing rather than decreasing, with the latest figures at a staggering 92%. In a further attempt to obtain an explanation of how, with all the claimed success of the strategies employed, this deplorable situation has come about, this author wrote an open letter to *DDN* (14), pointing out the tremendous discrepancies between such claims and raised a number of rigorous questions regarding the efficacy of the interventions being used. Given the obsession of the NTA with box ticking forms that indicate the achieving (or otherwise) of seemingly meaningless targets, this author also asked why the important and relevant objective of reducing the harm caused by re-offending did not appear to have a corresponding target. The question was also raised of why the universally preferred, abstinence-focused treatment for those who had been diagnosed as clinically 'dependent' was not being used.

To date there has been no direct response from the relevant parties. There was, however, a joint response from two prominent academics (15) who informed this author that using what they referred to as 'reconviction rates' is a 'crude measure' to judge the effectiveness of the treatment strategies since it failed to take into consideration 'the characteristics of offenders'. They further pointed out that neither did this 'crude measure' take into consideration 'the reductions in the frequency of offending'. They also kindly pointed to their own research wherein they found 'considerable reduction in the frequency of offending for those on DTOs'. No doubt, with the assurance that they will be robbed less frequently, the latter fact will come as a welcome relief to victims of drug related crime. Seemingly, this miraculous advance is due to the quality and type of treatment employed and therefore has nothing at all to do with the fact that street

prices in Europe of the most popular drugs are at their lowest levels ever, thereby reducing the number of occasions addicts have to go to 'work' in order to continue feeding their habit.

The respondents went on to point out that there is no reason to suppose that abstinence would lead to a reduction in reoffending, whilst choosing to ignore the strong probability that those who are abstinent and in recovery are less likely to reoffend than those who are still using.

On a more positive note, there can be no denying the advances that have been made in both scientific and pharmacotherapy approaches to harm reduction. The scientific approach continues to seek for the definitive gene that predisposes some to addiction, presumably with a view to find the 'magic bullet' that will neutralise it. Other scientific research has shown how the brains of addicts are 'different', together with the actual changes that take place in the brain with the onset of addiction. It is to be hoped that this dedicated work will eventually provide us with a solution.

The drug manufacturing industry has produced a variety of drugs which, to all intents and purposes, alleviate the cravings of addicts. Apart from the fact that the long term effects of the most recent drugs are yet to emerge, it is questionable whether or not any of these drugs will satisfy the psychological and emotional cravings of addicts for the experience of the high or the oblivion that many addicts consciously or unconsciously seek. In the interim Carl Jung's prescient comments are worth recalling:

> Science has no answer to this problem, psychotherapy alone is useless, what is required is a spiritual experience (16).

The terms 'spiritual experience' and 'spiritual awakening' are referred to in the simple programme of recovery offered by 12 step fellowships which millions of men and women of differing cultures, nationalities, and beliefs throughout the world, whether they be Christian, Muslim, Hindu, Buddhist, agnostic, or atheists, have found to be a lasting solution to their problem. It is defined as a personality change sufficient to bring about recovery from addiction: a change that appears to have different and varying manifestations. Many of the experiences appear to be educational rather than religious, inasmuch as they occur or develop, sometimes slowly, over a non-specific period of time. What is apparent from observation of those who have found this ultimate to be the ultimate form of harm reduction is a sweeping and far-reaching alteration in their reaction to life and the problems of living, which in turn permits them to live a healthy, productive, and satisfying life, alcohol and drug free.

The 12 step programmes appear to have borrowed extensively from medicine, psychiatry, and religion. It is also noted that the steps are based on the collective experiences of the first 100 **sober** members of Alcoholics Anonymous (AA). 12 step fellowships have been the subject of praise and criticism. On balance, the overall picture is favourable. However, researchers who have concluded that addicts who attend meetings regularly, together with appropriate interventions for those with co-morbidity issues, have a greater chance of a lasting recovery than those who do not and confess to being unable to identify any 'scientific' reasons for their undoubted success. This author, who has made a close perusal of the 12 steps, noted that unlike most programmes, it has no dates or specified period of time in which the programme is to be completed, thus members are free to choose when or to what extent they engage with the individual steps. Readers who are familiar with the transtheoretical model of behaviour change (17) will be aware that the framework and the progression through each stage, likewise, have no time limitations imposed.

Also of interest is the fact that the processes that members undergo as they progress through the steps bear a remarkable similarity to those found in the various stages of the transtheoretical model; therefore, each of the steps is not only compatible with the model, which also has withstood considerable critical examination, it fits very elegantly into it. This author has found that correlation to be of considerable help in bringing about change in many of his clients, among whom are a considerable number of alcoholics and addicts who had been judged by others as 'not ready'. Somehow, they appear to have 'become ready' through what could be described as the most effective form of harm reduction.

