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. Issue 4 continues to address the subject on an international basis with special attention to the history of the concept in the last of a three part series. The editors thank Peter Stoker for his skillful coordination of this multi-issue examination of such a challenging topic.

The Journal of Global Drug Policy and Practice, a joint effort of the Institute on Global Drug Policy and the International Scientific and Medical Forum on Drug Abuse is an international, open access, peer-reviewed, online journal with the goal of bridging the information gap on drug policy issues between the medical/scientific community, policymakers and the concerned lay public.

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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Harm Reduction – the Idea and the Ideology
Professor Dr A. Hamid Ghodse, Member and Past President, INCB.

Abstract:

The role of harm reduction within drug treatment services, against a background of emerging HIV infection is considered, and augmented by detail description of component services – needle exchange, substitute prescribing, and outreach services. The author concludes by commenting on the positives and negatives of harm reduction philosophy and practice, the basic aim of limiting harm amongst users being subjugated in some quarters as a ‘front’ for liberalisation of drug policies. The author argues for a more positive approach by health care professionals, rather than a sense of fatalism that can be induced by the very term ‘harm reduction’.

Keywords: Harm reduction, needle exchange, substitute prescribing, outreach services.

Author’s note: This article is drawn from the author’s textbook “Drugs and Addictive Behaviour; a guide to Treatment” - 3rd Edition, 2002, Cambridge University Press. The cooperation of the publisher, Cambridge University Press, in allowing this article to appear in this Journal, is much appreciated by the Institute on Global Drug Policy and the International Scientific and Medical Forum on Drug Abuse.

Harm reduction

Although the over-riding aim of treatment is to bring about permanent change so that those who abuse drugs and/or are dependent upon them can cope without, it is acknowledged that this may not be achieved for all those who seek help and that, even when successful, it may take a considerable period of time. A consensus therefore emerged that a more pragmatic response was indicated with greater emphasis on the need to prevent or at least to reduce the harm associated with drug abuse and dependence. This approach gained impetus because of the particular threat posed to injecting drug users and the wider community by HIV infection, and harm reduction (or harm minimisation) became the main focus of attention of many agencies. In the midst of new enthusiasms it is worth noting that harm reduction is not a new response. For years, some professionals have advocated that opiate addicts should be prescribed injectable heroin, which they prefer, rather than theoretically safer oral methadone, to prevent them resorting to black market sources with all the attendant hazards. They pointed out that the harmful consequences of drug abuse are rarely due to the effect of the drug itself, but are more often due to the method of its administration and the presence of adulterants. However, since the late 1980s, harm reduction has been formally identified as an approach to treatment and encompasses a range of different goals including stopping (or reducing) injecting, sharing injection equipment, illicit drug use, prescribed drug use and offending behaviour. Other lifestyle goals may also be covered by the umbrella term of harm reduction, including, a healthy lifestyle, getting a job, avoiding criminal activity, safe sex etc.

Needle exchange schemes

Needle exchange schemes are probably the most visible components of harm reduction programmes and, ever since it became apparent that intravenous drug users are a high-risk group for contracting HIV and, latterly hepatitis C, there has been a body of opinion advocating the provision of sterile injection equipment to addicts who inject drugs. It is argued that this will be a genuine public-health measure and good preventive medicine because, theoretically, if sufficient syringes were provided, there would be no need to share injection equipment at all, and the transmission of the HIV virus between addicts and from them to the non-drug-using population would be reduced.

The simplicity of this approach is appealing, but it has certain unbolt disadvantages. There is a very real risk, for example, that the easy availability of sterile syringes and needles may make the transition to injecting easier and more acceptable and might encourage more young drug abusers to start injecting and to do so sooner; equally there may be less incentive for others to give up injecting. Such a policy could therefore lead to an increased number of injectors within the population and an increased number of severely dependent individuals. Furthermore, it would not completely eliminate the sharing of injection equipment, which is associated with socialising and communal feeling in the drug sub-culture and not just with the shortage of needles, so there are bound to be some individuals who would carry on sharing regardless of the hazards. In addition, there will always be occasions when the drug user forgets to carry his/her own syringe or has attempted to have a fix when he/she did not intend to. [1]
Although the provision of sterile injection equipment is less simple than it first appears, syringe-exchange schemes have proliferated rapidly. Research into their effectiveness is difficult because of the long-time lag between infection with HIV and seroconversion (presence of detectable antibody) and because HIV is not exclusively transmitted by sharing contaminated injection equipment. However, it appears that using syringe equipment can contribute to the adoption of safer drug-use behaviour amongst injecting drug users and will therefore reduce the incidence of HIV among addicts. [2, 3] However, it should be noted that even without providing free syringes, fear of HIV infection may bring about beneficial changes in techniques of drug administration, with a reduction in all complications due to injection. [4]

Perhaps the best way forward is to judge each case on its merits, rather than to adopt a stereotyped response. Where it is clear that a stable addict does inject regularly and will continue to do so, and if one can be confident that the injection equipment will not be shared, it may be sensible to provide syringes and needles. On the other hand, it is foolish to pretend that the chaotic polydrug abuser, who is frequently intoxicated and for whom sharing injection equipment is an integral part of drug-taking behaviour, is a safe person to entrust with a supply of syringes and needles. On a more positive note, the provision of a "user-friendly" service, offering equipment that addicts want and need, is one way of attracting them into contact with health service professionals and thence, perhaps into treatment. Such programmes can offer holistic help and advice - for example on sexual risk behaviour - that also contribute to harm reduction in its widest sense.

Some countries have extended the concept of providing sterile injection equipment still further and have set up "shooting galleries" - specific facilities where drug addicts can self-inject with illicit drugs. The motivation for such developments may include a wish to remove addicts from the street and other places where self-injection offends many members of the public; concerns about the public health risks of needles and syringes that are disposed of in public places; and also a desire to minimise risk in the case of an overdose. Whatever the motivation, the provision of such "shooting galleries" contravenes International Conventions and, by providing a formal outlet for illicit drug trafficking, seems contrary to the concept of prevention in its more general context.

The provision of syringes and needles to addicts has been discussed in some detail because it is of considerable topical interest. It is not, however, the only aspect of harm reduction. Another similarly controversial question has risen about whether young solvent abusers, at risk of fatal accidents while intoxicated, should be instructed in safer techniques of solvent sniffing - such as not putting a plastic bag right over the head, not sniffing alone, not sniffing in dangerous places (e.g., roof tops, canal banks). Preventive education of this type, although potentially life saving, at best conveys a very ambivalent message about drug taking and at worst seems to encourage the practice.

These examples emphasise the unpalatable fact that the laudable aim of harm reduction may sometimes conflict with the much more important aim of preventing and reducing the underlying problems of drug abuse and dependence. It is worth noting that the harmful consequences of drug abuse were largely ignored by the general population until one of these consequences, AIDS, became a serious threat to themselves as well. The vociferous support for harm reduction since then suggests that it is motivated more in unthinking self-interest than in a genuine concern for the well-being of drug abusers. For the latter group, the best approach is undoubtedly to encourage them vigorously to become abstinent from drugs. This is achieved more easily if it is attempted early in a drug-taking career, and ideally it should be attempted before self-injection becomes established and causes severe physical and psychological dependence. Easy access to treatment facilities is therefore a very important factor in harm reduction. Only if treatment and persuasion fail should measures that may reinforce dependence be considered.

**Substitute prescribing**

The use of methadone for the stabilisation, detoxification or maintenance of opiate-dependent individuals has been described in some detail earlier in the chapter. One of the reasons for adopting this type of substitute prescribing is to attract more drug users to services, so that treatment, in its broader sense, can be initiated as soon as possible. It may have very positive benefits in terms of harm reduction, in that the patient may cease to use illicit drugs, may stop injecting, or at least use a sterile injection technique. However, while substitute prescribing may be a helpful tool in helping the drug-dependent individual to move towards abstinence or towards intermediate goals, there is a very real risk that this progress may be unacceptably slow and that the patient may be maintained indefinitely in an opiate-dependent state, without any clear decision having been taken that this is the right course of action for this particular
patient. It follows that if the potential benefits of substitute prescribing are to be fully realised, it is essential that treatment interventions should have a clearly defined aim, and that there are well-established routes into detoxification.

Outreach services

Despite general acknowledgement of the importance of easy access to treatment and the consequent growth in drug services in recent years, the majority of drug users are not in touch with these services. Indeed, there may be a period of several years between starting illicit drug use and making contact with a helping agency. Reducing this time lag early in a drug-taking career, when intervention is most likely to be successful, is essential for effective prevention. Because waiting for drug users to attend established services is clearly an inadequate response, outreach services have been developed that are proactive in making contact with drug users to offer them short-term help and to refer them on to appropriate helping agencies.

If outreach services are to be effective, some type of needs assessment is essential. For example, the reasons why existing services are not being used will have to be established and, if necessary, these services will be reviewed and modified so that they are acceptable and attractive to those who need them. In particular, outreach can aid the development of effective liaison and referral mechanisms between a wide range of agencies, including voluntary services and statutory health and social services.

However, outreach workers will never be able to achieve contact with all drug users, nor will they be able to achieve onward referral to an appropriate agency for all those with whom they do come into contact. Therefore, an important aspect of their work is to achieve change at community level and to achieve harm reduction by a cascading educational process. Thus, when working with a certain number of individuals, they also try to ensure that their message reaches other drug users with whom their client comes into contact. Because outreach developed as an attempt to reduce the spread of HIV and AIDS, much of the work is focused in this area, with an emphasis on advice on safer sexual practices and safer injecting practices and on practical measures such as the provision of condoms and sterile injection equipment. Effective harm reduction, however, encompasses far more than this, and outreach workers should not lose opportunities to discourage regular drug use among experimental users, to discourage injection by potential injectors, to encourage established injectors to switch to safer, oral administration of drugs and to encourage drug injectors and their sexual partners to be immunised against hepatitis.

Conclusion

It appears that, for some people, harm reduction has become an ideology and an end in its own right, rather than one component of a comprehensive and holistic approach to the treatment of substance dependence. While the concept has been embraced with enthusiasm in some countries, it remains controversial in others and this is perhaps because of some of the practices now subsumed under this heading. For example those who advocate the legalisation of drugs may do so, under a “harm reduction” umbrella. Furthermore, as indicated above, many harm reduction practices were introduced only in response to the threat of HIV/AIDS. In other words, they were public health measures, intended for the good of society as a whole, rather than focusing on what was best for the individual patient. The harm reduction measure “shooting galleries” can similarly be categorised as a method of social control and one which reduces the social visibility and inconvenience of drug injectors in public places. Focussing on the good of the individual patient permits greater clarity about what is genuinely harm reducing for them. Specifically, the over-riding aim should always be to reduce demand for drugs and to encourage abstinence. While some harm reduction practices may be expedient in particular sociocultural settings, anything that appears to encourage drug consumption should be treated with scepticism. On the other hand, harm reduction, in the sense of tertiary prevention, is a long-established and important component of medical treatment.

Finally, it is important to emphasise that the very term “harm reduction” risks conveying the gloomy and inaccurate message that substance dependence is not susceptible to effective treatment and that all that is possible is a reduction in the harm that it causes. Substance dependent individuals deserve a more positive and energetic response from health care professionals.

Biography

Professor Hamid Ghodse has been President of the International Narcotics Control Board since 2004. He is Professor of Psychiatry and International Drug Policy at the St. George’s Medical School, University of London, and the Director of the International Centre for Drug Policy at the United Nations Office in Vienna.

References


When Harm minimization is not harm minimization – Australia as a Case Study
Stuart Reece MBBS (Hons), FRCS (Ed.), FRCS (Glas.), MD, FRACGP

Abstract:
This paper is based on evidence given by the author to the Family and Human Services (FHS) Committee, House of Representatives, Parliament of Australia, in 2007. The Committee undertook an enquiry into the impact of illicit drugs in Australia and particularly the impact of harm minimization on Australian families. It released its final report on 13th August 2007 [1, Table 2.3, ] in which 31 recommendations were made. In general the committee were highly critical of various harm minimization practices in today's Australia, on which some $500 million is spent annually. The evidence given by this author was extensive and detailed, and constituted an assessment of current harm reduction practices in Australia, comparing them where applicable to other countries, and concluding with detailed suggestions as to how a more health-promoting strategy and range of practices could be initiated.

Keywords: Heroin drought, harm minimization, prevention, policy, addiction, epidemics, devastation.

1. Introduction
In the early months of 2007, the Family and Human Services Committee (chaired by Mrs. Bronwyn Bishop) in the House of Representatives, Parliament of Australia, began public hearings of an enquiry into the impact of illicit drugs in Australia, taking evidence from a wide range of witnesses with diverse attitudes to drug strategy. The findings of the FHS Committee were published on 13th August 2007. Amongst others, their recommendations included that the nation's stringent policing policies continue in force for their salutary and uniquely proven preventative role (including inducing the only heroin drought in the world); that basic and clinical research on the fundamental health impairments involved in drug addiction be dramatically up-scaled and used to inform and better educate a largely complicit treatment industry; and that the language and practices of harm minimization were deliberately confusing and duplicitous in that they were overtly and unashamedly intertwined with the rhetoric of the drug decriminalization movement both intra- and inter- nationally. In particular in this latter respect, FHS strongly enjoined that the word "harms" be dropped from this discussion and terms such as "damage", "devastation" and "destruction" be used to replace them [1, Recommendation 16 Page xxv] [1].

This author was an invited witness, and at the request of the Committee he augmented his initial evidence by supplementary submissions of evidence – this paper combines the gist of these presentations and concludes by setting out a range of initiatives which together are aimed at strengthening a health-promoting (as distinct from health-compromising) strategic approach.

Australia presently spends at least $500 million annually on harm minimization techniques - needles, methadone and addiction as well as ATODS (Alcohol, Tobacco, and Other Drug Services) personnel salaries. There is a clear need for urgent review, given that there are now 197,000 Hepatitis C patients - a disease which is clearly out of control in this group [2], and new HIV infections have risen 31% from 2000-2006 [3] with recent infections having risen from 97 to 284 or 182.5% [2,4] – most probably due to community fatigue with the harm minimization paradigm. Put simply, the community are bored with the message. Moreover, the advent of anti-viral therapies has rendered many harm minimisation practices less important to many consumers.

There is much that can be done to repair the damage and neglect which has occurred under what has proved to be an overly simplistic harm minimization paradigm.

It is frequently said by the leaders of the harm minimization movement that they take direct credit for the low HIV infection rate in Australia. Whilst it is true that HIV is low and that harm minimization provision is high, to assert that the one flows from the other is overly gratuitous, and in particular, assigns causality where it has not been formally demonstrated. What is beyond doubt is that the propagation of harm minimization has fostered a trivialized view of illicit drug taking to the point where it is widely considered an inconsequential activity by far too many of Australia's young people. This outlook has been promoted on the world stage, and it is no coincidence that the leading advocates for harm minimization are also the loudest voices for drug liberalization. As their confidence has grown, so have they become more open as to their long-term goals; harm minimization, sold to the community as (ostensibly) an HIV protection strategy, is now identified in their own words as nothing more than a veneer for the open drug society:
“In many countries it is time to move from the first phase of harm reduction – focusing on reducing the adverse consequences – to a second phase which concentrates on reforming an ineffective and harm generating system of global drug prohibition.” [5]

HIV is now rising. Hepatitis C is at a persistently very high level, and rapid infections of new users is evident. Australian society is blighted with one of the highest levels of drug epidemics amongst industrialized nations. In this setting, harm minimization is not only a seriously inadequate paradigm, but by fostering and sustaining false triviality, and promoting a (discredited) libertarian agenda, it self-evidently does a great deal more harm than good to the community as a whole.

2. Harm Minimization commentary – a summary

This summary of the evidence follows the same three main headings as stipulated by the FHS Committee.

2.1 The financial, social and personal cost to families who have a member(s) using illicit drugs, including the impact of drug induced psychoses or other mental disorders.

2.2 The impact of harm minimization programs on families.

2.3 Ways to strengthen families who are coping with a member(s) using illicit drugs.

These are considered in more detailed sub-sections (as follows).

2.1.1 ABS Deaths and ‘Years of Potential Life Lost’ (YPLL) data

Detailed ABS (Australian Bureau of Statistics) death statistics have been obtained for the period 1997-2005 (see Tables 1A to 1E). (Note that the data for 2005 will shortly be in circulation). On such a list drugs are responsible for 10,987 (1.9%) of a total of 528,721 deaths, in 8th place behind other well known causes such as stroke, heart attack, suicide and lung, bowel and breast cancers.

It is interesting to note that HIV/AIDS claimed only 1396 lives in this time, despite the enormous publicity and funding devoted to it (Table 1A). Similarly, despite the rhetoric of the ATODS industry which has been heard for years now, alcohol was directly responsible for only 2182 deaths, or 19.5% of those ascribed to drugs. Drugs, however, are responsible for 408,051 (4.9%) of 8,297,522 years of potential life lost (YPLLs) during that same period which is fifth most common and follows only suicide, car crash, heart attack and lung cancer (Table 1B).

A very interesting index is the number of years of potential life lost per death, which may be estimated by dividing the YPLLs by the number of deaths in that category. YPLL data was not produced for 2005. Methadone top scored at 46.3 years of life lost per death, followed by car wrecks at 41.9 years and drugs at 41.2 years (Table 1C). This shows that drug related deaths score first and third in the official ABS collated statistics for 1997-2004, and indeed, that methadone related deaths scored above all other major causes! This alone is reason for a re-think of the Methadone Maintenance Program.

When judged by individual cause of death, drugs are responsible for 41.2 years of life lost per death, second only behind motor vehicle accidents (41.9 years), which goes a long way to explaining the unusual community distress and tragedy associated with overdose deaths. Of the drugs responsible, opiates are the most common, accounting for 6901 (55.8%) deaths and 238,745 (58.5%) YPLLs.

The years of life lost due to methadone are worth considering. Table 1A ascribes only 78 deaths to methadone during this period. This figure should be clarified in that this relates only to those deaths in
which methadone was the sole drug involved. The full figure is 957 as shown in Table 1D and includes deaths in which methadone was found in combination with other agents. An approximate coefficient for methadone for translating numbers of deaths into YPLLs can be determined by averaging the coefficients for the years for which it is known. This figure is 45.3. When this is multiplied by the total number of methadone deaths including poly-drug deaths (namely 957), the total number of years of life lost in which methadone was involved may be estimated at about 39,419 (as indicated in Table 1E) - almost 10% of the drug related YPLLs lost in Australia. This is a profoundly shocking figure; it contrasts starkly with the figure for deaths from illicit drugs: 1.9%.

The massively subsidized methadone industry has never given a genuine account for this. Nor indeed are methadone prescribers, for the most part, held to rigorous accountability, in the same way as, say, naltrexone prescribers have been subjected to close scrutiny in every state of Australia. The standard defence of the methadone industry is that they have reduced the rate of opiate related death by four fold, as has been determined by numerous studies. Notwithstanding such a position, the significant mortality which has been defined after methadone warrants much deeper scrutiny.

In this context it is interesting to note that prominent harm minimisation advocate Dr Alex Wodak, when asked by the Committee to explain the high figure of methadone related deaths, declined to answer - an omission not unnoticed by them. This author addressed the subject by stating that methadone related deaths indicated life expectancy reduced by 46 years; i.e., death at around 30. The corresponding shortening for illicit drugs was around 41 years.

**DISEASE BURDEN AND EXTENT OF THE PROBLEM**

**TABLE 1A.: Deaths by Cause, to 2005**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Heart Attack</td>
<td>53697</td>
<td>9.40%</td>
</tr>
<tr>
<td>2</td>
<td>Lung Cancer</td>
<td>47442</td>
<td>8.00%</td>
</tr>
<tr>
<td>3</td>
<td>Stroke</td>
<td>33069</td>
<td>5.70%</td>
</tr>
<tr>
<td>4</td>
<td>Colon Cancer</td>
<td>27440</td>
<td>4.70%</td>
</tr>
<tr>
<td>5</td>
<td>Suicide</td>
<td>18224</td>
<td>3.10%</td>
</tr>
<tr>
<td>6</td>
<td>Breast Cancer</td>
<td>17771</td>
<td>3.00%</td>
</tr>
<tr>
<td>7</td>
<td>Car Crash</td>
<td>16044</td>
<td>2.70%</td>
</tr>
<tr>
<td>8</td>
<td>Drugs</td>
<td>11839</td>
<td>1.90%</td>
</tr>
<tr>
<td>9</td>
<td>Alcohol</td>
<td>2182</td>
<td>0.40%</td>
</tr>
<tr>
<td>10</td>
<td>HIV</td>
<td>1396</td>
<td>0.20%</td>
</tr>
<tr>
<td>11</td>
<td>Methadone</td>
<td>957</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>All Causes</td>
<td>528721</td>
<td></td>
</tr>
</tbody>
</table>

**TABLE 1B.: YPLL-75 by Cause to 2004**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Suicide</td>
<td>630737</td>
<td>7.60%</td>
</tr>
<tr>
<td>2</td>
<td>Car Crash</td>
<td>608904</td>
<td>7.30%</td>
</tr>
<tr>
<td>3</td>
<td>Heart Attack</td>
<td>509769</td>
<td>6.10%</td>
</tr>
<tr>
<td>4</td>
<td>Lung Cancer</td>
<td>503475</td>
<td>6.10%</td>
</tr>
<tr>
<td>5</td>
<td>Drugs</td>
<td>408051</td>
<td>4.90%</td>
</tr>
<tr>
<td>6</td>
<td>Colon Cancer</td>
<td>322263</td>
<td>3.90%</td>
</tr>
<tr>
<td>7</td>
<td>Breast Cancer</td>
<td>296617</td>
<td>3.60%</td>
</tr>
<tr>
<td>8</td>
<td>Stroke</td>
<td>293355</td>
<td>3.50%</td>
</tr>
<tr>
<td>9</td>
<td>Alcohol</td>
<td>45886</td>
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<tr>
<td>10</td>
<td>HIV</td>
<td>45170</td>
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</tr>
<tr>
<td>11</td>
<td>Methadone</td>
<td>3613</td>
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<td></td>
<td>All Causes</td>
<td>8297522</td>
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</table>

**TABLE 1C.: Mean YPLL by Cause to 2004**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause</th>
<th>No.</th>
<th>Relative Rate</th>
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<tbody>
<tr>
<td>1</td>
<td>Methadone</td>
<td>46</td>
<td>2.9</td>
</tr>
<tr>
<td>2</td>
<td>Car Crash</td>
<td>41.9</td>
<td>2.7</td>
</tr>
<tr>
<td>3</td>
<td>Drugs</td>
<td>41.2</td>
<td>2.6</td>
</tr>
<tr>
<td>4</td>
<td>Suicide</td>
<td>38.3</td>
<td>2.4</td>
</tr>
<tr>
<td>5</td>
<td>HIV</td>
<td>34.4</td>
<td>2.2</td>
</tr>
<tr>
<td>6</td>
<td>Alcohol</td>
<td>23.7</td>
<td>1.5</td>
</tr>
<tr>
<td>7</td>
<td>Breast Cancer</td>
<td>18.8</td>
<td>1.2</td>
</tr>
<tr>
<td>8</td>
<td>Colon Cancer</td>
<td>13</td>
<td>0.8</td>
</tr>
<tr>
<td>9</td>
<td>Lung Cancer</td>
<td>11.9</td>
<td>0.8</td>
</tr>
</tbody>
</table>

These tables show that of 11 common causes of death, Drugs was ranked 8th. When judged by Years of Potential Life Lost (YPLL), Drugs was ranked 5th. When judged by the YPLL per Death, Drugs ranked 3rd behind methadone. Note that these calculations assume a uniform 408051/9912 = 41.17 YPLLs per drug death. Note also that methadone deaths count only those cases where this was the only drug involved. Of the different drugs, by far the most serious was opiates, which ranked 1st both by numbers of deaths, and by YPLLs.

Opiate abuse forms the focus of the present study.
<table>
<thead>
<tr>
<th>Rank</th>
<th>Drug</th>
<th>Type - '05</th>
<th>%</th>
<th>Rank</th>
<th>Drug</th>
<th>Type to 2004</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All Opiates</td>
<td>6901</td>
<td>55.80%</td>
<td>1</td>
<td>All Opiates</td>
<td>238745</td>
<td>58.50%</td>
</tr>
<tr>
<td>2</td>
<td>Benzo's</td>
<td>2804</td>
<td>22.70%</td>
<td>2</td>
<td>Benzo's</td>
<td>105169</td>
<td>25.80%</td>
</tr>
<tr>
<td>3</td>
<td>Alcohol</td>
<td>1867</td>
<td>15.10%</td>
<td>3</td>
<td>Antidepressants</td>
<td>67478</td>
<td>16.50%</td>
</tr>
<tr>
<td>4</td>
<td>Antidepressants</td>
<td>1839</td>
<td>14.90%</td>
<td>4</td>
<td>Heroin</td>
<td>61220</td>
<td>15.00%</td>
</tr>
<tr>
<td>5</td>
<td>Heroin</td>
<td>1618</td>
<td>13.10%</td>
<td>5</td>
<td>Alcohol</td>
<td>40029</td>
<td>9.80%</td>
</tr>
<tr>
<td>6</td>
<td>Methadone</td>
<td>957</td>
<td>7.70%</td>
<td>6</td>
<td>Methadone</td>
<td>39418</td>
<td>8.60%</td>
</tr>
<tr>
<td>7</td>
<td>Opium</td>
<td>870</td>
<td>7.00%</td>
<td>7</td>
<td>ATS</td>
<td>26184</td>
<td>6.40%</td>
</tr>
<tr>
<td>8</td>
<td>Amphetamines</td>
<td>715</td>
<td>5.80%</td>
<td>8</td>
<td>Paracetamol</td>
<td>25525</td>
<td>6.30%</td>
</tr>
<tr>
<td>9</td>
<td>Paracetamol</td>
<td>672</td>
<td>5.40%</td>
<td>9</td>
<td>Other Narcotics</td>
<td>12022</td>
<td>2.90%</td>
</tr>
<tr>
<td>10</td>
<td>Other Narcotics</td>
<td>315</td>
<td>2.50%</td>
<td>10</td>
<td>Cannabis</td>
<td>9469</td>
<td>2.30%</td>
</tr>
<tr>
<td>11</td>
<td>Cannabis</td>
<td>250</td>
<td>2.00%</td>
<td>11</td>
<td>Cocaine</td>
<td>6917</td>
<td>1.70%</td>
</tr>
<tr>
<td>12</td>
<td>Cocaine</td>
<td>185</td>
<td>1.50%</td>
<td>All Drug Deaths</td>
<td>10987</td>
<td>All Drug YPLL's</td>
<td>408051</td>
</tr>
</tbody>
</table>

In the final FHS report, YPLLs were replaced by “DALYs” or disability-adjusted years of life lost. On page 44 the report cites a table as follows [1].

### 2.1.2 Disease
Drug related diseases are many and varied. The impact of drugs on disease is not only greater than usually supposed, but also more severe. Several analyses now have demonstrated consistent findings that the addicted require disproportionately far more medical and psychological health services than controls of the same age. Whilst Hepatitis B&C and HIV/AIDS are well known, so too is a list of disorders [6]. Whilst the list below is actually taken from a paper on older people’s diseases, virtually all pathologies have also been described in addiction – for example:
Hyperplasia/Neoplasia:
Adrenal hyperplasia, Angiosarcoma, Harderian gland adenoma, Endometrial hyperplasia, Lung adenoma, Lymphoma, Mammary gland adenocarcinoma, Mast cell tumor, Ovarian cystadenoma, Paraovarian cyst, Pituitary adenoma, Sarcoma, Thyroid follicular cell hyperplasia, Uterine leiomyoma/leiomyosarcoma.

Leukocytic infiltrates:
Kidney, Liver, Lung, Mesentery/omentum, Perineurium, Salivary gland.

Genito urinary system:
Hydronephrosis, Ovarian/testicular atrophy, Seminal vesicle dilation, Renal tubular.

Bone:
Decreased cancellous bone, Degenerative joint disease, Molar teeth periodontitis, Proliferations in the head/spine.

Neurological:
Hydrocephalus, Neuronal lipofuscinosis, Radiculopathy, White matter gliosis, and

Other:
Amyloidosis, Fatty change of the liver, Focal myocardial degeneration, Hepatocyte polyploidization, and Thymic involution.

This information is derived from research into common pathological features in mice by Bronson and Lipman, 1991 [7] and Cao et al, 2003 [8]. It is also important to appreciate that while many of these same disorders occur in non-addicts, they are much more severe in addicts. This author has had three patients whose eyeballs were completely replaced by fungus (Candidal endophthalmitis), many with heart valve infections requiring open heart surgery (which is of course very rare in patients in the 20-40 years age group), and one who had so many brain abscesses that his autopsy reported that “his brain had been largely replaced by abscesses, he was fitting severely, and we could not control this; that is why he died.”

It has also been largely overlooked that addiction itself suppresses the immune system, thereby making patients more susceptible to infectious conditions such as those mentioned above. This has not been factored into the harm minimization thinking.

The gateway activity of cannabis has now been proven by several scientific analyses. This has also been studiously overlooked by ardent harm minimization lobbies.

It has also been established, largely by scans done at the National Institute for Mental Health (NIMH) and the National Institute for Neurological Disorders and Stroke (NINDS), that all addictive drugs impede brain growth and development. This was one of the main subjects of a recent supplement in the Medical Journal of Australia[9, 10 and 11]. Furthermore, important stages of brain development occur in the teenage and early years up to about 26 years of age. Hence it can be confidently predicted that such addictions (or even supposedly “recreational” drug use) – from which habitual use typically stems – must impede brain growth and development, potentially in a permanent manner.

Indeed, health science leaders at Johns Hopkins Medical School in Baltimore accept that addictive agents are causally related to the onset of mental illness, an obvious connection - albeit still allegedly (according to Australian “experts”) in dispute in Australia.

2.1.3 Blood borne virus including HIV and Hepatitis C transmission
It is well known that intravenous drug use forms one of the major routes of spread of the HIV virus, and that therefore IVDU form a major target group for HIV preventative behaviours [12, 13].

It is also agreed that Australia leads the world in harm minimization in many respects – notwithstanding the very high rate of Hepatitis C and B amongst its drug users. One could well observe that the relatively trivial way in which drug use has been portrayed in the public health harm minimization paradigm has actually been a major cause of this calamity.

Currently, many Hepatitis C patients are becoming increasingly unstable and are beginning to decompensate in important ways including cirrhosis. This suggests that Australia’s encounter with Hepatitis C and the management of its 197,000 cases [2] is only just beginning.

Australia’s rate of new HIV infections has been rising since its low point in 1994. It is now double this level, and as reports come in from all over the country of new infections, this rate of increase seems inevitably set to rise quickly in the coming years.

Furthermore, many recent studies demonstrate that normal levels of activity in the brain and its circuitry are required to all low proper pruning and maturation of the dendritic and synaptic circuits in the brain which form the structural underpinning of memory and emotional states. As they are well known to
interfere with brain activation levels, their general disruption of memory and mood maintenance functions is entirely within their pharmacological and toxicological profile.

2.1.4 Drug-Related Crime
It is well established by many surveys that 70% of all property crime in Australia is drug related.

2.1.5 Family disruption – family of origin and family formation
This is widespread and typically severe. It applies both to the family of origin from which drug users come and any subsequent families that such patients try to establish.

2.1.6 Intergenerational transmission of drug taking behaviour
Several patients treated by this author were introduced to drugs at 1, 2 or 6 years of age by addicted and dealing families as strategies to control normal child behaviour.

2.1.7 Intergenerational transmission of drug related morbidity including cancer and fetal malformations
Evidence has been published of more than 1,000% elevation of the risk of leukaemia in the off-spring of cannabis smoking mothers [14]. This is related to extensive chromosomal damage which has also been identified in such patients.

2.1.8 Aggressive behaviours
This is now being reported increasingly from many sites in the community such as hospital admissions departments, doctors' surgeries, shopping malls, etc. Its presence is underscored by large posters in hospital admissions areas declaring

"Violence will not be tolerated in this place. Victims will be supported in the referral of the matter to the police."

(Princess Alexandra Hospital Accident and Emergency Casualty Department)

Reports on this problem have recently appeared from both sides of the country in the Medical Journal of Australia[15, 16].

2.1.9 Prostitution related behaviours, crimes and risks of violence
Prostitution and the sex industry generally are well acknowledged to be major routes by which drug habits are funded. Most of the addicted sex workers met in this author's clinic agree that they would not work if their addiction could be successfully addressed. Since established prostitution is notoriously difficult to dislodge, an obvious course of action is to target effective treatments at such populations to free them from the necessity of such high gain employment.

2.1.10 Failure of achievement of major life goals
The proponents of the harm minimization paradigm seem to think that it is a relatively trivial concern if teenagers and people in their twenties and thirties "get wasted" thereby "wasting a few years." Since these are the key formative years of their lives when normal life tasks such as gaining a training and/or qualification and forming a stable life partnership occur, then clearly such activities will be seriously jeopardised.

2.1.11 Long term welfare dependence
It would seem obvious that if patients have a malformed brain, have a mental condition, have unstable personal relationships or families of origin which cannot cope with their behaviours, have a poor employment record and no training behind them, then they are likely to be long term social security dependents, as are their children. To this of course must be added the effects of nutritional deprivation from such families, the effects of drug exposure to their offspring in utero, and even the poisoning effects of the addictive drugs on the egg and sperm prior to fertilization.

Indeed the Barker hypothesis [17, 18] suggests that the changes of ageing, which seem to be accelerated in drug addicts, begin in utero and prior to conception when egg or sperm are damaged. It is therefore highly likely that ageing and degenerative changes begin in such offspring prior even to fertilization. Clearly, this area merits further study.

2.1.12 Maintenance of addiction, even across a major heroin drought
The 'harm minimization paradigm' is obviously related to long term drug addiction; its flagship is the 'methadone maintenance treatment' (MMT) program. The advent of the Australian heroin drought is well known - what is less well known is that this was the only nation where drought occurred. Of course, there was no evidence that the number of national methadone program registrants (about 39,000) declined during this time. The MMT has the ability, to a large extent, to negate the effect of such a drought.

This effect could presumably be extrapolated to other drugs such as cannabis and amphetamine with similar results.

2.1.13 Long term mental conditions
In addition to the impacts - mentioned above - of addiction degrading the normal processes of brain development, illicit drugs impair vitally important normal patterns of brain cell regeneration which are
required for normal processes of memory and emotional stability. Furthermore, they cause cell death. This particularly applies to the stimulants and to combinations of stimulants and cannabis which have a superadditive effect. Opiates added to this cocktail further exacerbate this cell death effect.