Conclusions

> This author is of the opinion that what is 'passed off' as harm reduction in the UK is, in reality, a process that facilitates the continued use of toxic, psychoactive drugs. Whether or not that is the intention is open to speculation. What is indisputable is the fact that it is simply not working insofar as the rehabilitation and recovery of addicts and alcoholics are concerned – an outcome which includes relinquishing criminal activities, living in a safe and stable environment, and, in the fullness of time through gainful employment, becoming a self supporting member of society. Further, the architects of this disaster persist in hiding their failure by the time consuming and expensive process of producing sanitised statistics (which do not in anyway aid recovery but do enable politicians to claim success in achieving meaningless targets), meaning that the scourge of addiction currently damaging our society is likely to escalate.

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History of Harm Reduction – Provenance and Politics, Part 1

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Abstract

Published in three parts, the history of 'so-called harm reduction' - starting with its conception in and dissemination from the Liverpool area of Britain in the 1980s - is described in comparison with American liberalisers' 'Responsible Use' stratagem in the 1970s and with subsequent so-called Harm Reduction initiatives in the USA, Canada, Australia, Britain and mainland Europe. The text takes extracts from or synopses of papers presented by various writers on both sides of the argument. Reasons as to why the packaging of 'Harm Reduction' has fared better than 'Responsible Use' are explored as are some possible reasons why the present, Harm-Reduction-biased situation has come about. The paper concludes by suggesting possible ways forward for those advocating a prevention-focused approach – learning from history.

Keywords: harm reduction, drug prevention, strategy, policy, politics

1. Introduction

The assessment of so-called 'Harm Reduction' (and its older stable-mate, 'Responsible Use') is far from straightforward. It is at the centre of a longstanding conflict between those who advocate avoiding drug misuse/abuse and those who advocate excusing and/or facilitating it. Like all conflicts, the front line is pushed this way and that to the extent that both sides sometimes risk losing their bearings in the mist that surrounds the arguments.

In the conflict about harm reduction, what one might term 'The War about The War on Drugs', the exchanges are more complex than just swapping bullets – different salvoes contain philosophy or practicality or politics – or permutations thereof.

Former Director of the Office of Drug Control for the state of Michigan, USA, Robert Peterson, has suggested (1) that those pressing for legalisation – and using Harm Reduction as a convenient vehicle to get there – can be considered as one of three types of 'drug warrior':

- **Theory warriors**
  Those who argue in terms of economic, legal, political and health criteria, and often argue that the costs of illegality outweigh the benefits (though their selectivity of evidence is often challenged).
- **Rights warriors**
  Those who argue that the rights of the individual user outweigh those of other citizens, and their rights should not be intruded upon by government.
- **User warriors**
  Tapping into the motivation of self-interest, institutes and pressure groups – such as CATO, NORML, Drug Policy Alliance and the ACLU – have found it convenient to take up the users' cause (even though only one third of the total population of drug misusers actually supported legalisation when this was surveyed in I991).

Each side accuses the other of blindly 'cherry picking' data to suit themselves – overlooking the 'beam in their own eye'. Whilst there is a crucial difference between presenting data to illustrate a point and collecting only data which support one's own argument, forsaking all other, a charitable observation would be that we all do the former and try our best to not to do the latter.

Whilst the practicalities of structuring an 'overview paper' such as this demand that papers are grouped by country, it must be recognised that we live in the age of the Internet, and papers which describe experiences in one country soon whistle round the Net and are freely quoted in other countries. Similarly, whilst the date of a paper can be useful in explaining the historical progression, papers are used now, with often scant appreciation of when (and perhaps therefore, why) they were written.

The reader is recommended to read the full source articles from both schools of thought and to follow the trail to the many other papers which are indirectly indicated. It makes for an enlightening process. Clarity is not guaranteed, but a clearer understanding of why there is confusion may result.

This paper starts by looking at America, the birthplace in the l970s of the notion of 'Responsible Use', and then moves to Britain where 'Harm Reduction' in its present form was conceived in the l980s. As the new concept of Harm Reduction gathered pace and spread as a powerful 'meme', other countries such as Canada, Australia and mainland Europe became influenced.

The paper then explores reasons why 'Harm Reduction' as a meme evidently fared much better than 'Responsible Use'. In conclusion, suggestions are made as to a constructive way forward for protagonists of the prevention approach.

2. Scene-Setting

John Stuart Mill, considered by many to be the 'Father of Liberty' was born in London in 1806. A prodigiously intelligent man, the culmination of his career came in the celebrated essays he published between 1859 and 1865, in particular, his classic work 'On Liberty' (2). Many of those who wish to legalise or liberalise drugs employ philosophic arguments, quoting from this treatise to justify their position. But in doing so, they are making a fundamental strategic error.Their favourite quote is:

> Over himself, over his own mind and body, the individual is sovereign.

However, this is but one sentence in many which unequivocally qualify the statement and which emphasise that the individual has an obligation to society and that the rights of society outweigh those of the individual.On the Penguin Books edition of Mills' classic text 'On Liberty', the dust jacket gives a more apposite quote:

> ... the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others...