2.1.14 Short term violent mental states including those difficult to contain
There are myriad accounts in the community of erratic, violent, aggressive and dangerous behaviour by patients either under the influence of addictive drugs or in an acute withdrawal phase. There have been numerous encounters, many of them dangerous and personally threatening. Doctors have been killed in these encounters - such as the well publicized case of Dr. Khulod Maarouf-Hassan in Melbourne.

2.1.15 Lack of quality mental health services
It is axiomatic in clinical practice that if patients are having acute difficulty with drug induced states they receive at best summary, perfunctory and terse treatment in hospital casualty departments. The difficulties of families with drug-using parents or children are magnified enormously by this lack of specialist mental health support. The expenditure by the Prime Minister of $3 billion on mental health from April 2006 under the "Beyond Blue" program is perhaps beginning to impact this appalling situation [17].

2.1.16 Lack of quality medical protocols to treat stimulant offenders
It is a desperately sad commentary on the appalling lack of quality control within Australian medicine that radical calls for chronic stimulant prescription to stimulant abusers have emerged. This has emanated from some of the highest authorities of addiction medicine in the land, and yet this comes at a time when leading figures in the USA have concluded that such agents are definitely neurotoxic – also that they are directly responsible for the epidemic of mental illness and criminality, including reduced public safety. Communities pay the price for this misinformed ideology, which runs directly contrary to expert medical opinion in addiction research neuroscience.

2.1.17 Lack of any basic sciences research and expertise within Australia on addictive drugs
It is a national disgrace that there are no basic researchers in the addiction sciences in this country. International observation by this author coincides with the abiding impression of many leading scientists in other countries, which is that the area of addiction toxicology is being systematically avoided, apparently for ideological reasons. Many new biological systems are being discovered, both in the brain and in other body systems, and yet these are not being investigated.

This author has estimated that $50 million over three years would go a long way to addressing what appears to be a deliberate oversight. (See Section 2.3.1 below)

Eminent titles of the world's leading research journals include Nature, Science, Nature Neuroscience, Neuron, Cell, Journal of Neuroscience, and the New England Journal of Medicine. It is clear from the presentations to the FHS Committee that not only do the Harm Minimization lobby not publish in these journals, they appear to never read them - such eminent journals were never referenced in any of their published works. This demonstrates the weakness of the harm minimization evidentiary position, notwithstanding their frequently repeated mantra about "evidence based medical practice".

There is a similar absence of modern scientific data of any sort from Dr Wodak's testimony, which appears to be much more reliant on quotes as to the size of the illicit drug trade and policy reports aimed at the decriminalization objective. This must be a concern for any investigating committee focused on the welfare of the community.

2.1.18 Drug dealing in schools
It is a matter of recent history that there is substantial drug dealing occurring in schools, an appalling situation which cries out to be corrected. However, this is unlikely to occur while the dominant paradigm is one of acquiescence plus harm minimization. It is apparent that some of the suggested 'corrections' - such as drug testing, undercover operations in schools, and drug sniffing dogs - find themselves at odds with the tolerant atmosphere surrounding the harm reduction philosophy.

2.1.19 Methadone increases addiction
It is no secret that most patients continue to use heroin even on methadone programs. Usual figures quoted are a reduction from 26 times monthly to 4-5 times. However, if the total duration of the addictive habit is extended by five times, then any gain in terms of supposed reduction in injection frequency is clearly lost. This is also reflective of the lack of methadone programs holding addicts accountable for behavior and reinforcing expectations with drug screening and evaluation of arrest reports. Again, it is the atmosphere of tolerance that drives a significant part of the problem. It is also the concept of methadone as a necessary endpoint rather than a transition point that adds to the problem.

Methadone typically intensifies addiction by leaving opiate receptors permanently coated with opiates. Methadone patients frequently experience secondary side effects, especially anxiety, so that many series report 50-70% incidence rates of also putting these patients on strong benzodiazepines, particularly alprazolam - a strong drug frequently associated with fatal overdose. The exacerbation of addiction by such programs clearly needs to be factored in to any rational evaluation of them.

In contrast, naltrexone reverses all such effects non-specifically and has uniform anti-addiction effects extending beyond its purely opiate related effects.
2.2 The impact of harm minimisation programs on families
These headings in the FHS evidence are covered by statements in Section 2.1.

2.3 Ways to strengthen families who are coping with a member(s) using illicit drugs.

2.3.1 Appropriate Australian Research in Addiction in the basic sciences
The lack of "hard biological sciences" research in the toxicology of addiction and the careful avoidance of the truth has allowed the present absurd "fairyland" like situation to develop in Australia.

The decrepit and disheveled state of many drug affected persons is well known. It is known that addictive drugs impair cell growth and division. They also accelerate cell death processes. These changes, combined with the DNA toxicity (which has been previously demonstrated for cannabis and tobacco) are the cellular and molecular underpinnings of ageing at the cellular level. These findings suggest that the poor appearance of addicted persons, together with many well known features of their pathology - including poor teeth, high rate of infections, high rate of tumours and very high death rate - actually reflect an accelerated pattern of ageing at the level of the whole organism.

If these changes could be better understood, it is very possible that significant gains could be made in other related health areas. If addiction accelerates ageing, then it stands to reason that addiction-blocking agents may well slow this change down. Clearly, this needs to be quantified by further research. Similarly, if addiction accelerates the development of hardening of the arteries and of cancer, then understanding such molecular pathways may well teach us valuable lessons about the causation of these diseases, including the yielding of important new molecular targets for major drug therapies.

More research is clearly needed while the toxicology of addiction is being neglected globally. The nation which is best resourced to study these issues will lead the world in these areas. Such resourcing will need to set aside additional funding, over and above the core research budget, to allow for developments in other scientific areas which may be of relevance.

Topics such as ageing of the immune, dental, hair, psychiatric, stem cell and cervical cancer systems will be relevant. New evidence suggests that many of the changes described in brain ageing [20] are also found in addiction [21]. In turn, this suggests important ways in which the changes of addiction can be studied in the brain from an ageing perspective. Modern techniques such as PET and SPECT brain imaging are documented by such as Dr. Daniel Amen from California [22] and can be studied in 3-D colour in rotational views online [23]. Further, the Melbourne group of Professor John Currie at St. Vincent's hospital has indicated their readiness to be involved in a naltrexone implant study, with a particular focus on the toxicology and brain ageing effects.

2.3.2 Scientifically correct anti-drug education of our children and our community
Of course, for the truth to have any impact it must be substantially and sustainedly resourced. Good educational programs in addiction studies exist in several nations and include web based computer interactive learning, cartoon-like adventures of the chemical factories inside patients' brains and the inclusion of addiction in all other school subjects which have been used successfully in the USA, Sweden and New Zealand. This is in addition to fact-packed government web sites. Australia has much to do in this respect.

2.3.3 Naltrexone implant demonstration studies in each capital city
The longest lasting naltrexone implant in the world has been developed by Dr. George O'Neil in Perth. It is the best because it lasts the longest, somewhere around 5-6 months. A trial of the safety and efficacy of this device is presently being conducted in Perth.

It usually takes in the vicinity of $1 billion to bring a drug to market, which clearly is beyond the resources of either the Perth clinic or even the West Australian Government. This is having the effect of creating long delays. The outcomes of this trial are already obvious, brilliant, and in addiction medicine, as radically superb as the HPV vaccine has proven in infectious disease. This situation might be constructively addressed by government through equipping, up-skilling and evaluating those programs which, in its six year history, have already shown promise.

Another potential return on investment lies in statistically powerful evidence by the Perth clinic that naltrexone implants also extinguish the use of all addictive drugs.

Such programs need to be supported by pre- and post- treatment facilities such as addiction medical wards where patients are cared for at the appropriate stage of treatment. Families also need support. The implants, of course, need to be supplied and funded as do the drugs which are usually administered in combination with it, in a manner analogous to the way in which methadone treatment is presently underwritten by state and federal governments. The treatment should also attract an appropriate Medicare item number. Providers will require special training and accreditation to prevent unbridled pecuniary interests from discrediting the therapy as is well known to have occurred with the oral formulation of naltrexone. It must also be accompanied by post-treatment counselling and housing where this is appropriate. The fiasco where patients emerge from detox and have nowhere to go but their dealer's house must be addressed, either by government or community agencies.
Professor Gary Hulse of the University of Western Australia presented evidence to the FHS Committee on his trial of naltrexone implants, which suggested very encouraging results. I think this is more than obvious to all the clinicians who have used naltrexone implants.

2.3.4 Rimonabant Demonstration programs in selected clinics
Rimonabant (Sanofi-Synthelabo “Accompia”) is a new CB1 cannabinoid blocker which has shown great promise in the treatment of virtually every chemical addiction including tobacco, alcohol, amphetamine, cocaine and opiate addition, and also for food addiction and hypertension. It is presently available in eight nations in the world and is likely to be entering the Australian market in 2008.

Clearly, there is a need for its assessment in the Australian context, particularly in parallel with naltrexone implants for refractory cases where the problematic secondary addiction is either not opiates or is poly-drug related in addiction to opiates.

2.3.5 Proper protocols for stimulant abuse treatments
The irrational situation where stimulants are recommended for stimulant abuse needs to be formally redressed, if not by experts inside Australia, then by offshore expertise. It is indefensible that the Australian public continue to be held captive by ideological preferences of an ideologically-driven lobby.

2.3.6 Improved mental health facilities for acutely and chronically intoxicated patients
There is a very obvious need for the upgrading of mental health facilities to cope with unpleasant emergencies of intoxicated and threatening patients. Such programs need to be accompanied by appropriate public education.

3. Implementation systems
There are a number of basic principles which relate to this improved approach: Drug Free Australia talk about “harm prevention” assertively when people will listen. Further, several (including this writer) agree with Bronwen’s Bishop’s committee findings that we would do very well to leave the word “harm” in the dirt, in favour of other words such as “devastation”, “destruction” and “danger”.

The whole of the community has an interest in getting its people - especially the young - off drugs; therefore, the whole of the community needs to work together to get people off drugs. Given the young age of many users, taking people off drugs needs to be a high priority of our health care systems. The power of science should be mobilized with excellent standards of practice; the power of medicine should be mobilized likewise. Open access is an important design priority.

Guidelines follow from these principles:

Each major (capital) city affected by illicit drugs requires at least one access point for such patients. For practical purposes this implies an entry point, be it a clinic, a hospital, or some combination of the two; adequately resourced in terms of staff, ancillary drugs and equipment and resources. Implants and treatment must be free of charge at the time of treatment, and treatment must be timely - preferably on the day that request is made.

To achieve this new system, certain issues must be addressed with particular reference to naltrexone implants.

Scientific Agenda Setting
Appropriately-focused units must be selected to establish the nation’s research agenda in this new approach. The group in Brisbane with its affiliates in Perth and Melbourne would appear to be the most appropriate for this purpose.

3.1 Medical Standards Credentialling and Maintenance
It is well known that one of the world leaders in naltrexone medicine is in Perth and their unit, together with its links to Brisbane, would appear to be best one in which to look for leadership in this area. Melbourne also has an excellent record in this area. Other units in the addiction field are likely to be more obstructive than constructive.

3.2 Establishment and Support of Addiction Treatment Access Points
As is mentioned above, first access points would need to be established in each affected capital city. Preferably, private clinics and hospital based units would be asked to work together in this regard, as this has been found to be most successful, based on the Perth model.

3.3 Naltrexone Implant Supply
In time it is assumed that the naltrexone implants will be made readily available to all patients who need them. This process needs to be fast tracked, which appears NOT to be occurring at the present time. In view of its importance to the management of this epidemic, it would appear that some external supervision needs to be implemented to prevent unnecessary barriers and interminable delays being introduced into a system which becomes unnecessarily complicated and obtuse. Perhaps a provisional listing arrangement needs to be reached so that tests and trials etc. can be continued while the few remaining outstanding
regulatory issues are resolved. It is completely contradictory that at a time when there are strident cries for
the legalization of illicit drugs, despite their well documented disastrous implications for health, and all
kinds of potions and concoctions are available to almost anyone (even pregnant women) as "alternative
health remedies", that a agent such as this is forced to suffer impossible and unrealistic delays while
administrative hoops are completed. The most recent estimate from Perth is that a further three years will
be required, given the latest requirements by our federal regulatory authority the Therapeutic Goods
Administration (TGA). What is happening in practice is that the more time passes and development and
testing occurs on this device, the longer (rather than the shorter) the implants become from registration.

Far from important medical issues being identified in the testing process, it is trivial matters such as the
need to increase the number of rooms in the "Good Manufacturing Practice" (GMP) accredited facility
(which had just been specially built) from three rooms to nine! Clearly, such a non-transparent process
requires increased public accountability urgently, as every indication is that the harm minimizationists/legalizers are having a party via their tightly controlled bureaucracies at the expense of the
global management of these pressing addiction epidemics. It is curious that the same people who
stridently argue that science be ignored and testing is not required for the illicit drugs presently scouring
the globe are the very same voices who invent problems and barriers and bogey men to make the
implants increasingly unavailable. One must wonder if they would do so well in other nations which are
more realistic about the shortcomings and overt follies of harm minimization dogmas.

3.4 Time from TGA Registration of Naltrexone Implants to PBS listing
As noted, it is important that this be minimized.

3.5 Associated Pharmaceutical Supply
Various other drugs are routinely used in association with the prescribing of naltrexone, particularly early
on when patients are commencing treatment. Clearly, these need to be made available to authorized
clinics for prescribed and appropriate use.

3.6 Hospital Back-up and Support
The Perth experience demonstrates unequivocally that the most successful model for ensuring that all
patients presenting receive same day treatment is to work with the close relationship of a nearby tertiary
referral centre. One obvious way in which to proceed, which has been used to great effect in the USA, is
to offer direct federal dollar benefits to all casualty departments dealing appropriately with such cases.
Indeed, the Medical Journal of Australia recently featured reports from casualty departments in both
Sydney and Perth of the enormous resource inputs required by such disorderly addicted patients
presenting to inner city casualty departments[15, 16].

3.7 Ancillary Staff Provision
Clearly, detox units would need to be staffed appropriately, in a manner analogous to that in which
methadone units are staffed at present. That said, it would be obvious that the basic thrust and ethos of
units aimed at detoxification would be quite different from those aimed simply at long term addiction
maintenance.

3.8 Medicare Speed Limit – The 80/20 Rule
One feature of the present Medicare arrangement is the "medical speed limit" it imposes on doctors,
known as the 80/20 rule. This rule has been arrived at by government and the profession in consultation
and states that a doctor may not see more than 80 patients on 20 days a year, for to do so constitutes
prima facie evidence of over-servicing and warrants immediate referral to the PSR (Professional Services
Review) system. Whilst this might be appropriate for general medical consultations, it will be hardly
practicable in circumstances such as alluded to herein. Indeed, its rigid application might well potentially
make quite impracticable the suggestions referred to above.

Clearly, practitioners working in point of access facilities have every likelihood of being overwhelmed by
patient numbers, at least in the initial phase of the treatment roll out. For this system to be workable, it
would require either that Medicare's 80/20 rule have an exemption clause written into it (i.e. "excepting
drug addiction referral clinics") or that the scheme operate independently of Medicare entirely so that its
activity does not raise flags on the Medicare computerized statistical warning system.

4. Conclusions
There is now ample evidence that the so-called harm reduction paradigm has been propagated across
Australia with devastating impact on social order, motor vehicle accident rates and child protection issues,
along with 197,000 cases of Hepatitis C infection and several sexually transmissible diseases – notably
chlamydia (up from 2,500 in 1982 to over 50,000 in 2006) [2].

The underlying ethic of harm minimization can be characterized as a 'promise from society' that risky and
hazardous behaviour can be regularly indulged in by people whose minds have been impaired by the
chemicals they have ingested, safe in the knowledge that little or no fall out will ensue and that
Government will ameliorate the consequences of such folly. This seems counterintuitive to the point of a
complete breakdown of reality testing. If the harm minimization paradigm portrays a correct construct of
our real world experience, then the realities of life in the environment it portrays should support the image
it projects. Harm minimization fails this reality test, and dismally so. It seems all but certain that its main
architect suffers from an attitudinal problem [24, 25], whilst the field as a whole suffers from terminal conflation with drug legalization objectives which are overtly, even proudly stated [5].

The FHS report is correct to cite the vagaries of the language employed by harm minimization as a major cause for concern. The power of language in an argument is too often underrated, with fatal consequences for the opponent. As an example of harm minimization word power, one piece of dialectical ingenuity stated that the aims of harm minimization could be achieved in an environment where drug use itself rose [26].

Living in Australia, one is powerfully aware of two dominant trends, namely that the feeling amongst the general public that ‘something is rotten in the state(s) of Australia’ and that this may have something to do with the ceaseless flood of pro-harm minimization rhetoric, itself relying on the (relatively) lower level of HIV prevalence as a foundation [13, 27]. This is very difficult for the lay observer to rationalize when many surveys over decades have shown that Australia’s drug use indices for most classes of drugs are worse than in most other developed countries.

So, what might other rationales tell us?

Firstly, it is important to note the existence of countries with low HIV rates such as Sweden and falling HIV rates such as Uganda, where personal responsibility is the basis of social policy rather than individual irresponsibility - as is advocated by the proponents of harm minimization. This is a salutary reminder that [A] by no means necessarily follows from [B]. Whilst [A] and [B] may co-occur, one of the most basic tenets of any scientific analysis - including drug strategy - is that correlation neither implies nor proves causation.