And therein lies the key phrase - harm to others.For the driving force in the thinking of a drug aficionado is that the individual is sovereign, and the only harm that is significant is harm to that individual – harm to others can be dismissed as of secondary importance to the user. Mill rejects this, taking direct issue with those who abuse substances and making it clear that, because of the harm caused to others by this individual action, such abuse should be repressed by law. This was particularly far-sighted, given that he wrote it in l859 when drug availability was low and its abuse was virtually non-existent in western nations.

In the context of morality, law and punishment, Mill says:

> Whenever, in short there is definite damage, or definite risk of damage, either to an individual or to the public, the case is taken out of the province of Liberty and placed in that of morality or law.

Punishment is seen to be right:

> ...for such actions as are prejudicial to the interests of others ...the individual is accountable [to society] and may be subjected either to social or legal punishment if society is of the opinion that the one or the other is requisite for its protection.

Misguided reliance on Mill is not the only example of drug liberalisers wishing to live in another time. One of the studies frequently cited as 'evidence' of the innocuous nature of cannabis is the 1896 Indian Hemp Commission report.A premier libertarian in Britain, Dr. Colin Brewer, who is a senior member of the International Anti-prohibition League, frequently eulogises Victorian times as an example of how we might have 'drug peace' instead of 'drug war'.

Those who are more familiar with Mill's work take a more objective view.Gertrude Himmelfarb, editor of 'On Liberty', makes the point that "Mill's principle of liberty is less applicable than before, given that our social reality today is infinitely more complicated." For those of us who are familiar with the drug culture, Himmelfarb might be accused of missing the point. The main purpose of ingesting drugs is precisely to depart from 'our social reality today'. It follows that anything which enables or excuses this departure, including 'cherry picking' useful phrases from 150 year-old documents, is fair sport.

3. America in the Seventies and later

Although the Office of Substance Abuse Prevention now rejects the term 'Responsible Use',back in the 1970s many people were less aware of the implications. A rash of deaths from huffing (solvent sniffing abuse) produced a proposal to give guidance on less risky methods of sniffing. This followed on recommendations drafted in the early 1970s for education on 'Responsible Use' of alcohol, including recommendations for drinking and driving (as distinct from 'not drinking and driving'). David Duncan, et al in 1994 in the *Journal of Drug Education* wrote a work entitled 'Harm Reduction – a New Paradigm for Drug Education'(3). Duncan characterised this as a milestone in drug policy history, the start of a paradigm shift, and he remarked that such shifts can often be huge but equally are often incremental and so creep up on society unawares.

Society may have been unawares, but some people certainly were not. One of those who read Duncan's treatise was Dr. Robert DuPont, a drug specialist who had earlier publicly recanted his support for permissive approaches to drugs – especially cannabis. DuPontsent a stiff letter to the editor of the *Journal* saying that Duncan's article was a regurgitation of 'the failed Responsible Use initiative of 20 years ago'

and commenting that whilst there might be a place for harm reduction in tertiary prevention - to mitigate the effects on hard core users - harm reduction was a disastrous idea in primary prevention in schools in that it would undercut the overriding goal of non-use.Typical of the propositions in the Duncan article was the notion that 'Harm Reduction is consistent with the human experience …' and 'Prevention often increases harm'. Particularly fascinating were his 'findings': that moderate users of drugs were healthier psychologically and enjoyed higher life satisfaction than either abusers or non-users. One may also be intrigued to learn that marijuana users enjoy better social skills, a broader range of interests and more concern for the feelings of others than non-users. DuPont reacted emphatically. He was in a strong position to make criticism - since up to that point he had been a member of the Journal's board of directors – but not any more; he resigned so that his name could 'no longer be associated with this dangerous message'.

Others have – perhaps wishfully – perceived a paradigm shift in drug policy. In a retrospective paper entitled 'A Kinder War' written in 1993, the high priest of drug liberalisation, American university professor Arnold Trebach (4) spoke of a change being in the air. There was, he perceived, greater understanding of:

> …[the] enduring reality of drug use, the absurdity of even attempting to create a drug-free society, and the need to treat drug users and abusers as basically decent human beings.

In I980 an organisation called the Drug Abuse Council spent $10 million, most of it from the Ford Foundation, to produce a 300 page report entitled *Facts About Drugs*. It included such gems as the statement that users are no threat to society, only abusers are;it supported the idea of giving heroin to heroin addicts and – not surprisingly – it proposed, as a Harm Reduction expedient, the decriminalisation of cannabis. It suggested that there should be a distinction between what it called 'recreational use' and 'misuse that harms society'. It went on to say that "by adhering to an unrealistic goal of total abstinence from the use of illicit drugs, **opportunities to encourage responsible drug using behaviour are missed"**.The Drug Abuse Council comforted itself in the supposed validity of its recommendations by predicting that '…heavy use would prevail for the next few years….' In fact, from the year of their report's publication and for the succeeding 11 years, America brought about an astonishing public health success which yielded an overall reduction in the use of all substances by all ages of 60%, removing 13 million drug-users from the slate.In this as in everything else the Drug Abuse Council had got it wrong.