Secondly, even the leading advocates of harm minimization themselves, have, in quoting a UN report of less triumphant times, conceded that it is not possible to proof-test their theories because of the vagaries and complexity of real world situations and the impossibility of controlling for extraneous confounding influences [24].

This, of course, prompts a very important question, namely “What other factors which obtain in Australia might reasonably be said to contribute to its low HIV infection rate?” Several may be listed:

- There was a free high quality health system for testing;
- There was a free high quality health system for treatment;
- The HIV epidemic was largely localized in Sydney amongst men who have sex with men, enabling testing and treatment to be targeted and expedited;
- Highly active, anti-viral triple therapy was instituted relatively early in the HIV epidemic and administered free to patients;
- The rise of the epidemic lagged a little behind those overseas so that there was some time to implement lessons from abroad;
- It was possible to achieve early protection of the blood supply, dating to even before the availability of an HIV test, but using Hepatitis B as a surrogate marker;
- These factors implied that the epidemic began “lower and slower” than in other places and that the gap to the widespread availability of triple therapy was much less. In this sense, combined with a degree of behaviour modification in the 1990’s in high risk target groups, the exposure of the at-risk population was minimized;
- The social context within which the epidemic occurred was actively managed by the target population, and a cultural shift was induced in law and media in favour of the homosexual lobby. This may well have had an impact on the behaviour of the risk group, which was and still is the primary vector [3] in terms of establishing community goodwill and a perceived degree of social cohesion of an amount sufficient to induce a degree of cultural change in relation to high risk drug and sexual practices.

All these factors imply that the nexus between harm minimization and Australia’s low HIV r
The “Local” Matters: A Brief History of the Tension Between Federal Drug Laws and State and Local Policy
Kevin A. Sabel, Ph.D.

“All politics is local.”
– Thomas P. (Tip) O’Neill

Abstract:
In the U.S., drug policy is traditionally viewed as a national issue, since federal laws apply to all state and local jurisdictions. The historical review of drug policy presented in this article, however, shows that there remains a constant tension between drug policymaking by federal and state/local actors. Accompanying this dynamic is an ever-changing emphasis on either use reduction policies (i.e. those focused on reducing drug prevalence) or harm reduction policies (i.e. those focused on reducing the potential harms of both drug use and drug policies). Analysts need to be sensitive to these twin dynamics (federal versus non-federal loci of drug policy control and use reduction versus harm reduction philosophies) which result in considerable drug policy variation throughout the United States. A more accurate scope of drug policy analysis would focus on the juridical relationship between national, state and local policies and practices. History shows that these are not new phenomena in drug control, even if they are often overlooked in present-day analyses.

Keywords: Drug Policy, Politics, Federal/Local, Prohibition, Harm Reduction.

Introduction
The traditional scope of drug policy analysis has been to focus mainly on national drug laws and practices. Comparative analysis of policy tends to be based on different policies employed in different countries (e.g. U.S. drug policy versus Holland’s drug policy). Such a broad view ignores both an important historical and current reality in drug control: Most drug policy decisions are made at the local level, based on the unique needs of different localities. As Reuter and Haaga (1990) [1] argue, “a focus on national strategy...is misplaced because it ignores the local nature of drug problems” (p. 36). In order to move toward more local analyses, this article summarizes the history of drug policy in the United States, arguing that cycles of federal and non-federal action have always characterized the nature of American drug policy just as cycles of acceptance (in the form of a harm reduction policy framework) and non-acceptance (in the form of a use reduction policy framework) have been a hallmark of American attitudes toward drugs. It is necessary to understand the potential for local variations on drug control in order to accurately analyze drug policies. As a first step toward that goal, this paper highlights the historical tension between federal and non-federal policies. The final section discusses some of the implications raised by this tension.

Drugs in the New Republic
Until Congress passed the 1906 Pure Food and Drug Act, drugs like heroin and cocaine were unregulated. At the turn of the century, heroin was a primary ingredient in some tonics and elixirs, and doctors began to notice their patients consuming unusually large amounts of cough syrup containing the drug (Durlacher, 2000) [2]. Americans first widely used cocaine in a few very popular drinks, including Vin Mariani, a combination of red wine and coca leaf extracts (March, 1997) [3]. Cocaine products were labeled as an antidote for the melancholy and a healthy stimulant for athletes. “Baseball players have found by practical experience that a steady course of coca taken both before and after any trial of strength or endurance will impart energy to every movement,” read one advertisement for coca-based wine (Madge, 2001, p. 63) [4]. Soon, a popular drink called Coca-Cola™ emerged with cocaine as a principal ingredient. By 1885, cocaine became available in 15 different forms, including powder. Parke, Davis & Company described cocaine as:
A drug which, through its stimulant properties, could take the place of food, make the coward brave, the silent eloquent, free the victims of alcohol and opium habits from their bondage, and, as an anesthetic, render the sufferer insensitive to pain. (Jonnes, 1999, p. 20) [5]

Powder cocaine was the United States Hay Fever Association’s “official remedy,” and scientific experts worldwide touted the drug as non-addictive and benign (Hammond, 1887) [6]. Indeed, by not at least trying cocaine, people were supposedly losing out on potential health benefits such as increased arterial action and increased mental ability. Cocaine could not keep this sanguine reputation for long, however. Reports of cocaine addiction and criminal acts fueled by the drug signaled a shift in public attitudes, and cocaine
quickly lost its status as a healthy stimulant (Mattison, 1887) [7]. Drug policy historians often refer to this time as “America’s first drug epidemic,” since cocaine use became more widespread and in turn its harms more evident (e.g. Jonnes, 1999 [5]; Musto, 1971/1999) [8].

State and Local Intervention

The growing worry that cocaine and other drugs like heroin were dangerous manifested itself first in state and local regulation. Because the federal system offers states and localities considerable discretion on how to create and implement a wide array of social policies, state and local differences in drug policy were commonplace at the turn of the 20th century. For example, lawmakers in Pennsylvania reacted to a statewide rise in morphine use (the state was home for a few leading morphine manufacturers) by outlawing the drug in 1860. Illinois passed a law against cocaine in 1897. Ohio had done so a decade before. The Atlanta City Council passed an ordinance in 1901 allowing cocaine use only with a prescription. Other states like New York soon followed. Anti-morphine and heroin laws also came to various states: e.g., Texas (Musto, 1971/1999) [6].

Local drug control mechanisms, however, did not always restrict drug use. Many jurisdictions flirted with experimental treatment procedures like controlled drug distribution to addicts. Musto calls this time a period of state and local statute revision and treatment experimentation (Musto, 1971/1999) [8]. For example, lawmakers in New York State set up facilities for drug maintenance for addicts. A Jacksonville, Florida, doctor established free narcotic prescriptions in 1912 for drug addicts (a practice which would later prompt federal intervention). Tennessee lawmakers decided in 1913 to register drug addicts and allow them to legally obtain opiate prescriptions. At the same time, Massachusetts lawmakers prohibited drug use by prescription. No national attempt was made to regulate these drugs. Until 1914, many agreed that such far-reaching federal intervention would be deemed unconstitutional.

The Federal Government’s Involvement in Drug Control

Controlling drugs was a difficult task for local and state governments to shoulder on their own. Cocaine use, for one, was not receding in the early part of the 20th century, and the image of the cocaine addict – paranoid, obnoxious, and apt to commit crimes – in particular frightened many Americans and prompted growing concern about addiction (e.g. Mattison, 1887 [7]; Wright, 1909 [9]). Groups urged the federal government to take legislative action. A delegate from the American Medical Association sent to Washington in 1913 to discuss the possibility of a national anti-drug law expressed his frustration at the ineffectiveness and incongruence of different state and local policies.

There are few if any subjects regarding which legislation is in a more chaotic condition than the laws designed to minimize the drug-habit evil... in many of the states anti-narcotic laws are so comprehensive that practically every retail druggist would be subject to fine or imprisonment were an attempt made to enforce the legislation ostensibly in force, while in other states the laws are so burdened with exceptions and provisos as practically to nullify every effort to control the traffic in narcotic drugs. (Wilbert & Motter, 1912, p.14) [10]

Throughout his presidency, Taft expressed his disdain for cocaine and opium and urged Congress to pass federal anti-drug legislation (Keller & Lemberg, 2003) [11]. The President wrote a special message to Congress about the “pressing necessity” of anti-drug legislation twice in 1911 and again in 1912 (Special message of the President, 1911 [12]; President's message on foreign policy, 1911 [13]; President’s annual Message, 1912) [14].

Because the Constitution essentially grants wide powers to the states, however, the Congress could not simply pass federal anti-drug legislation and force its implementation. But with pressure mounting, the government devised a law to regulate health professionals (e.g. pharmacists) by requiring them to register for tax stamps and keep strict record-keeping of the drugs they prescribed. This was codified in the Harrison Act of 1914, the first significant piece of anti-drug legislation on the national level. Still, claiming an exemption for the indigent or incurable, local drug maintenance clinics flourished in the late 1910s and early 1920s. In 1919, however, the Supreme Court decided two crucial cases that left the federal government with expansive powers to control drugs under the Harrison Act by confirming the constitutionality of the Act’s tax on physicians and the way in which drugs were dispensed “in the course of professional practice only” and via “prescriptions” (U.S. v. Doremus, 1919) [15] and (Webb et al. v. U.S., 1919) [16]. The Supreme Court, in these two close decisions, strengthened the Harrison Act’s enforcement power by mandating that even those registered or the best organized physicians could not simply maintain addicts on their drug of choice. The Harrison Act, then, was not only legitimized, it was toughened, and a broad national anti-drug policy based firmly in the goals of reducing drug use remained in place.

Alcohol Prohibition

In analyzing the impact of federal drug prohibition, some policy analysts and commentators explore alcohol Prohibition as a main point of comparison (e.g. MacCoun & Reuter, 2001) [17]. The period of Prohibition is often referred to as the lifespan of the 18th Amendment, which was enacted in 1920 and then repealed in 1934. Several states and localities, however, banned alcohol before this amendment (Merz, 1930) [18]. By 1919, 26 of 48 states had already established some form of Prohibition – representing the power of states and localities in determining their own drug laws.
Prohibition was (and still is) actually a misnomer, however, because though selling alcohol was banned, consuming drinks was still legal. In this sense, alcohol was never completely prohibited or criminalized. To illustrate the influence of localities on drug laws, though, it is useful to note that the repeal of the Prohibition amendment in 1934 did not mean that localities lost their ability to ban alcohol. In fact, Barrow, Alaska, weary of the negative social consequences of alcohol use, voted to fully ban alcohol as late as 1994 (Kleber, Califano, & Demers, 2005) [19]. The residents of this northernmost city in the United States reported some positive consequences of the new policy. One year later, however, residents voted to repeal the ban. Many other counties in America still prohibit alcohol sale today (or at least certain types of alcohol) absent a national amendment in place (e.g. counties in Texas, Louisiana, North Carolina and Mississippi). The discussion of Prohibition is useful here since it highlights the great variation and latitude given to states and localities regarding drug policy.

The Narcotic Division – the First Drug-Law Enforcers
The federal government used its new Harrison Act powers – which were affirmed by the 1919 Supreme Court decisions (and an amendment in Congress) – to arrest several physicians and pharmacists who were supplying addicts with drugs throughout the country. A special narcotics police force of about 170 agents was set up under the Bureau of Internal Revenue to enforce the new federal drug law. The Narcotic Division successfully targeted the various drug maintenance clinics that had emerged in places like metropolitan New York City, Hartford, upstate New York, New Orleans, Atlanta, Los Angeles, Cleveland, Memphis, and Houston – about 80 clinics in total (Musto, 1971/1999) [8]. The Narcotic Division soon became the Federal Bureau of Narcotics and was transferred to the Treasury Department. Its commissioner, Harry J. Anslinger, enforced drug-laws strictly (Normand et al., 1995 [20];Jonnes, 1999 [5]; Musto, 1971/1999) [8]. Steadily, anti-drug laws on the federal level increased in severity. A mandatory minimum two-year sentence for first time drug possession was passed in 1951. Though it was never applied, severity reached an apex in 1956 when juries could order death for those convicted of selling heroin to minors.

Marijuana and Federal Enforcement
During the federal government’s early involvement with drug policy, it had not dealt with marijuana. The Federal Bureau of Narcotics was already burdened with enforcing cocaine and heroin laws, and Commissioner Anslinger did not see marijuana as a major threat (Musto, 1971/1999) [8]. There were also questions about how effective an anti-marijuana law could be, and if it would hold up to standards of constitutionality. Still, pressure was mounting from political leaders and citizens alike, including newspaper owner Randolph Hearst, to do something about the drug, especially since its popularity among immigrants and the jazz community left the establishment uneasy (Himmelstein, 1983 [21]; Morgan, 1981) [22]. In 1936 a newspaper editor from Colorado’s Daily Courier wrote to Anslinger, “Is there any assistance your Bureau can give us in handling this drug (marijuana)? Can you enlarge your department to deal with marijuana? Can you... help us?” (Musto, 1971/1999, p. 223) [8]. At the same time, films like Reefer Madness (1936) depicted marijuana-crazed teens as suffering from paranoia and uncontrollable violent tendencies (Hirllman & Gasnier, 1936; Himmelstein, 1983).

Commissioner Anslinger conferred with some experts about the marijuana issue in 1936 and decided that something had to be done about the drug, at least to quell growing political concern about the appearance of federal inaction. The Marijuana Tax Act was passed in 1937 and essentially prohibited the sale, manufacture and use of marijuana. Enforcement powers were given to Anslinger and his agents at the Bureau of Narcotics.

The Rise of the “Medical Model”: Harm Reduction is Born
As arrest rates for using and selling marijuana and other drugs rose, use seemed to be on the decline in the 1930s and 1940s compared to rates from the late 1800s (Report of the Mayor’s Committee on Drug Addiction, 1930 [24]; Jonnes, 1999) [5]. However, during the 1960s, surveys indicated an upsurge in drug use and drug glamorization in the media (Goode, 1993 [25]; Kleber, Califano, & Demers, 2005 [19]; SAMHSA, annual [23]; Johnston, O’Malley, & Bachman, 1994) [26]. Commissioner Anslinger retired in 1962, and growing support for what would be called the “medical model” – the first real emergence of harm reduction – emerged in the ranks of the U.S. government. Increasing resources were to be directed to research into mental health, and psychiatrists and government officials alike began losing faith in the strict drug law regime which flourished in the 1940s and 1950s. Many began to look again at the “medical model” of controlling drug use, characterized by treatment, maintenance, and in turn less emphasis on law enforcement. The Harrison Act rendered heroin prescription out of the question, but a new method of maintaining addicts – relying on the heroin substitute methadone – grew in popularity. Methadone’s aim to stabilize the lifestyle of the addict increased its political attractiveness with groups like the American Medical Association and the American Bar Association. Anslinger-type policies seemed to be on the decline, and methadone became well established in narcotic treatment centers nationwide. Drug substitution, a policy administered in the infamous Jacksonville clinic as described earlier, had returned to cities and states. These experiments greatly pre-dated modern-day harm reduction policies such as needle-exchange programs in the Pacific Northwest (which emerged in the late 1980s) or heroin maintenance clinics in Europe (which emerged in the mid 1990s). In the 1960s local clinics, the Bureau of Narcotics did not pursue these clinics with the same ferocity as they had soon after the passage of the Harrison Act under Anslinger (Musto, 1971/1999) [8].
The Controlled Substances Act (CSA)

Timothy Leary’s famous “turn on, tune in, and drop out” phrase became a clarion call for individuality and drug tolerance in youth culture (Leary, 1968, p. 223) [27]. Drug use escalated in the 1960s and 1970s with the number of new cocaine users, for example, rising five-fold from 1965 to 1970 (SAMHSA, annual) [29]. From 1965 to 1967, only 0.1 percent of people between age 12- and-17 had ever used cocaine, but rates rose throughout the 1970s and 1980s, reaching 2.2 percent in 1987 (National Institute on Drug Abuse, 2004) [28]. Marijuana use also peaked in the late 1970s (SAMHSA, annual) [29]; Johnston, O’Malley, & Bachman, 1994) [29]. Democratic administrations in the 1960s began to deal with other domestic problems they found more pressing, like racial tension, gender inequality and poverty.

Republican President Nixon was elected in 1968 at a time when drugs divided the younger and older generations. Concerned about an increase in drug use, the Nixon Administration was responsible for a revision of the Harrison Act. This new legislation, passed in 1970, was known as the Controlled Substances Act (CSA) and classified drugs according to their dangerousness, addictive potential and medical utility. Because only the U.S. Justice Department can reschedule drugs, this system of classification gave the federal government even more powers over controlling drug use. This classification system would again bear rise to policies based in use reduction, though states soon followed their own drug policy path which – once again – de-emphasized enforcement and the federal priorities of reducing drug use.

Back to the States: Marijuana Decriminalization Reaches its High Point

In 1970 strict federal anti-drug laws were re-introduced in the form of the Controlled Substances Act. The drug-using behavior of many Americans, especially with respect to marijuana, however, continued apace. In 1967 the number of new marijuana initiates was 500,000; between 1974 and 1979, however, that number hovered around 3.5 million for each year (SAMHSA, 1980 [29]; Johnston, O’Malley, Bachman, 1994) [26]. Lifetime marijuana use had jumped from 1 million people in 1965 to 24 million seven years later (National Commission on Marijuana and Drug Abuse, 1972) [30]. To reflect the growing acceptance of marijuana use, groups began mobilizing to legalize or decriminalize the drug.