Advice for students - The harm reduction approach

Many have attempted to summarise 'the harm reduction approach'. One example is Dr. Tom O'Connor of North Carolina Wesleyan College who developed a tutorial (5) for the Faculty of Education. It seems likely that the tutorial has been amended over the period since it was first produced; the version downloaded in 2007 includes references up to 2004.

O'Connor seems to regard drug misuse as inevitable, and he therefore sees harm reduction as a necessary reaction. However, he is not alone in focusing on the needs (or wants) of the drug user, whilst giving no more than passing acknowledgement to the rest of society.

He starts with a definition, seeing it as an attempt to:

> …minimize the dangers of drug use, teach people how to lessen or curtail the problems associated with taking drugs, and also try to diminish the levels of drug use. Harm reduction is a type of demand reduction, but not in the law enforcement sense of the term. Harm reduction is a macrosociological strategy which seeks to reform society, not the individual. Harm reduction is based on **compassionate pragmatism** instead of **moralistic paternalism**.

Sobriety, asserts O'Connor, simply isn't for everybody.

He gives mention to critics of the harm reduction approach (e.g. Dupont & Voth 1995) who said that harm reduction was:

> … just another way to rationalize legalization of drugs, it's giving up on the goal of a Drug Free America, and it sends the wrong message (encouraging people to experiment with drugs).

Ultimately, opines O'Connor, it depends upon one's values. (But he underpins his position by using selective and tendentious 'examples' of what this might mean). 'Cherry picking' season is open once more.

> If one gets upset over the fact that anyone, anywhere is able to alter their consciousness with drugs, then that person is likely to support use reduction, no matter what. Likewise, if someone believes that all drug users should suffer harm in some way, then they aren't likely to support harm reduction. If one doesn't care about what people do to alter their consciousness, but cares about the societal problems that such behavior contributes to, then one is likely to support harm reduction.

Critics of Harm Reduction are - quite speculatively – accredited with espousing a third option - Harm Elimination - which, O'Connor ventures, is a kind of 'drive them into treatment' or 'drive them out of

business' or 'drive them nuts' strategy, depending upon how you look at it. O'Connor considers that this kind of approach is effectively the content and intent of the official policy toward alcohol and tobacco.He cites advertising bans, high taxation, restrictions on smoking locations, designated driver programs and product liability lawsuits against manufacturers which have helped, more than anything, to keep the worst excesses of alcohol and tobacco abuse under control. How this can be defined as 'driving people nuts' is a secret only Dr O'Connor knows.

O'Connor then moves on to invoke Pareto's Law (originally generated to describe the land ownership situation in Italy, where 80% of the land was found to be owned by 20% of the population). It has been widely borrowed since, for example to highlight e.g. that '80% of the problems in an organization (or a society) are going to be caused by 20% of the people'.Applying this to illicit drug use, he suggests that 20% of the population is going to have a drug problem which causes harms to the other 80%, i.e., to society as a whole.

He then suggests that to reduce this problem's size, harm reduction could approach 'those who maybe want to stop' in the following ways:

- access to treatment would be easier if "controlled" use or "moderate" use were OK (Author's note: This is an assertion often seen in liberalising treatises, but with no explanation of something that sounds like a complete non-sequitur)
- the user might be convinced to switch to a drug less associated with harm, or to a method of ingestion (e.g., nasal instead of intravenous) that produces less harm
- the user might become motivated to consider abstinence as a long-term goal, once they start receiving and seeing positive reinforcement for the harm reduction.

Needle or syringe exchange, in O'Connor's opinion is

> ... a viable public health measure which does not encourage drug use, and in fact, seems to encourage the seeking of drug treatment.

The official government position, says O'Connor, has long been that giving free needles to addicts is like giving matches to a pyromaniac.As contrast, he cites the American Medical Association which has taken the position that physicians should be allowed to prescribe sterile syringes to persons addicted to injecting drug use (O'Connor's source for the AMA position was the DRC Network).

In commenting on workplace drug testing, O'Connor essays a little humour, courtesy of former Los Angeles Laker basketball star Kurt Rambis:

> I'm in favor of drug tests, as long as they're multiple choice.

But O'Connor sees little to smile at about workplace drug testing, which he sees as a stark contrast, even an opposite to Harm Reduction.

> Drug testing invades privacy, and is most likely an example of harm maximization.

After all, says O'Connor, throughout the ages, workers in various occupations have used drugs, and he quotesGahlinger (2004) who reports that despite the widely-held view that drugs have no right to be in the workplace, some 8% of American workers use drugs at work(which means 92% don't). The three major harms he sees resulting from such behaviour are: intoxication-related problems, employee reliability problems and other employee problems. The government's response has been to encourage drug testing – with a high level of acceptance in the workplace.