Capitalizing on the country’s tolerance toward marijuana, marijuana-supporters organized and founded NORML, the National Organization for the Reform of Marijuana Laws. Between 1972 and 1978, NORML was on the front line in helping to decriminalize marijuana in eleven states. As states decriminalized marijuana, an industry emerged to assist people in their drug-taking. This industry manufactured drug paraphernalia — toys and gadgets designed to enhance drug use. So-called “head shops” also sold promotional materials and “starter kits” targeted to young, aspiring drug users (Rusche, 1995) [31]. By 1977, some 30,000 drug paraphernalia stores were conducting business across the nation.

The legalization movement got a major push on the national level in 1977 when President Carter’s special assistant for health issues, Dr. Peter Bourne, testified in front of a House of Representatives committee in favor of decriminalizing marijuana. He also advocated for cocaine to be given decriminalization status. In 1974 he wrote that:

Cocaine...is probably the most benign of illicit drugs currently in widespread use. At least as strong a case could be made for legalizing it as for legalizing marijuana. Short acting — about 15 minutes — not physically adding and acutely pleasurable, cocaine has found increasing favor at all socioeconomic levels in the last year. (Bourne, 1974, p. 5) [32]

Though Bourne resigned in 1978 after being accused of allegedly using cocaine himself (and writing an illegal drug prescription), the marijuana decriminalization movement reached its high-point in 1977 when Carter (1977) [33] said the following in a message to Congress:

Penalties against possession of a drug should not be more damaging to an individual than the use of the drug itself... Nowhere is this more clear than in the laws against possession of marijuana in private for personal use.

President Carter’s words did not translate into much further action, however, and no state has decriminalized marijuana since 1978. That said, most of the original decriminalization states have kept their lenient marijuana laws in place as of 2007. Though there is a comprehensive federal anti-drug law in the form of the CSA, states continue to set their own penalties and enforce laws according to local practices and culture. For example, the cities of Berkeley and San Francisco treat marijuana as their “lowest law enforcement priority” while New York City continues a campaign started in the mid-1990s to crack down on small amounts of marijuana possession and dealing (Berkeley Municipal Code [34]; Kane, 2002 [35]; Golub et al., 2003) [36]. A hybrid of drug policies — varying widely in different localities — began to take shape.

The Reagan-Bush Era and the Re-Federalization of Drug Policy

By 1979, drug use was at historically high rates: 70% of young adults (18-25) had tried an illicit drug in their lifetime, one in nine high school seniors used marijuana daily and the number of cocaine users quadrupled from the level some five years prior (SAMHSA, annual) [29]; Johnston, O’Malley, & Bachman, 1994) [29].
A movement against drugs led by some concerted parents emerged in the late 1970s in reaction to the pressure from NORML and others to decriminalize drugs. Growing numbers of parents organized nationwide on local, state, and national levels (Rusche, 1995) [31]. Reacting to personal experiences with their own children and drugs, the parent movement helped to convince policy makers to bring policy back to the federal government and reverse the trend toward state decriminalization (Baum, 1996 [37]; Manatt, 1979 [38]; DuPont, 1980 [39]; U.S. Department of Education, 1986 [40]; White House Conference for a Drug Free America, 1988) [41].

In part encouraged by parents, President Ronald Reagan called drugs “America’s number one problem” and vowed to bring back the focus of drug policy to the federal government (Newsweek, 1986) [42]. The U.S. government seemed particularly alarmed at the growing problem of crack-cocaine – the smokable, faster-acting version of powder cocaine.

The media covered the issue of crack extensively, reporting of “almost instant addiction.” Crack was on the cover of news magazines, dominated television and newspaper coverage, and was labeled “America’s drug of choice,” by NBC. The New York Times reported that crack was spreading to the suburbs. In 1990, William Bennett, America’s first official “drug czar,” said it might soon invade every home in America. The harmfullness of crack was compared to the bubonic plague and called “the most addictive drug known to man” in Newsweek magazine (Bennett, Dilulio, & Walters, 1996) [44]. As if this enormous amount of media coverage was not enough to gain the attention of lawmakers, the death of two highly respected athletes as a result of cocaine use added more urgency to government action on drug policy (Martz, 1986 [43]; Bennett, Dilulio, & Walters, 1996) [44].

First Lady Nancy Reagan became a cultural icon for the “war on drugs” and added strength to anti-drug crusaders by exclaiming that “every drug user is an accomplice to murder.” Her “just say no” campaign remains one of the most remembered government slogans in American history (Goode and Ben-Yehuda, 1994) [45]. Polls showed that in the mid-1980s Americans rated drugs as the most important policy dilemma in the country (Goode, 1983) [25].

President Reagan began a series of speeches in mid-late 1986 calling for a revitalization of federal anti-drug efforts. This culminated in the Anti-Drug Abuse Act of 1986 which enacted tough mandatory minimum sentencing for drug users and increased federal dollars for supply-reduction efforts. In 1988 a revision of this Act created the Office of National Drug Control Policy (ONDCP) whose director – known as the “drug czar” – would oversee all anti-drug budgets and provide a coordinated national strategy to counter drugs. Congress enacted the Mail Order Drug Paraphernalia Control Act in 1986 as part of the Anti-Drug Abuse Act. Unsuccessful judicial challenges to the federal paraphernalia laws were brought by NORML.

Though the government seemed to be succeeding in re-federalizing drug policy again with the new legislation, some cities and states decided to take their own course of action. In June of 1986, New York City mayor Ed Koch urged the death penalty for any drug dealer convicted of possessing at least a kilo of cocaine or heroin. Two months later, New York Governor Mario Cuomo called for a life sentence for anyone convicted of selling three vials of crack – roughly $50 worth of the drug. On the west coast, the state of California continued to leniently apply marijuana laws, the use of which was (and still is today) essentially decriminalized (Males, 2001) [46]. Cities like San Francisco and Baltimore went further and extended the “medical model,” especially in regards to heroin users (with the introduction of needle exchange programs, for example), in the mid-1980s and early 1990s (Shenk, 1989) [47].

President George H.W. Bush also focused intensely on the federal “war on drugs.” Bush continued to talk about the danger of drugs in major speeches. Along with William J. Bennett, who repeatedly told the media that inaction on crack would lead to the drug “invading every home in America,” he also released the nation’s first National Drug Control Strategy, a concise document highlighting ways to counter both the supply and demand of drugs (ONDCP, 1989) [48].

Moving Drug Policy Back to the States

In 1992, Americans ushered in a popular president, Bill Clinton, who preferred a softer tone on drug policy in contrast to the hard-line approach taken by the Reagan and Bush administrations in the 1980s [49]. The immense drug control efforts of that decade seemed to wane in the early 1990s as concerns shifted to a staggering economy and international terror threats. President Clinton reduced the staff of the Office of National Drug Control Policy by roughly 85 percent and appointed a neutral drug-czar, police chief Lee Brown (Bennett, Dilulio, & Walters, 1996) [44]. Of 1,742 presidential statements and other utterances in 1994, Clinton mentioned illegal drugs only 11 times – drawing criticism that he was unwilling to take drug policy seriously on the federal level (House Committee on Government Reform and Oversight, 1996) [50].

Even his closest Democratic friends were angry: “I’ve been in Congress for over two decades. I have never, never, never seen a president who cares less about drugs,” remarked Democratic Representative Charles Rangel on national television news in 1996 (Bennett, Dilulio, & Walters, 1996) [44].

During the 1996 presidential campaign, President Clinton answered these critics by reviving the Office of National Drug Control Policy and appointing an outspoken Gulf War general, Barry McCaffrey, as drug-czar. McCaffrey was given cabinet-level status and a staff of nearly 200. His leadership style contrasted dramatically with his quiet predecessor, and his efforts at ONDCP were lauded by many anti-drug hawks, regardless of political affiliation (Rusche, personal communication, 2004). McCaffrey tried to re-nationalize drug policy by releasing a lengthy National Drug Control Strategy and appearing numerous times in the
national media. A simple search on Lexis-Nexis news-search conducted in 2005 showed that in his first year in office, McCaffrey has mentions in 104 news articles, versus 32 for his predecessor, Lee Brown (Lexis-nexis search, 2005) [51].

McCaffrey’s tenure tested the limitations of the viability of a truly uniform national drug policy. In 1996, efforts in two states began a wave of state and local drug law innovation that brought the tide of drug policy decision-making away from the federal government once again. Three wealthy financiers (George Soros, Peter Lewis and John Sperling) funded two statewide voter referenda in California and Arizona aimed at allowing marijuana (and in Arizona’s case, all drugs) to be used for medical purposes. Although the “supremacy” clause of the U.S. Constitution renders federal law superior to state and local laws, these referenda would in essence override Congress’ provisions in the Controlled Substances Act which banned marijuana for all uses because of simple non-adherence to federal laws by state authorities and marijuana activists.

The initiatives drew fierce opposition from the federal government. When voters approved both referenda in November of 1996, McCaffrey, joined by Attorney General Janet Reno and Health Secretary Donna Shalala, announced several initiatives targeting any doctor recommending marijuana for any purpose. McCaffrey stated that “…nothing has changed. Federal law is unaffected by these propositions” (Federal News Service, 1996 [52]. Attorney General Janet Reno promised law enforcement intervention on dispensaries set up to distribute marijuana and against doctors who recommended the drug: “We will not turn a blind eye toward our responsibility to enforce federal law,” Health and Human Services Secretary Donna Shalala said. McCaffrey and members of Congress then used “dangerous” at states’ attempts at any legalization of marijuana. In the end, the U.S. government probably found it politically and logistically difficult to enforce federal drug laws onto the states (McCaffrey, Reno, and Shalala were also successfully sued in federal court for threatening the doctor-patient freedom of speech relationship; see Conant v. Walters, 2002) [53]. Instead, it appears the California and Arizona initiatives opened a floodgate for drug policy reform on the state and local level. As the Drug Policy Alliance, America’s leading drug reform organization states:

State legislatures are traditionally at the forefront of policy change, serving as “laboratories” for new ideas and solutions. Drug policy reform is no exception: on issues of drug sentencing, medical marijuana, overdose prevention, and expansion of effective drug treatment services, many states are working for better ways to reduce the harms associated both with drugs and with current drug policies. (Drug Policy Alliance, 2004) [54]

Indeed, the Drug Policy Alliance boasts of over 150 reforms — e.g. needle exchange programs, local seizure laws, hemp cultivation programs — that have occurred on the state and local level. It seems that the trend of drug policy making shifted in the 1990s back down to the states and cities.

Drug Policy in the 21st Century

The election of George W. Bush as U.S. President in 2000 brought with it some hope for supporters of state and local drug policy making. On the campaign trail, then-Governor Bush told the Dallas Morning News in regards to medical marijuana that “each state can choose that decision as they so choose” (Feeney, 1999) [55]. But just like McCaffrey’s threats of federal intervention on state reforms that did not play out in practice, President Bush’s lenient stance on state drug policy making during the campaign contrasted sharply with his actions in office.

Soon after his confirmation, Attorney General John Ashcroft led a campaign to re-establish the federal government’s grip on drug policy. “Operation Pipe Dreams” targeted drug paraphernalia shops, both on the internet and in cities, which, in his opinion, defied the parent-led federal anti-paraphernalia law passed more than a decade earlier (Bulwa, 2003) [56]. Ashcroft’s law enforcement efforts also targeted medical marijuana dispensaries in places like Santa Cruz and San Francisco. Bush’s drug czar, John Walters, joined Ashcroft in his contempt for local drug policy reform by actively campaigning against ballot initiatives and legislative items in states that sought to ease drug laws (i.e. deviate from federal laws). Reformers complained that “…vigorous federal opposition … ha(s) prevented states and localities from implementing their own initiatives and have created a general climate of fear and vulnerability among patients and providers” (Drug Policy Alliance, 2004) [54].

Even with the federal government’s actions, states and localities have become increasingly independent in their drug policy decision making and in practice. During the 2004 election cycle, multiple localities (e.g. Columbia, MO; Oakland, CA; Ann Arbor, MI) passed regulations to ease marijuana enforcement. Though they were unsuccessful, local and national interest groups sought full marijuana legalization in a number of states. Even national election cycle since 1986 has seen some local drug policy initiative put before voters in at least one city or state. And although a landmark decision by the U.S. Supreme Court in 2006, (Gonzales v. Raich, 2006) [57] reiterated Congress’s power to control drug manufacture, distribution and selling within states, local “cannabis clubs” continue to sell drugs in states like California – apparently unconcerned about federal law enforcement action.

Implications

Given the political design and the history of policy making in the United States, it seems that an accurate depiction of American drug policy would rely more on an evaluation of the dynamic between national,
state, and local laws. Interestingly, however, the discussion of drug policy is almost always framed in terms of federal mandates and cross-country comparisons, rather than on local issues (e.g. Kleber, Califano, & Demers, 2005 [19]; MacCoun & Reuter, 2001) [17]. Below is a discussion of some consequences of this problem.

Variations in Policy
What happens when only federal statistics are used to characterize American drug policy? Unfortunately, only a partially accurate picture of policy is presented. Incarceration rates for drug possession, for example, are often a state or local issue, since that crime is almost exclusively targeted by local authorities, even when the drug involved is as serious as crack-cocaine. Additionally, there is probably a considerable difference between laws that exist in principle (de facto) and laws that are applied in practice (de jure).

The U.S. Sentencing Commission noted that of the 41 percent of federal defendants sentenced to charges related to drug possession and trafficking, only 34 people were sentenced for the possession of crack-cocaine, and usually in relation to a plea deal. The Commission notes that “although simple possession of five or more grams of crack cocaine requires a mandatory minimum sentence of five years imprisonment, federal prosecutions for simple possession of crack cocaine are rare (only 69 cases in total between 1998 and 2000)” (U.S. Sentencing Commission 2002) [58]. It would appear instead that those caught in possession of crack, and indeed any drug, are falling under state, not federal, jurisdiction (Sabet, 2002 [59] and 2005 [60]).

There are even wide variations among the states themselves. Cocaine provides another example. In Michigan, an offender with 50 grams of cocaine in his possession cannot receive more than 20 years in state prison. Not too far away, that same offender in Minnesota would have needed only three grams of cocaine to spur a possible 20-year sentence. Someone with 200 grams of cocaine in his possession in North Carolina cannot receive more than 7 years of prison, yet a person with that same amount in Louisiana receives between 20 and 60 years (Sabet, 2005) [60]. Table 1 below details the laws against first-time cocaine possession in all states and the federal government. Though cocaine is the example used here, virtually any drug law could be used as an example of wide variation among states.

Table 1: Laws for first time use of cocaine in the U.S., the 50 states, and the District of Columbia. Italics show substantial (possible or real) deviations from federal law

<table>
<thead>
<tr>
<th>Type of government and amount</th>
<th>JAIL TIME (min.-max., or just maximum if applicable)</th>
<th>FINE AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FEDERAL GOVERNMENT (any)</strong></td>
<td>1 year maximum</td>
<td>$1,000-$100,000</td>
</tr>
<tr>
<td>(5 grams with intent to sell)</td>
<td>10-16 years</td>
<td>same as above</td>
</tr>
</tbody>
</table>

Alabama (any) 1-10 years $5,000
28 grams 3 year mandatory minimum $50,000
500 grams 5 year mandatory minimum $100,000
Alaska (any) 5 year maximum $50,000
Arizona (any) 2.5 maximum $2,000-$150,000
Arkansas (any) 3-10 years $10,000
California (any) 1.5-3 years $20,000
Colorado (any) 2-6 years $2,000-$500,000
25 grams 2 year mandatory minimum $2,000-$500,000
450 grams 4 year mandatory minimum $2,000-$500,000
Connecticut (any) 7 year maximum $50,000
Delaware (any) 1 year maximum $2,300
5 grams 3 year mandatory minimum $50,000
50 grams 5 year mandatory minimum $100,000
District of Columbia 5 year maximum $1,000
Florida (any) 5 year maximum $5,000
28 grams 3 year mandatory minimum $10,000
200 grams 7 year mandatory minimum $50,000
Georgia (any) 2-15 years $0
28 grams 10 year mandatory minimum $200,000-$1,000,000
200 grams 15 year mandatory minimum $300,000-$1,000,000
Hawaii (any) 5 year maximum $10,000
3.54 grams 10 year maximum $25,000
28.35 grams 20 year maximum $50,000
Illinois (any) 1-3 years $25,000
15 grams 4-15 years $200,000
100 grams 6-30 years $200,000
Indiana (any) 1.5 years maximum $10,000
3 grams 4 years maximum $10,000
Iowa (any) 1 year maximum $250-$1,500
Kansas (any) 1.9-2.17 years $100,000
Cities and the "Federal Analogy"
Since states can differ on policy delivery and outcomes, one must also consider the way local laws can dramatically differ within a state itself. California’s drug arrest and incarceration practices offer a good example of variations in local laws and practices within a state. Though largely unknown (MacCoun & Reuter 2001, p. 97) [17], marijuana is legally decriminalized in that state, and arrest and incarceration practices for all drugs are dramatically different depending on the county or city you are in.

<table>
<thead>
<tr>
<th>State</th>
<th>Minimum Years</th>
<th>Maximum Years</th>
<th>Minimum Fine</th>
<th>Maximum Fine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kentucky (any)</td>
<td>1-5 years</td>
<td>1-5 years</td>
<td>$1,000-$10,000</td>
<td>$1,000-$10,000</td>
</tr>
<tr>
<td>Louisiana (any)</td>
<td>5 year maximum</td>
<td>5 year maximum</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>28 grams</td>
<td>20-60 years</td>
<td>20-60 years</td>
<td>$50,000-$150,000</td>
<td>$50,000-$150,000</td>
</tr>
<tr>
<td>Maine (any)</td>
<td>1 year maximum</td>
<td>4 year maximum</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>14 grams</td>
<td>10 year maximum</td>
<td>25 year maximum</td>
<td>$20,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>Maryland (any)</td>
<td>4 year maximum</td>
<td>25 year maximum</td>
<td>$25,000</td>
<td>$25,000</td>
</tr>
<tr>
<td>28 grams</td>
<td>25 year maximum</td>
<td>25 year maximum</td>
<td>$50,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>Massachusetts (any)</td>
<td>1 year maximum</td>
<td>4 year maximum</td>
<td>$1,000</td>
<td>$25,000</td>
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<tr>
<td>Michigan (any)</td>
<td>25 grams</td>
<td>1-4 years</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>50 grams</td>
<td>10-20 years</td>
<td>10-20 years</td>
<td>$25,000</td>
<td>$25,000</td>
</tr>
<tr>
<td>Minnesota (any)</td>
<td>5 year maximum</td>
<td>20 year maximum</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>3 grams</td>
<td>20 year maximum</td>
<td>25 year maximum</td>
<td>$500,000</td>
<td>$500,000</td>
</tr>
<tr>
<td>6 grams</td>
<td>25 year maximum</td>
<td>4 year maximum</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Mississippi (any)</td>
<td>1-4 years</td>
<td>2-8 years</td>
<td>$50,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>.1 grams</td>
<td>1-5 years</td>
<td>4-16 years</td>
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<tr>
<td>Missouri (any)</td>
<td>7 year maximum</td>
<td>5-15 years</td>
<td>$5,000</td>
<td>not available</td>
</tr>
<tr>
<td>150 grams</td>
<td>10 years - Life</td>
<td>not available</td>
<td>$10,000</td>
<td>not available</td>
</tr>
<tr>
<td>Montana (any)</td>
<td>5 year maximum</td>
<td>20 year maximum</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Nebraska (any)</td>
<td>1-4 years</td>
<td>1-6 years</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Nevada (any)</td>
<td>1-4 years</td>
<td>1-6 years</td>
<td>$50,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>4 grams</td>
<td>1-4 years</td>
<td>1-6 years</td>
<td>$100,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>Oklahoma (any)</td>
<td>7 year maximum</td>
<td>5 year maximum</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Oregon (any)</td>
<td>33-42 years</td>
<td>5.83-7 years</td>
<td>no less than $50,000</td>
<td>no less than $100,000</td>
</tr>
<tr>
<td>Pennsylvania (any)</td>
<td>3-5 years</td>
<td>2.92-3.5 years</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Rhode Island (any)</td>
<td>1.5 years maximum</td>
<td>5.83-7 years</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>500 grams</td>
<td>10 year maximum</td>
<td>80 years - Life</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Ohio (any)</td>
<td>.5-1 years</td>
<td>.5-1.5 years</td>
<td>$2,000</td>
<td>$2,000</td>
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<tr>
<td>5 grams</td>
<td>5-1.5 years</td>
<td>2-15 years</td>
<td>$10,000</td>
<td>$10,000</td>
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<tr>
<td>25 grams</td>
<td>1-6 years</td>
<td>2-15 years</td>
<td>$100,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>Tennessee (any)</td>
<td>2-10 years</td>
<td>5 years maximum</td>
<td>$100,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>South Carolina (any)</td>
<td>2 years maximum</td>
<td>5 year maximum</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>.65 grams</td>
<td>15 years maximum</td>
<td>15 years maximum</td>
<td>$25,000</td>
<td>$25,000</td>
</tr>
<tr>
<td>South Dakota (any)</td>
<td>10 years maximum</td>
<td>10 years maximum</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Texas (any)</td>
<td>49-2 years</td>
<td>1 year maximum</td>
<td>$750-$2,500</td>
<td>$750-$2,500</td>
</tr>
<tr>
<td>1 gram</td>
<td>2-10 years</td>
<td>5 year maximum</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>4 grams</td>
<td>2-20 years</td>
<td>2 year maximum</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Utah (any)</td>
<td>5 year maximum</td>
<td>5 year maximum</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Vermont (any)</td>
<td>5 year maximum</td>
<td>5 year maximum</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>2.5 grams</td>
<td>10 year maximum</td>
<td>10 year maximum</td>
<td>$100,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>Virginia (any)</td>
<td>1-10 years</td>
<td>1 year maximum</td>
<td>$500,000</td>
<td>$500,000</td>
</tr>
<tr>
<td>Washington (any)</td>
<td>5 year maximum</td>
<td>5 year maximum</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>West Virginia (any)</td>
<td>25 - 5 years</td>
<td>25 - 5 years</td>
<td>$1,000 maximum</td>
<td>$1,000 maximum</td>
</tr>
<tr>
<td>Wisconsin (any)</td>
<td>1 year maximum</td>
<td>1 year maximum</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Wyoming (any)</td>
<td>1 year maximum</td>
<td>1 year maximum</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>3.01 grams</td>
<td>7 year maximum</td>
<td>7 year maximum</td>
<td>$15,000</td>
<td>$15,000</td>
</tr>
</tbody>
</table>
In the city of San Francisco, where a marijuana decriminalization ordinance has been city law for more than a decade, policy observers have commented that “marijuana possession arrests declined sharply from the 1980s to the 1990s and private pot smoking is effectively decriminalized” (Males, 2001) [46]. The arrest rate for drugs in San Francisco County, in fact, corroborates this assertion. In San Francisco, the arrest rate for simple drug possession fell 56% from 1995-1996 as compared with 1980-1984; in Alameda County, where the city of Berkeley lies, the arrest rate fell 23%. With the exception of Los Angeles County (which fell 33%) and San Diego County (which fell 9%), all of the other counties showed large increases in arrest patterns, Fresno county topping the list at +131%. Thus, the counties of San Francisco and Alameda – as compared with other counties like Fresno and Orange that have no such marijuana ordinances – arrested less serious drug offenders in the past twenty years. Incarceration figures vary dramatically, too – with the more drug-lax regions predictably imprisoning fewer people. Researchers from the Justice Policy Institute, specifically studying California laws, report that “…because California counties pursue drug policy enforcement in sharply different ways, wide variations exist on how laws are implemented at the county level” (Macallair et al., 1993, p. 12) [61].

Although the state creates the laws, often times it is local authorities – those directed by county and city governments – which make the majority of the decisions regarding arrest and prosecution of criminals. This relationship is referred to often as the “federal analogy” and opens the door to enforcement variations on the sub-state level since local officials in different counties and cities make important decisions that impact drug users. Federal districts matter too, it seems. Deciding whether or not to prosecute a drug criminal in state or federal court seems to matter a great deal depending on what federal district you reside in. The U.S. Sentencing Commission reported some “surprising variations” between federal districts and their choice whether or not to prosecute at the federal level which led them to conclude in 1995 that “...these data suggest that the uniform national policy Congress had hoped to engender does not play out in practice (because)... there are some surprising variations in prosecution practices” (U.S. Sentencing Commission, 2002; see this report for examples of this variation).

Cross-country Comparisons: Dangerous Territory?

Besides leading to simplistic analyses of American drug policy and national trends, an over-reliance on federal laws and statistics can amount to potentially misleading comparisons between the United States and other countries. These comparisons and their conclusions, written about extensively in drug policy literature (e.g. Bennett, Dilulio, & Walters, 1996 [44]; MacCoun & Reuter, 2001 [17]; Goode, 1993 [25]; Gray, 1998 [62]; Kleber, Califano, & Demers, 2005 [19]), do not address the complexity of local policymaking in the United States. It would seem then that over-relying on federal statistics to characterize American drug policy and then comparing that analysis with statistics in other countries (themselves conceivably impacted by local policy variations) is potentially superficial and misleading. For example, Reinarman, Cohen, & Kaal (2004) [63] compared the experience of regular marijuana users in San Francisco, California and Amsterdam, Netherlands, “two similar cities with opposing cannabis policies.” The researchers find that their marijuana use levels in both cities were very similar, and thus they conclude that cannabis policies have minimal impact on use levels, despite “criminalization” in San Francisco and “de-facto legalization” in Amsterdam. But this conclusion is based on an erroneous assumption that San Francisco has a policy of “criminalization” in the first place. As discussed above, however, the city’s attitude toward marijuana could be regarded as remarkably similar to Amsterdam’s. Ignoring the wide variation in both the legislative responses at state level and the scope for varied operational responses at the city level within states, many analysts of U.S. drug policy over-emphasize federal guidelines as starting points for policy analysis (some exceptions include Haaga & Reuter, 1990 [1]; Kleiman & Smith, 1990 [64]; Murphy, 1997 [65]; Sabet, 2005 [60]; ImpacTeen illicit Drug Team, 2002) [66].

Conclusions

American drug policy can be characterized by a persistent power struggle between federal and non-federal laws and practices. This dynamic has resulted in a hybrid of drug policies with wide variations – from strict enforcement of marijuana laws in places like New York City to virtually no enforcement of those laws in San Francisco, for example. From the early days of non-federal involvement to current trends characterized by a tenuous relationship between strong national policy and continued local drug policymaking, the history of drug policy in the United States cannot be properly characterized without special attention drawn to these local nuances. Though these efforts are sometimes met with skepticism (or, in practical terms, the use of federal law enforcement powers) from a federal government insistent on maintaining a strong grip on drug policy creation and implementation, local policies persist and thus have the potential to widely affect members of their respective communities. Regrettably, these local outcomes have been rarely measured thoroughly, leading to gross overgeneralizations of American drug policy (e.g. Reinarman, Cohen, and Kaal, 2004) [63]. There seems to be a great need to know what the relative effects of these many local policies are and to evaluate these effects within a common framework. Future research should address these concerns so that drug policies can be more comprehensively – and accurately – evaluated.

Biography

Kevin A. Sabet, Ph.D. is a MHRA/NDRI postdoctoral fellow and a policy consultant in private practice based in New York, NY. He recently graduated from the University of Oxford as a Marshall Scholar and a Warr-Goodman prize recipient. He regularly contributes to the media and worldwide governments on various issues of drug policy and served as the Senior Speechwriter at the Office of National Drug Control Policy under Gen. Barry McCaffrey (2000) and John Walters (2003-2004).
References


Associated references by Musto:


19. Kleber, H., Califano, J., & Demers, J. (2005). Clinical and societal implications of drug legalization. In Lowinson, Ruiz, Millman, & Langrod (Eds.), *Substance Abuse: A Comprehensive Textbook*. Fourth Edition. Baltimore: Williams and Wilkins. In Barrow, crime decreased 70% and there was a reduction from 123 alcohol-related emergency room visits the month before the ban to 23 the following month. When they re-legalized alcohol, local observers noted that the local detoxification center began to fill with patients and alcohol-related murders grew (Kleber, Califano, & Demers, 2005).


Putting ethics in its place – right at the heart of drug policy debates
Dr Gregory K Pike, PhD

Abstract:
Making decisions of an ethical and moral nature is part of the everyday business of human existence. It is not possible to be value free or to act without making a moral or ethical decision of one sort or another, for good or ill. Personal decisions about taking mind-altering drugs have ethical dimensions, and these frequently have particular reference to pleasure. Pleasure needs to be understood with nuance and distinctions made between pleasures which are in keeping with human fulfillment and those that are not. Ethics can also be valuable in understanding the roots of overarching policies like harm minimization. Harm minimization has its basis in the ethical theory of utilitarianism which judges actions by considering the balance between pleasure and pain. It is argued that this is a flawed approach and that harm minimization not only promotes unethical practices, but ultimately ends up failing the very people it seeks to assist.

Keywords: ethics, morality, utilitarianism, harm minimization, pleasure, autonomy, policy

Introduction
Debates about drug policies are confounded by a wide variety of quite complex matters. Whilst these include law, treatment, education, international relations and scientific evidence, to name a few, more basic is the philosophical framework from which these are derived. And foundational differences in that framework can lead to very different perspectives on policy. The area of philosophy in which many of the basic questions lie is the field of morals and ethics (1), and while it has been forcefully put at times that morals and ethics should be left out of the drug debate, it is impossible to do so, since morals and ethics are unavoidable. That drug policies contain profound ethical questions cannot be denied, but perhaps the desire to do so comes from the quite basic differences in perspective coming from voices in the debate. More controversial still is the proposition that substance abuse itself is primarily a moral problem. This is not to say that drug abuse is ‘simply a moral problem’ and therefore the hard work of assisting someone to become drug-free does not require detailed and dedicated attention to the mental, physical, spiritual and financial devastation often caused by drug abuse, but rather that an ethical perspective informs how that work is to be done. Debates about ethics and about the drug policies which arise from ethics can be hard going, and one of the reasons for this is ethical subjectivism or moral relativism. As Budziszewski so starkly puts it,

"Once upon a time it was possible for a philosopher to write that the foundational moral principles are the same for all ... Today all that has changed. A thinker ... can no longer expect most people to agree. In fact he must expect most people to disagree. He will be told that the foundational moral principles are not the same for all ... They might not even be right for all, and they are certainly not known to all. (2)"

About moral knowledge, he goes on to say,

"... not only was moral knowledge universal, but the determination to play tricks on moral knowledge was universal, too. A law was written on the heart of man, but it was everywhere entangled with the evasions and subterfuges of men. (3)"

Ethical reasoning is now much harder work because of competing moral philosophies that ultimately lead to very different decisions being made in a wide range of fields from drug policy to end-of-life to biotechnology and genetics. Consensus is harder to reach, and therefore clear policy-making can be stymied. Reminiscent of De Quincey’s nineteenth century ‘opium-eating’, during which he described his experience of “… mighty and equal antagonisms …” (4), the various sides of the drug policy debate cannot agree because of foundational differences in their basic ethic. Nevertheless, despite competing moral philosophies, it is possible to find agreement on many of the basic virtues and values that promote human fulfillment, and in the modern era, much of that agreement can be found in human rights instruments like the International Declaration of Human Rights. This human rights document, and many others like it, is committed to providing a framework within which human beings can flourish. It promotes values like freedom, respect, courage, social interaction, good health and so on that can be used to inform appropriate policies not only in the drugs field, but in every field.
Whilst it is an oversimplification, within the drug debate one side holds the basic conviction that mature individuals should be legally permitted to use currently illicit mind-altering drugs, much like they may choose to use tobacco, caffeine or alcohol, and the other side holds the basic conviction that the currently illicit mind-altering drugs should remain illegal. Another oversimplification, but useful for the purposes of beginning a discussion, is that it is reasonable to say that the first group either consider such use morally acceptable or at least an individual’s choice even if morally unacceptable, and the second group consider such use morally unacceptable. And there are a variety of reasons why each would conclude so. It is important to note that something that is generally agreed to be wrong may not necessarily be the subject of legislation (5). This is the difference between ethics and law. However, in a democracy something that is the subject of proscriptive legislation is always generally agreed to be wrong. If the community consensus shifted and the general agreement changed, the law would then change to reflect that shift in ethical perspective. If this happened, it might sound like the community is being relativistic about ethics, and that would be because it is.

For those who consider drug use morally unacceptable, the decision about whether to apply restrictive legislation or not is based upon the extent to which drug use is considered a private matter that harms self but not others as well as the extent to which personal liberty to carry out self-harming behaviour can be justified. On the first count, a strong case can be made that harm as well as the risk of harm does extend to others from ‘personal’ drug use, and therefore John Stuart Mill’s famously enunciated principle in On Liberty cannot be fairly applied.

The only purpose for which power may be rightly exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant. (6)

On the second count, one might appeal to legal paternalism to argue that there are times when the state should protect people from themselves. Indeed, there are numerous examples where the state does just that, for example, seatbelt laws or helmets for cyclists. Moreover, international law proscribes selling oneself into slavery, even if that were, bizarrely, an expression of liberty. Another take on this is that a law based upon pure paternalism is rare and that, in reality, there are other factors that are taken into consideration. For example, the community, through the state, must bear the not inconsiderable cost of rescuing people from the consequences of their risky or outright self-harming behaviour, and therefore some form of paternalism is justified. Furthermore, where there are obvious benefits that arise from risky behaviour, as is the case with certain sports, it is much easier to justify not applying legal paternalism than when the benefits are few, misrepresented, counterfeit, or absent.

Much more could be said about the complex relationship between ethics and law in relation to drug abuse, but it will not be explored further here.

Instead, because ethics and morality pervade numerous other private and collective aspects of the field of substance abuse, two of these will now be addressed. They include the moral legitimacy or otherwise of recreational (7) use and the ethical underpinnings of harm minimization. Ethics does, of course, have much more to say in a wide range of areas within the field of substance abuse, for example about modes of addiction treatment, truth-telling in drug policy debates, conflicts of interest and hidden agendas, formal and material cooperation by individuals or the state in harmful practices, and the ethics of including in research addicted individuals or those otherwise vulnerable because of their drug abuse. (6) In addition, modern neuroscience is now beginning to uncover interesting details about the brain and decision-making in general and moral decision-making in particular. Some of these findings and how they accord with studies that have explored decision-making impairments resulting from drug abuse are important, but they are beyond the scope of this paper.