Presumably, in O'Connor's eyes, it is more acceptable to have 8% of your workforce using drugs of abuse than it is to 'invade their privacy' – and you may even, he suggests, 'maximise harm' by discouraging use. There may be some of the general public who are sanguine about 8% of their bus drivers, surgeons, pilots, teachers etc misusing drugs, but the odds are heavily against O'Connor getting a majority vote on this one.

Cannabis.com - discontent

If O'Connor showed some restrained discontent with 'invaders of privacy', the cannabis.com website was veritably seething with outrage at the US Government (Republican variety) and its policy of not funding needle exchange programmes abroad – which it was doing in line with its general, anti-use policy. In December 2004 (6) they vented their spleen about the US government indulging, as they saw it, in 'Bashing Harm Reduction Abroad':

> A Republican effort to stamp out needle-exchange programs abroad incensed editorial boards at The Washington Post and The New York Times last weekend. Conservatives are trying to stamp out harm reduction abroad is no small story, but both pages missed the fact that this is only the latest instalment in a long story of strings-attached giving that has been changing U.S. foreign aid policy for years. Foreign aid has become an American adventure in social engineering".

> The US Government had given large sums to the Global Fund to counteract HIV/AIDS already, and much more was expected, but suddenly the President announced a whole new programme; PEPFAR. It was smaller in its ambitions than the Global Fund, but it soon became clear that they had fundamentally different missions. PEPFAR enthusiastically endorsed the so-called **"ABC" approach – Abstinence, Be Faithful, and Condoms.**
>
> Representatives Mark Souder (R-Ind.) and Tom Davis (R-Va.) are now trying to keep American aid money out of the hands of any organization that promotes clean needle exchanges. Assistant Secretary of State Robert Charles has already succeeded in scaring the United Nations Office of Drugs and Crime (UNODC) out of mentioning harm reduction in its literature.

By all means hold views, cannabis.com seemed to be saying, but it is unfair to stop the money for projects of which you don't approve.

Soros and Company

Someone who can never be accused of stopping the money – at least not for his disciples – is George Soros. Best known in Britain for nearly destroying sterling when he gambled against it on Black Wednesday 1992, the multi-billionaire, in addition to his own fortune, has extensive influence on the Quantum Trust - worth in excess of $700 billion. Less reverent sources than this Journal have taken to spelling George's surname 'oro'.

Soros funds several campaigning organisations. The Open Society defines its mission as advancing democracy. It gives grants to many countries in many ways (and much of this philanthropy is not, of itself, a target for criticism). It is when the Open Society ventures into drug politics that reservations start to appear. Here are a couple of typical examples:

- At the micro end: Hungarian schools (Soros is Hungarian by birth) can receive grants only if they train pupils in Harm Reduction – working from a manual with pictorial coaching on how best to roll a cannabis joint. (The Harm Reduction value of this tuition is not explained).
- At the macro end: Soros poured money into the Democratic attempt to oust George Bush from the White House in 2004, and Soros proclaimed that he would "join a monastery if Bush won". The Democrats came up short, but there is no sign yet of Soros being measured for his monastic robes.

In between these extremes, Soros has applied himself to his own brand of social engineering, drawing heavily on his liking for the thinking of Karl Popper, whilst favouring such things as euthanasia - and of course legalisation of drugs. In his autobiography, *Soros on Soros*, he sets out his utopian vision for managing a drug-filled world – with himself as one of the managers, perchance.

Some time before Soros became prominent as the primary bank-roller for drug liberalisation, a significant initiative emerged in London, UK. Prominent libertarian Arnold Trebach had been teaching in the London School of Economics over several years and had established his prominence as a libertarian by publishing his book (7) under the snappy little title of *Why we are Losing the Great Drug War and Radical Proposals to Make America Safe Again*. A cluster of fellow libertarians flew to London for discussions with Arnold and out of this came the Drug Policy Foundation. Why had so many mountains travelled to Muhammad? Respect for the good professor? Perhaps. Avoidance of the US Freedom of Information Act? Unlikely – not thought to be applicable to non-government meetings. More likely is that Britain (at that time) was less alive than the USA to the issues surrounding drug policy, so there were fewer switched-on observers to blow the whistle.

The next initiative came from Soros when he embarked on founding and funding the Lindesmith Institute, with university academic Ethan Nadelmann at its helm. In 2000 the Drug Policy Foundation and the Lindesmith Institute merged to become the Drug Policy Alliance.

Soros, according to the AP (Associated Press) wire of 25 August 1997 (8) quoted in *Time* magazine, had by that time already poured over $90 million into - as he put it – "weakening drug laws". With today being almost ten years on, it is not unreasonable to estimate that by now the tally is at least double that figure. Soros described himself, modestly, as "a sort of deus ex machina"– which the Oxford English Dictionary translates as "An unexpected power saving a seemingly hopeless situation". In the same *Time* magazine article George's friend Byron Wein, a senior strategist at Morgan Stanley, said:

> You must understand it. He thinks he's been appointed by God to solve insoluble problems.