‘Recreational’ Drug Use

The reasons why people initiate drug use are complex; however, there can be little doubt that the feeling that is derived, or at least sought, is often pleasurable or otherwise an adventure into unreality and therefore desirable. Several explanations can be found; the following is from Nick Stafford who posted his view online:

I believe it is my human right to use opiates or any other drug I feel like using, for whatever reasons I may have. I feel my life has been enriched by the use of heroin, marijuana, speed, acid and other drugs. I believe that drugs should all be legally available, and I will continue to use these drugs, if I so desire, for the rest of my life. (8)

For Stafford, all other ethical considerations have been subjugated to personal desire and the right to choose, both of which are premised on the pursuit of pleasure as an end in itself. Of course, autonomy and choice are valid ingredients in ethical decision-making. But the failure to take into account any other ethical consideration, including a consideration of what it is that promotes human flourishing, leads to a perverse individualism in which the common good of all is substantially undermined.

...strong emphasis on autonomy... has led ethicists and others to ignore or discount to different degrees the fact that individuals make decisions as social beings - that is, as persons with many characteristics closely tied to their social, cultural, ethnic, and family contexts and that these social aspects of the person impact relevantly and often crucially on their actions and certainly on their beliefs. (9)
One could go further and argue that not only is there a requirement for individual action not to undermine the common good of the community, but that there is a requirement for individuals to promote the common good by positive contributions to the community. Such a sentiment has a long and rich history, particularly in the various religious traditions. (10)

The justification for personal drug use also comes from far more notable figures than Nick Stafford. In his recent book, *Romancing Opiates*, English writer and retired physician Theodore Dalrymple charges Samuel Taylor Coleridge and Thomas De Quincey, amongst others, with producing,

> Romantic claptrap [that] invests intoxication by opiates with a philosophical significance beyond mere indulgence. (11)

In a chapter appropriately titled, *The literature of exaggeration and self-dramatization*, Dalrymple ruthlessly exposes Coleridge and De Quincey for their self-indulgent and dishonest accounts of their supposed mind and consciousness expansion whilst under the influence.

> Gosh! Opium not only calms you down while sharpening your faculties and honing your intelligence, but makes you a better, kinder person. No pharmaceutical purveyor of an antidepressant ever bid up his product higher than that. Take but a little heroin, therefore, and your intellect will be majestic. Your thoughts will be coherent, your powers of mental synthesis unparalleled. You will recover the pristine, pre-social beauty of the human character of which Rousseau speaks so eloquently. A drunk is a drunk, but a heroin addict is a philosopher. (12)

This ‘wisdom of intoxication’ was taken up by 60s gurus like O’Leary to the detriment of a generation, and in Dalrymple’s opinion remains, along with boredom and meaninglessness, the root causes of modern society’s problem with drug addiction. It may take some years to exorcise the influence.

Apart from the deceit of consciousness expansion, the appeal of pleasure in its various forms remains a key factor in drug use. In a recent article, Cameron Duff chides policy makers for ignoring this primary purpose of drug taking, enlisting the work of Michel Foucault on ethics and the use of pleasure:

> Indeed, Foucault’s work on ethics and the use of pleasure gives rise to a series of critiques of contemporary drug policy and the ways in which it tends to privilege the ‘problem’ of harms whilst eliding the consideration of pleasure. (13)

Duff wants pleasure to be incorporated into the drug policy equation, and as it turns out, perhaps not unexpectedly, he recommends easier access to drugs that induce pleasure. Perhaps he is braver than others so far who have advocated liberalisation on the grounds of harm minimization, but in reality see pleasure as a desirable goal that is factored into the pleasure/pain calculus. The fact that pleasure doesn’t get that much of a mention may be because the promotion of pleasure is a risky business because many others would see it as counterfeit pleasure; after all, perhaps the pleasures attributed to drugs like cocaine, heroin or ecstasy can be achieved by other more authentic means that have a richness, depth and enduring wholeness unattainable with drugs. At least this is the thesis of writers like A. Ernest Wilder-Smith. (14)

The importance of pleasures and pains and their relationship to the human condition, as well as to good and evil, have their roots in Greek philosophy. Writing circa 300 BC, Epicurus noted that:

> we always act to avoid pain and fear

and that:

> pleasure is the first good innate in us, and from pleasure we begin every act of choice and avoidance, and to pleasure we return again, using the feeling as the standard by which we judge every good. (15)

In the seventeenth century Thomas Hobbes consolidated this view:

> ... if I derive pleasure from something, it is good, whereas if it causes me pain, it is evil. (16)

Thus what is subjectively experienced as pleasure or pain Hobbes objectively defines as good or evil. If there is something that gives me pleasure, then it can be called good, and if there is something that causes me pain, then it can be called bad. This is not only a relatively simple way to determine good from evil, but it is also centered upon my judgment and perspective and mine alone. This reliance on my judgment or perspective might be satisfying for me and bring me some pleasure or avoidance of pain, but to say that good has been served and evil averted requires something more.

Another obvious corollary of this mode of thinking is the problem that arises when my particular pleasure happens to contribute directly or indirectly to someone else’s pain. How then can what I call good as a consequence of the pleasure I derive be at one and the same time evil for another because of the pain
they experience? Furthermore, pain and pleasure can be intricately connected, occurring in the context of one event, for example in childbirth or during a marathon run.

This leads to the conclusion that pleasure in and of itself cannot be equated with good. Pleasure is an experience that can be derived from that which is good as well as from that which is evil. As Thomas Aquinas has said:

In the moral order, there is a good pleasure, whereby the higher or lower appetite rests in that which is in accord with reason; and an evil pleasure, whereby the appetite rests in that which is discordant from reason and the law of God. (17)

Aquinas identifies good pleasures as those which are in keeping with objective goods as appraised by reason and evil pleasures which are contrary to reason and not aligned with objective goods. It is another way of saying that pleasure can be derived from acts which cause human beings to flourish, but it can also be derived from inherently harmful acts that diminish humanity and lay waste to human lives. Pleasure alone cannot define what is good, just as pain alone cannot define what is bad.

To more clearly distinguish 'good' from 'bad' requires understanding that the badness of what is bad is what Germain Grisez describes as "the distorting, damaging, or corrupting factor. This factor is a privation, a real lack of something which should be present and perfect." (18) The converse of this is that goodness is fullness of being. Just as badness is privation, so goodness lies in the fulfillment of our potentialities. (19) Both good and bad are real, and their effects are really experienced by human beings. To be taught the whole truth about something is liberating and fulfilling. To be given a partial truth, a half-truth, leaves us still to some degree in the slavery of ignorance and therefore unfulfilled.

But there is a secondary sense in which the terms 'good' and 'bad' are used. Humans are sensible beings as well as intelligent beings. As intelligent beings, we make choices. We can choose between that which is good (fulfilling) and that which is bad (ultimately unfufilling). As sentient beings, we respond emotionally to things around us which are suited to us or unsuited to us. Our emotions arouse within us possibilities for action while our intelligence considers the reasons for and against acting on the possibilities proposed to us by our emotions.

When emotion and intelligence work together in harmony, what is brought about is "both pleasant (the sensible good is experienced) and fulfilling (the intelligible good is served)." (20) Grisez gives some examples. Eating a good meal provides the person not only with pleasure but also the objective/intelligible goods of health and sociability.

So there are both intelligible goods and bads/evils and sensible goods and bads/evils. An intelligible good is one which is objective, fulfilling and fundamental such as knowledge, health, well-being, sociability and so on. Intelligible evils are the real deprivation of those goods, such as ignorance, sickness, disability, alienation from others and so on.

Sensible goods and evils are the feelings of pleasure and pain experienced at an emotional level, either of attraction or repugnance.

Grisez gives an example of the distinction between sensible and intelligible goods and evils:

The distinction between sensible and intelligible goods is most obvious when a choice for an intelligible good overrides emotional repugnance to a sensible evil which will be experienced by the act itself. For example, one chooses to undergo painful dental treatment for the sake of the intelligible good of healthy functioning teeth. But in undergoing the treatment one experiences pain. Unlike the intelligible evil of the loss of one's teeth, the sensible evil of pain is a positive reality. Thus sensible evils are not privations, and sensible goods are only partial aspects of the intelligible goods which fulfill a human person as a whole. (21)

The point here is that a sensible evil, such as pain, is not necessarily a 'bad'. Human beings need to be able to experience pleasure and pain for reasons of survival. Pain is as real as pleasure and is as beneficial to the human being as pleasure.

The long shot of all this is that equating pleasure with good and pain with evil simply cannot be made. Later, in the discussion of harm minimization and its association with the ethical theory of utilitarianism, it will hopefully become clearer that it is the failure to fully appreciate these relationships between good and evil, pain and pleasure that contribute to the adoption of harm minimization as a solution to substance abuse.

With all this talk about pleasure from drug use, it is worth noting that this is really a rather limited picture. Just as Dalrymple exposed the exaggeration and self-dramatization of Coleridge and De Quincey, perhaps a more realistic account of the 'pleasure' of drug use will reveal rather more decidedly unpleasant experiences than advocates would like to admit. The following account was the result for a 41 year old of using a hallucinogen, but bad trips of different types can result from any mind-altering substance.
My entire being - my soul, I suppose - began to scream in anguish, in terror, in horror. This, surely, was the worst place in the universe for a human soul to be. I can't say why or how or what this was; it doesn't translate to our consensus reality. I just know that it took me utterly and horribly. I wanted to get out of there with every fiber of my being. After what was maybe two or three minutes of this, I came to believe that I was, in fact, in hell: Hell, the real place - no red demons with pitchforks, no fire, no frozen lakes - just pure, non-stop, overwhelming, spiritual torment. And it seemed to be eternal. I believed, not in the way we think normally or have a notion, but rather as an indisputable, immutable truth in the core of my small, small self, that I had made some huge mistake in my life ...  

Besides the bad trips, the reality is that when recreational drug use turns to addiction, someone is no longer seeking pleasure or any other-worldly experience or is likely to get one. Rather, the real experience will instead be to avoid the unpleasantries of withdrawal, both physical and psychological. If there had been some pleasure in the early stages, this new reality must come as a cruel joke, a mean, seductive trick where getting back can be like climbing Everest.

**Harm Minimization and Utilitarianism**

For ethics to be able to assist in understanding what has become the most prevalent yet controversial approach to drug policy, it is essential to obtain some clear definitions.

Lacking a clear definition, the concept of harm-reduction or harm-minimization is in danger of being co-opted by persons who have very different conceptions of what harm-reduction means in terms of policies and programs. (23)

There are several problems that one initially encounters when considering what has variously been called harm minimization or harm reduction in relation to drug policies. The first is that at face value, while both terms have general appeal, they have been applied in a variety of ways and in differing contexts so that their meaning is confused, primarily because their application in the real world has led to the implementation of practices which arguably have not always reduced or minimized harm. Indeed, it could and has been argued that overall harm has never been reduced or minimized where these policies have been implemented.

Furthermore, minimizing harm is conceptually quite different to merely reducing harm. If harm is reduced by a fraction of a percent, assuming such measurements can in fact reasonably be made, then one can claim to have achieved harm reduction, but, in practice, next to nothing has changed. On the other hand, harm minimization at least sets a goal which is bringing harm to a minimum, the least it can be, whereas harm reduction is relatively meaningless, setting no articulated goals.

To confuse matters further, while the two terms have often been used interchangeably, there are also policy statements in which harm reduction has been assigned as a subset of harm minimization. Thus harm minimization has been adopted as an overall policy and harm reduction used in reference to particular treatment strategies applied only to those who are serious drug users and for whom, it is argued, there is no chance they will ever stop using drugs. Ethically this begs the question as to why we would accept merely reducing harm as sufficient for the most seriously affected people, whereas minimizing harm, a much more rigorous standard, is applied to everyone else. Could it be that lurking behind this kind of distinction is an eugenic impulse to regard some people as simply being beyond the pale, irrecoverable, and not worth the candle? Whatever the case, definitions of either harm minimization or harm reduction are difficult to construct but have nevertheless been attempted. One attempt by the Drugs and Crime Prevention Committee of the Parliament of Victoria takes the following form:

A policy or practice or strategy is harm-minimizing if it is fully reasonable to expect that it will reduce existing or future harm to the greatest degree allowable by the resources and conditions that prevail in the particular context of its application, without necessarily requiring the reduction or elimination of drug use. (24)

The last phrase of this definition appears oddly attached and unnecessary for the definition to function. One wonders whether it being there unmasks part of the meaning of harm minimization, which may be to sanction continued drug use.

It is at this point that the identification of harm minimization with the utilitarian theory of ethics can be made. Just as harm minimization is predicated upon the task of measuring outcomes rather than being based upon primary principles or long-held ethical norms or the goods constitutive of human fulfillment, utilitarianism, also known as consequentialism, likewise focuses on consequences or outcomes in its determination of the moral good. Utilitarianism is based upon Mill's observation that human beings strive to be happy by seeking pleasure and avoiding pain. As the name implies, utility or usefulness to achieve a chosen end is the key. Outcomes or consequences are what counts, not so much how one gets there. Another way of saying this is that the means are justified by the ends.

The philosopher Peter Singer describes utilitarianism/consequentialism thus:

Consequentialists start not with moral rules but with goals. They assess actions by the extent to which they further these goals. The best known, though not the only, consequentialist theory is utilitarianism. The classical utilitarian regards an action as right
if it produces as much or more of an increase in the happiness of all affected by it than any other alternative action. (25)

From a public policy point of view (as well as from the individual's point of view when making a moral choice) such utilitarian calculations are not possible unless one can objectively identify all of the relevant pleasures and pains, apply weight to each, and then perform the necessary calculations to reach the desired goal of the greatest happiness for the greatest number. For example, for heroin use this would involve identifying, weighing and appropriately balancing all of the consequences in the pleasure/pain calculus for all individuals affected.

For utilitarianism nothing is inherently wrong in and of itself, and therefore acts, which traditional ethical theories have determined to be unethical, may be justified as part of a process to achieve a good outcome.

Even if one could identify all the pleasures and pains of all individuals affected by heroin addiction (an impossible task), the fact is that they cannot be weighed up because we have no scales by which pleasures and pains can be commensurated. This attempt to commensurate the incommensurable, somewhat like adding the weight of the page to the number of words on the page and dividing that figure by the area of the page, is incoherent.

Others have contended that, in reality, utilitarianism as a modern moral philosophy is a form of justification for arbitrarily chosen acts. As one bioethicist puts it:

Indeed it will be argued that partisan attachments to particular moral philosophies is no basis for public policy because modern moral philosophy is in disarray, that modern moral philosophers "offer a rhetoric which serves to conceal behind the masks of morality what are in fact the preferences of arbitrary will and desire." (26)

When it comes to drug policies that are founded upon utilitarianism as expressed in harm minimization, the argument is that since drug use is pleasurable and not inherently harmful, some sort of pleasure versus pain calculus can be carried out that allows the development of policies that minimize the overall harms, the majority of which arise, it is argued, from the policies of prohibition. More precisely, as noted earlier, harm minimization in practice takes the pleasure or benefit component of drug use for granted and weighs harms against each other in the belief that the overall outcome will be better. But no such calculation can be undertaken, especially since many harms simply cannot be measured in a way that allows them to be balanced one against another.

In the scientific era there is a particular risk when it comes to measuring outcomes. That risk has arisen in the context of applying the scientific method to fields in which there are complex human behaviours and complex causes. Scientific analysis in the field of substance abuse needs both very careful structuring and implementation and even greater care when it comes to interpreting the results, for there are many filters applied to the data, including ideological ones.

The humanist trust in reason and science allows the abstraction of moral problems from their full human context. The solving of moral problems becomes a technical construct in which full credibility is given to the pretence that all relevant factors may be identified and in some way scientifically quantified. (27)

This trust in the application of the scientific method to complex drug policy questions which have important ethical aspects is associated with an attraction to utilitarianism.

Utilitarianism is attractive to those minds which reflect these assumptions because it appears to be 'scientific', 'rational', and 'certain'. It appears to offer a scientifically safe method of computing morally good acts while at the same time appealing to the pragmatism of scientific elites who identify the public interest with the successful outcomes of their scientific protocols. (28)

Thus many of the studies that assess the efficacy of needle exchange facilities, for example, do so by measuring certain parameters in abstraction from the complex human behaviours that result from their implementation. Some of those behaviours may include practices that contribute to the use of drugs by others who may previously have avoided them, but an analysis of such a possibility would be extremely difficult to carry out. In a recent US Surgeon General's Review on needle exchange facilities it was categorically stated that "syringe exchange programs ... do not encourage the use of illegal drugs". (29) One wonders whether this refers to participants or the wider community, whether it was a conclusion based on lack of evidence, how diligently the researchers went looking for evidence and how in practice the data was collected, compiled, analyzed and interpreted.

Likewise, a medically supervised safe injecting facility might claim to be successful by calculating the number of overdose emergencies it has successfully managed which might be claimed to have otherwise resulted in death, but it cannot effectively measure the impact the safe injecting room has had on the ability of individuals to seek treatment to be free from their addiction. So whilst harm minimization purports to take into account, within reason, all factors that might contribute to
harm, in reality the process is very selective and leaves out of policy deliberations important and potentially serious harm that can come to individuals and the community. One example would be where the harm of addiction itself remains or even increases in severity in treatments like methadone or heroin maintenance.

Conclusion

All deliberations about drug policies are founded upon one ethic or another, claims to the contrary notwithstanding. While little has been said here about what ethic they should be established upon, it can be argued that much better can be done than harm minimization founded upon utilitarianism.