Dangerous liaisons

Whether the drug problem was insoluble or not, the concept of Harm Reduction became a 'meme' spreading vigorously in fertile ground – and not just in the private sector.

'Memes' were first described by Richard Dawkins in his book *The Selfish Gene*, as a "unit of culture, spread by imitation". Where a meme is vigorous in its structure, it will spread the more rapidly – a kind of 'viral thought'. What this means in lay terms is that if one creates a concept and dresses it in currently popular terms that trigger a positive response in the current culture, it is likely to 'catch a wave' in the mind of the group receiving it, and that concept will infect a whole area (or society) with lightning speed. Conversely, concepts that seem dull or lifeless (or have just plain come at a bad time) in the current culture are less likely to propagate. Survival of the fittest.

In the particular context of drug policy, International Task Force on Strategic Drug Policy and National Drug Prevention Alliance (NDPA) member Brian Heywood (based in the UK) developed an illustrative paper (9) in 2004 entitled 'Assaying Information in the World of Substance Misuse'. The paper also addresses the difference between 'good science, bad science and non-science' (or nonsense, if one prefers) and offers the Shermer Standard as a basis for assaying (paper available on NDPA website http://www.drugprevent.org.uk/).

The introduction of the meme 'Harm Reduction', the outlining of what it constituted and the timing of its launch – when workers in the field were (a) fatalistic about prevention, (b) ready to consider liberalisation and (c) looking at many aspects of their lives for something that would answer the new-found threat of HIV/AIDS - was near-perfect. And as memes go, it went.

A major challenge for prevention workers is to find the meme that will help correct the present imbalance in policy, but in the l980s and 90s drug scene workers were not alive to this, and prevention was washed aside by the great tsunami that was Harm Reduction.

Even major national bodies were not immune to the effect. In 1996 at Emory University in Atlanta, Georgia, the first Southeastern Harm Reduction Conference (10) was – appallingly – co-hosted by America's prestigiousCenters for Disease Control.Some of the very well known libertarian groups with which CDC rubbed shoulders included the Drug Policy Foundation, the Lindesmith Foundation and Eric Sterling's Criminal Justice Policy Foundation.A specimen statement from this bizarre grouping was:

> In allowing users access to the tools needed to become healthier, we recognise the competency of their efforts to protect themselves, their loved ones, and their communities.

The notion that one way of becoming healthier might be to stop or, indeed, never start being drug users would presumably have been lost on this gathering.

Bless this weed ...

The meme of Harm Reduction did not stop at the church door. Earlier examples of some religious groups becoming accepting of drug misuse include the Family Council of Drug Awareness (11) based in Los Angeles, which suggested that God wanted his people to ingest cannabis, and 'every other green plant' vide: 'He causeth the grass to grow for the cattle and **herb** for the service of man' (Psalm 104: 14 – 15). After all, the 'Tree of Life' was, according to the Family Council, no more or less than a giant cannabis plant (probably). Harm reduction was to the fore, of course; overindulgence was frowned upon and should be avoided to reduce harm. FCDA's overall conclusion would seem to be that Christians have a sacred duty to get cannabis inside themselves on a regular basis.

Social responsibility was another touchstone for liberalisers. Currently, ChristiansforCannabis.com pleads for "socially responsible decisions based on true justice concerning drug policy".

Social responsibility must of course extend to '**Responsible Use'** (sound familiar?) and should be rewarded, as was announced by NORML on 20 January 2007 with 'Life Insurance Coverage for Responsible Cannabis Smokers'. To qualify, one must 'reduce harm' by being, and presumably remaining, a 'moderate toker'. NORML's Executive Director Allen St.Pierre said, "Unlike tobacco or even alcohol, moderate use of cannabis – even when used long term – is not shown to have significant negative ramifications on health or mortality". So, as the cannabis users would say, 'Smoke 'em if you got 'em' – but don't forget to take out your NORML insurance.

Kingpins with Tarnished Crowns

In a seminal paper, Michael J Ard (12) took an interest in NORML and in its companions in drug misuse campaigning. His 1995 article in http://www.culturewars.com/ examined what he called 'The Kingpins of Drug Legalisation'. In just 5000 words, Ard gives such an illuminating, in-depth coverage of the issue that it should be required reading for any student of this field.

In his critique of the drug libertarian 'kingpins', their motives and their driving forces, he suggests that their unifying emotion is 'counter hegemony' – the brainchild of Italian communist theorist, Antonio Gramsci (also known as the 'Gramscite Endgame'). The Gramsci method is to dismantle the dominant culture, not

to frontally attack the whole establishment; collapse of that should (they hope) follow the death of the culture.

Whilst each of the primary arguments of liberalisers has been torpedoed many times, the kingpins do not confront opposition, they merely ignore it. The issues they avoid are, if anything, greater than those they espouse. Not least on the list of ignored issues are what Ard calls 'the externalities' – street violence, child abuse, workplace damages, education regressions, family breakdowns and general health costs. Liberalisers pay lip service to these factors, but their practised application of 'so-called harm reduction' falls well short of them, being almost totally user-focussed.

What drives the kingpins? The DEA feels the kingpins are 'some of the media', some quarters of academia, and some folks exasperated at progress thus far against the drug problem. They seek to 'normalise' drug taking, which many of them have experienced without big consequences. They hold in contempt Judeo-Christian norms of morality, and they believe in 'Statist solutions', i.e., those in which the state has substantive control over social and economic affairs.

Who are the kingpins? Ard identifies all the 'usual suspects' – George Soros, Norman Dennis, the ACLU, NORML, Cato Institute, Drug Prevention Alliance, Arnold Trebach, Ethan Nadelmann, Milton Friedman, William Buckley, Mathea Falco, Kurt Schmoke, George Schultz, David Geffen and so on. As George Orwell put it, "There are some mistakes only intellectuals can make".

Whilst the label of 'intellectual' may not fit comfortably around the necks of some of the above, they do seem to merge around one common theme – a pining for a return to the radicalism and hedonism of the 1960s (as they perceived that era). Giving this romanticism a cold douche of reality, Ard references Myron Magnet, who in his paper 'The Dream and the Nightmare: the Sixties Legacy to the Underclass' (13) fingers the 1960s for spawning many of the social problems we are still wrestling with today - including illegitimacy, homelessness, domestic violence, urban poverty – and, not least, drug abuse. We don't give up on trying to prevent these other social problems, despite our success rate being well short of 100% ;why then should we give up on drug prevention and resort solely to the 'conditional surrender' that is harm reduction?

Ard concludes by proposing that the best way to defend against this 'counter-hegemony' is to understand the extent of the movement, its potential to do harm, and its likely agenda – the Gramscite endgame, i.e., capture the culture and destroy it. Identifying and exposing the interconnected members and ridiculing their abstract arguments ought to manipulate the Kingpins into a more exposed position, with the risk of defeat for them. 'Know thine enemy', Ard counsels.

It also makes sense to 'Know thine allies' – and for prevention-focussed workers this would include the Family Research Council. In the council's magazine *Insight*, writer Rob Maginnis (14) produced a perceptive analysis of Harm Reduction; he noted the support from William F Buckley and the ACLU which he cited as "a leading promoter of Harm Reduction".(The ACLU has always been a major player in drug liberalisation, yet they are rarely seen or mentioned in this context. A possible explanation for this protected position may be the high percentage of ACLU members or supporters amongst the media).Maginnis gives an early example of Harm Reduction in Holland in the l970s when they were handing out needles in an attempt to limit the spread of hepatitis – this was before the AIDS epidemic had become apparent.

The ACLU is quoted as asserting that:

> Harm Reduction assumes drug-users civil rights and individual autonomy should be respected, it treats drug users as important participants in the process of gaining and maintaining control over their drug use, and makes no moral judgement based solely upon an individuals' use of drugs.

Harm production in needle exchanges

Many optimistic opinions are presented in unqualified support of such 'so-called harm reduction' initiatives as 'needle exchanges'(NEPs) and 'drug consumption rooms' (also known as 'shooting galleries'). In contrast with these upbeat reports, Dr Eric Voth (15) has examined actual progress reports for a wide number of NEPs, and in his analysis he finds significant grounds for concern.

Average needle requirements are estimated to be around 3,000 needles per year for a heroin addict and around 7,000 needles a year for a cocaine addict. Much is made by claims of 'safe' procedures including return of used needles to the agency. Study of 131 such agencies found that of nearly 20 million needles issued, more than 7 million needles were never seen again at the agency.

Claims are also made that needle sharing is less with NEP participants. The reality is somewhat less cheering: Chicago found 39% of NEP participants shared, compared to 38% of non-participants. Injection risks were found to involve 68% of NEP participants, compared to 66% of non-participants.

Vancouver's NEP has provoked more scrutiny than many. Since 1988 HIV prevalence amongst clients has risen from 2% to 23%. Some 27% of participants share needles. The overdose death rate is the highest in Canada.

Montreal's NEP found a 33% probability of HIV seroconversion for NEP participants, compared to only 13% for non-participants. Seattle found a higher risk of hepatitis B amongst NEP participants (1.81) than non-participants (1.3). Seattle made a salutary conclusion which all should memorise: 'Drug treatment programs that lead to cessation or reduction in drug injection may lower risks of both HCV and HBV in current drug injectors'.

In Puerto Rico, the NEP produced no significant change in injection habits. Only 9.4% moved on into full treatment. The success rate in return of needles never got better than 40.3%.

In Australia, there are 36 times more overdoses in the 'Drug Consumption Rooms' than in the rest of the Kings Cross area (where the 'rooms' are located).

In India, prevalence 'pre-NEP' (1996) was 1% for HIV, 8% for Hepatitis B and 17% for Hepatitis C. By February 2002 the figures had risen to 2%, 18% and 66%, respectively.

The overall findings included the conclusion that most NEPs are not 'exchanges' – they are needle 'hand-out' programs; there is no clear reduction in HIV or hepatitis; NEPs do nothing to change the underlying destructive behaviour; they have no advantage over outreach treatment or abstinence programs, and they are – in short – a misguided use of limited financial resources.

Birth of the Parent Movement

American drug policy and drug prevention experts Calvina Fay, Sue Rusche and Stephanie Haynes all define the Seventies as a period in which responsible use was the lubricant that allowed a whole generation to slide down the slope into drug abuse.Rusche cites use prevalence figures which are stark and inescapable. In 1962, less than two per cent of the American population had had any encounter with any illegal drug. But by 1979, 34 % of adolescents, 65 % of high-school seniors and 70% of young adults had tried drugs. It wasresponsible use policies which fuelled this escalation. Between 1973 and 1978, 11 American states decriminalised marijuana. Some 30,000 'head shops' sprang up to supply a curious population with drug paraphernalia. At the same time schools drug education materials taught children how to 'use drugs responsibly'.

At first, parents were unwitting collaborators in this unfortunate process in that they were blind to what was going on. But when their eyes were opened, they reacted strongly and assertively. Parent groups, such as Sue Rusche's National Families in Action, PRIDE - the Parents Resource Institute for Drug Education, and the National Federation of Parents for Drug-Free Youth, sprang up all over America until at one time there were more than 8,000 such groups.

All three experts are still in action today; Sue Rusche runs NFIA – National Families In Action, whilst Stephanie Haynes serves on the board of DPNA - the Drug Prevention Network of the Americas - which helps develop prevention-oriented strategies across Latin America as well as North America. Calvina Fay has now completed more than 25 years of drug policy expertise and is now serving as Executive Director of Drug Free America Foundation, arguably the most powerful prevention body in the USA. The Institute on Global Drug Policy (IGDP) and the International Task Force on Strategic Drug Policy (ITFSDP) have, with her guidance, become key players on the international stage. Their scientific critiques of Harm Reduction – for example their Resolution on 'so-called Harm Reduction' (16) launched at the Brussels conference in 2005 - proved to be a pivotal contribution to the global dialogue.

The parent movement hammered the professionals who had swallowed the Harm Reduction notion, and the parents were extremely successful in producing a paradigm shift of their own, back to prevention. The parent movement defined 'drugs' as any and all illegal drugs, plus any legal drugs (such as alcohol and tobacco) used illegally, for example, by those who were under age. Simple strategy goals were defined:

- Prevent use before it starts.
- Encourage and assist users to stop.
- Help those who can't stop to find treatment so that they can.

Parent campaigns closed the 'head shops' and put a stop to any decriminalisation. Several states have more recently succumbed to expensive PR campaigns and have swallowed the notion of using raw cannabis as 'snake oil' medicine, which just goes to show that you **can** fool the people some of the time, if your advertising budget is big enough. But in terms of non-medical use, no state has decriminalised marijuana since 1978, and several have actually re-criminalised it. Under the sterling work of the Parent movement in the Seventies and later, the "responsible use" message went into the garbage can to be replaced by the "no use" message.

Would that it were that straightforward today! How was it that the American parent and family movement, consisting almost entirely of volunteers, managed to intercept and prevent this collapse – and yet the second onslaught, under the banner of 'Harm Reduction' proved almost unstoppable? One explanation is offered in Part 3 of this paper in the section entitled 'How did we get into this mess?'

Parts 2 and 3 will appear in future issues of this journal and will include the following sections:

4. Britain in the Eighties and since (Britannia waives the rules)

5. Oh, Canada!

6. Advance Australia Fair (and God Defend New Zealand)

7. Europe

8. Taking stock – where are we now?

9. How did we get into this mess?

10. What should be our rational response?

11. And in conclusion …

Mr. Stoker is Director of the National Drug Prevention Alliance (NDPA), which he helped form. He has completed more than 20 years in this field and has helped three other charities to form, all running well. His first 7 years in the field were as a drugs/alcohol counsellor in a London drug agency; he also created and delivered a wide range of trainings and was a Government 'Drug Education Advisor' to some 100 primary and secondary schools. In 1987 he completed a one-month study tour throughout America, under the auspices of the US State Department. He has delivered workshops at more than 10 PRIDE conferences, and in 2004 he received the PRIDE International Award for services to prevention. He has completed technology transfer trainings in Poland, Germany, Portugal and Bulgaria. In 2001 he was awarded a First Prize in the Stockholm Challenge contest for websites with a health-promotion value. Mr. Stoker is often to be seen or heard on TV, radio or in national/regional newspapers and has authored many articles and papers. For 30 years prior to this career he was a professional Civil Engineer, running projects up to £5,000 million at present-day values.

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