What utilitarianism really fails to do is to provide either an account of humanity’s desires to promote its best and highest ideals or to provide a solid touchstone that will not shift with the tides of arbitrary preference and desire. It fails to acknowledge that humans dream of the best they can be and then strive for it. Harm minimisation, by being grounded upon utilitarianism, suffers the same basic shortcoming. It cannot provide an account of what is really the best for human beings who have been trapped in the conundrum of addiction, nor can it provide a vision for a way out to a much better existence. In some respects it amounts to a council of despair inasmuch as many of its policies represent an abandonment of people to their addiction.

The best drug policies need to be built upon the basic values that contribute to the circumstances in which human beings can truly flourish. These basic values include things like social interaction, knowledge, trust, health, safety, play, freedom, reason, integrity, courage, wisdom, authenticity, equity and substantive fairness. These values are real, never mutually exclusive and, to varying degrees, attainable. They are really worth aiming for. And while reality is messy, complicated and imperfect, the best that can be done should be the best that can be done. Harm minimization fails on many grounds, but perhaps its primary failure is the failure to recognise that aiming for less guarantees less.

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References

1. The terms ethics and morals will be used approximately interchangeably.


3. Ibid. 4.


5. Obvious examples arise in personal sexual ethics; for example, adultery is generally morally proscribed by the majority of the community, but in modern societies the law has retreated almost entirely.

6. Mill J S. On liberty. New York: Rowman and Littlefield; 2005. Mill can also be quoted thus: “No person is an entirely isolated being; it is impossible for a person to do anything seriously or permanently hurtful to himself without injuring at least to his near connections, and often far to his next degree.” And, “if he deteriorates his bodily or mental faculties, he not only brings evil upon all who depended upon him for any portion of their happiness, but disqualifies himself for rendering the services which he owes to his fellow creatures generally, perhaps becomes a burden on their affection or benevolence; and if such conduct were very frequent hardly any offense that is committed would detract more from the general sum of good.”

7. The term ‘recreational’ is used here with caution and only in deference to its popularity in public debates about drug abuse. In fact, the term is quite inappropriate in reference to abusing drugs. The Collins dictionary defines recreation as “refreshment of health or spirits by relaxation or enjoyment” which, by linking recreation to health, excludes drugs of abuse.


10. For example, the Golden Rule – “Do unto others as you would have them do unto you”, Jesus, Matthew 7:12.

12. Ibid. 65.


17. Summa Theologiae, la liae. 34 a. 1.


19. Ibid. 117.

20. Ibid. 119.

21. Ibid. 120.


28. Ibid.


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Abstract:

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 various countries. The text takes extracts from or synopses of papers presented by various writers on both sides of the argument. As the scope of a historical review of Harm Reduction - over several decades and across several countries - is necessarily large, this paper is presented in 3 parts. Part 1 examines the developments in the USA; whilst Part 2 looks at Britain, Canada, and Australia. Part 3 considers mainland Europe, and then goes on to explore reasons why the package called 'Harm Reduction' has fared better than 'Responsible Use' as well as 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

7. Europe

Because much of the public’s debate about harm reduction and liberalisation is centred on the USA, UK, Canada and Australia, one could be forgiven for thinking that mainland Europe is not engaged with this struggle. Far from it.

Of course Holland and Switzerland have had their share of the spotlight, but other countries can show much from which to learn. Baltic country Lithuania is unique in Europe in refusing to use the term 'Harm Reduction' in its documents; it has an excellent support network for problem users and helps them limit harms from their use, but Lithuania does not want to embrace any notion or terminology continuing the hidden agenda of drug liberalisation. Neighbouring country Latvia has a prevention centre in its capital Riga that would be the envy of any country.

But of all the countries in this region it is Sweden that has the most admirable prevention-based strategy. Having actually tried an acquiescent policy after World War II focused on a growing amphetamine problem, Sweden found the Harm Reduction cure to be worse than the disease and switched to a restrictive approach thereafter. Today, Sweden has the lowest prevalence of drug use in Europe and has several commendable prevention programmes in its array. Treatment centres are either voluntary or mandatory, and results are roughly the same from both.

To be Seen as ‘Normal’ is All We Ask

British pro-drug activists were never slow to promote their wares in the export marketplace: the European Movement for the Normalisation of Drug Policy (EMNDP) had its first meeting in Swindon, England, in 1989, but the Merseyside dope disciples (O'Hare and company) were more ambitious (or perhaps more encouraged) to head for the USA the year before that. They found themselves feted by libertarians 'in the street and on the Hill'. Amongst those on this promotional trip was Pat O'Hare, now Director of the International Harm Reduction Association. O'Hare and colleagues presented a paper with the innocuous title of 'Drug Education, a Basis for Reform' to a Maryland conference convened by a relatively new organisation called the Drug Policy Foundation, about which we now know a little more! Thanks to the late, great Otto Moulton whose vast library is now established in Drug Free America Foundation, there is a library tape of what was actually said by O'Hare and his companion Ian Clements at that conference; it bears little relationship to the written paper. O'Hare told his largely American audience that ‘England has absolutely nothing to learn from America’ and added that ‘...this 12-step rubbish is absolute cr*p’. One member of the audience made so bold as to ask O'Hare, ‘What are the 12-steps?’ ‘I don’t know,’ he responded (but he did know they were ‘absolute cr*p’). He then invited his audience to consider the notion that:

If kids can't have fun with drugs when they're kids, when can they have fun with them?

O'Hare was demonstrating that when it comes to radicalism, we Brits can show the former colonies a thing or two.
One milestone on the Harm Reduction road was the establishment of European Cities on Drug Policy (ECDP). Their first International Conference was held in 1990 in the German city of Frankfurt and produced the so-called Frankfurt Resolution, calling for heroin distribution to addicts, decriminalisation of cannabis and the provision of shooting galleries. It initiated a recruiting drive, and one of its first disciples was Scotland, much to the disgust of Scottish prevention colleagues. According to Glasgow’s Families For Change organiser Maxie Richards, ‘... harm reduction has become a vested interest of the Social Service industry, and with only one purpose: keeping social peace at the cost of dispensing drugs’.

European Cities Work in Harmony

In 1994 Stockholm, Sweden, saw the first meeting of what was to become a major vehicle in harmonising European drug policy at the city level, promoting good practice in prevention and resisting the pressures from those who favoured legalisation. ECAD (European Cities Against Drugs) membership comprises mayors of European cities, and to date more than 250 cities have joined. The organisation runs regular international conferences as well as projects involving member countries in cooperative ventures. ECAD has an Advisory Board with members from Turkey, Russia, Lithuania, Poland, Sweden, Finland, Iceland, Ireland, Bulgaria and Norway. Until his death in 2003, London city alderman Peter Rigby was a key activist.

In 2003 Dr. Kerstin Kall, Chief Medical Officer of the addiction clinic at Linkoping University Hospital in Sweden, produced a very useful, dispassionate appraisal of Harm Reduction in comparison with other interventions. She noted that Estonia has the fastest spread rate for HIV, with other former Soviet states not far behind. In the face of this concern, WHO and UNAIDS have rated work against HIV above work against drugs. Current suggestions by some that drug penalties should be relaxed in order to ‘solicit’ attendance at HIV clinics are dubious, Kall feels. Needle exchanges did partly slow HIV spread – but greater effect could be observed from other medical interventions, coupled with public health education on the themes of ‘Don’t inject/don’t share/boil your works/use condoms’. Needle exchanges are not observed to be as effective as testing and counselling. The idea that illegality of a drug deters visits to clinics is a myth. Equally, downgrading policy as a scheme to elicit greater use of Harm Reduction is seen to be extremely debatable – the ‘road paved with good intentions’ leads to its usual destination.

A Threat or a Promise?

At an ECAD conference in Reykjavik, Iceland, in April 2002, former Swedish MEP MaLou Lindholm gave a most perceptive paper on the workings of the EU. Her theme was, ‘Is EU a threat to or a possibility for a restrictive drug policy?’ The following is an extract from her paper:

All the member states of the European Union (EU) have signed the UN conventions on drugs and doing so have committed themselves to act for a humane restrictive drug policy in accordance with these conventions. Drug policy is not a competence area for the EU since it is a part of the third pillar, where EU has no right to formulate any binding laws or directives. Every country is independent and the national parliaments are to decide in democratic order. But the EU has big indirect impact on drug policies in its member states through recommendations, agreements, financial support, through laws and directives in other political areas.

If the EU and its bodies (the European Parliament (EP), the Commission (Com), the Council of Ministers and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) strongly supported and worked to implement the UN conventions and the UNGASS declaration, the EU could play a positive role for a restrictive drug policy in Europe and in the world.

Sadly, this is not the case! It is almost impossible to find any written or pronounced support from the EU Commission, the EP or the EMCDDA for the UN conventions on drugs. On the contrary, direct and indirect support is given to the Harm Reduction policy and projects. By this the EU helps to undermine the UN conventions and a restrictive drug policy.

A look at the political groups in the EP shows the same pattern as in most member states. The most drug liberal political groups are the Radicals followed by the Social Democrats (Labour), the Greens, the Leftwing and the Liberals. The Conservatives and the Christian Democrats support a restrictive drug policy. However, it is important to notice that there is no consensus in any political group, except from the Radicals who are all in favour of the liberalisation of drugs.

The main body of Radicals in EP consists of members of the Italian TransNational Radical Party (TRP) which focuses on the liberalisation of illicit drugs. The TRP as well as other drug liberal MEPs takes every opportunity in the EP to write drug liberal amendments to reports from different committees. The amendments and speeches support efforts for decriminalisation and liberalisation of cannabis and reconsideration of the UN conventions on illicit drugs.

The drug liberal organisation CORA (Radical Antiprohibitionist Coordination) associated with the TRP has, thanks to some MEPs, its office inside the building of the EU
Parliament. This makes it possible for CORA and its members to operate and lobby the politicians directly and also to be updated on what is the agenda in the different committees. They can, and do, organise meetings and conferences inside the Parliament. They can, without any charges, use the phone, fax and internet of the Parliament. The EU taxpayers pay the bill!

A major problem in the EU, as well as in national parliaments, is that politicians in general have almost no drug-political knowledge. Their ignorance can be partly excused since it is mostly due to the fact that they are dealing with other political areas. But too often it is also a result of lacking interest, which is worrying; as a result they easily fall victim to drug liberal or harm reduction lobbyists.

The EU funds many projects in the field of drugs. A majority are projects promoting Harm Reduction, very few promoting a restrictive drug policy. For instance, ECAD (European Cities Against Drugs), a network of more than 260 European cities who support the UN conventions and work for a restrictive drug policy, has twice applied for funding – and twice been rejected. In contrast, the organisation ECDP (European Cities on Drug Policy), consisting of only approximately 30 cities which have signed the Frankfurt Declaration and work for harm reduction and decriminalisation of cannabis, has received funding for many years from the EU. To summarise: the EU is probably one of the main threats to a humane, restrictive drug policy.

It is quite possible that a new drug-liberal Resolution might be proposed to the EP. It would have a heavy political impact if the EP nations supported a ‘European Cannabis Policy’ and a review of the UN conventions on illicit drugs in a more ‘pragmatic’ way.

In the Council of Europe (COE) with its 43 member states, an attempt was made in January 2002 to have the drug liberal report by British MP Paul Flynn adopted. If it had been adopted, it would have had big political impact – and it almost was. But just before voting, the majority of politicians were convinced that adopting the Flynn report would be a huge mistake, contravening as it did both the UN conventions and the international agreements which their countries had signed. The Flynn report was rejected.

In fact, it is now known that a Harm Reduction Convention is being drawn up (2006/7) for submission to the European Parliament – and it has already achieved some sympathy with some key players.

**Semantics in Drug Policy**

One outcome of the much greater funding which libertarian entities enjoy is their greater output of writing/s embracing their beliefs. Several professed ‘overviewers’ speak of the ‘great weight of argument for Harm Reduction’ – without acknowledging that this greater weight derives from much greater disposable income allowing a greater tonnage of paper to be churned out.

Frequent allegations are made against Prevention-based entities, accusing them of flowery language, whilst turning a blind eye to their own. Giancarlo Arnao, founder member of the IAL (International Antiprohibition League), has even gone so far as to publish a paper on the topic. (25) He directs his fire against the UN, accusing them of having ‘a semantic system which evinces a tautology’. Say no more!

He starts by criticising people for using the word ‘narcotics’ when they mean drugs in general – and he has a point there. He then objects to the word ‘abuse’ as too stigmatising for use of illegal drugs and the word ‘addiction’ similarly stigmatising compared to ‘dependence’. Arnao concludes by examining what he calls ‘The Semantics of the Single Convention’, asserting that the UN has been willfully drafted in perjorative terms – but he produces no evidence of the ‘dirty work at the crossroads’ he alleges.

In truth, the greater credit for ‘semantics skills’ management must be awarded to the libertarian tendency; they have consistently outmanoeuvred the opposition by clever use of words. For instance:

- **Soft Drugs** – a brilliant nomenclature implanting the notion of relative harmlessness

- **Medical Use** – better defined as ‘medical excuse’ when speaking of raw (as-grown) cannabis ingested by smoking; two respects in which medical authorities reject the notion (not to be confused with pharmaceutically prepared cannabinoid extracts which are ingested by oral sprays or similar and for which there is emerging promise of medicinal use)

- **Recreational Use** – a term normally applied to healthy hobbies and interests and having no relevance to the use of illegal substances

- **Ecstasy** – one of several slick marketing names by suppliers

- **Harm Reduction** – replacing the earlier term ‘Responsible Use’ which was more open to criticism by non-users (Who can gainsay ‘reducing harm’? Many do gainsay it when the definition of ‘harm’ is narrow and self-serving.)
Prohibition – a mental trigger term implanting the idea that prevention of the use of illegal drugs is equal to the US alcohol policy in the 1920s (This term conjures up an image of a policy that was doubly ‘bad’ – firstly, because it denied folk a drink, and secondly and worse, it was American and thus useful for libertarians who frequently use anti-American slurs to discredit any prevention-based approach.)

The real purpose of using the word ‘prohibition’ is to generate a meme (a mental trigger, as described in the section entitled ‘Dangerous Liaisons’ in this paper). A study by Robert Peterson (1) examines whether the usual mental triggers caused by use of the word ‘prohibition’ are justified. Peterson says:

Did prohibition fail? Surprisingly, from a health and economic perspective, prohibition accomplished its goal, saving America both money and lives. Even though alcohol use was not illegal, prohibition significantly lowered alcohol consumption, whilst cirrhosis deaths were cut by over a third, and alcohol psychosis fell dramatically. Even with gangster killings, the overall murder rate declined. From 1905 to 1990 the murder rate rose 300%; during the prohibition period, 1918-1929, it only rose 30%; subsequent to prohibition, the murder rate accelerated again. Arguments against prohibition are clearly based more on public opinion and social consensus than on economic or health data. Since the repeal of prohibition, alcohol consumption has tripled. Alcohol is also strongly linked (together with illicit drugs) to violent and property crimes. The real lesson of prohibition is not whether society should absorb either the heavy cost of legal alcohol or the heavy cost of legal street drugs; it is whether society can tolerate multiplying the cost of legal alcohol by legalising other drugs. From an economic, health or legal perspective no justification for legalisation can be made.

The Pursuit of Happiness, German Style

Bremen, Germany, does not automatically spring to mind in the context of pro-drug campaigning, but it undoubtedly has a dedicated campaigner in Professor Dr. Lorenz Bollinger. In 1994 he was the editor of a book with the cosy little title of ‘De-Americanizing Drug Policy’ (27). The book was a compendium of arguments for liberalisation, and it came out of a conference the previous year which Dr. Bollinger also hosted in Bremen’s Institute of Drug Research (BiSDRO). The conference attracted not a few familiar names – Peter Cohen (Amsterdam), Diane Gordon (New York), Mario Lap (Amsterdam), John Morgan (New York), Ethan Nadelmann (New York), Freek Polack (Amsterdam), Craig Reinerman (California) and Lyn Zimmer (New York).

Bollinger's own contribution to the conference centred on his paranoia that all drug control policies have a hidden agenda. By this premise, they are designed either to give one nation control over another (with the USA fingered as the main blackguards) or to give enforcement agencies the tools to socially control target groups – in effect imposing a ‘police state’. In contrast with such oppressive nations/people, liberalisers are the ‘good guys’. One’s view, as ever, depends upon where one stands.

The conference book opens with a suitably-emoted dedication:

These pages are dedicated to all those who, in the pursuit of happiness, have obtained and consumed certain substances defined as illegal and thereby got miserably entangled, detained and stigmatized by the criminal justice system.

Bollinger Spills the Beans

It is only seldom that the operational system for promoting and advancing Harm Reduction is honestly described. The Hanf-Magazin (Hemp Magazine), which provides grass-roots information, published an article by Dr. Lorenz Bollinger (28) in its August 1998 issue. Bollinger is not only co-director of BiSDRO, he is also a Professor for Criminal Law and Criminology at Bremen University, a qualified psychologist and psychoanalyst. Faced with a ‘significant change’ in the attitudes amongst the expanding body of drug proponents and protected against prosecution for criminal offences by informal agreements with local and regional criminal authorities, the following article by Bollinger displays an understanding of the law that is more in keeping with that of a dealer than a lawyer.

What Bollinger understands by grass-roots movements is, for instance, the illegal setting up of the ‘shooting gallery’ by ‘aksept eV’ in Bremen. The aim of this deliberate violation of the law was to push for a legal decision at what is seen as an ‘opportune moment’ - because several penologists had already spoken out against taking legal measures against ‘shooting galleries’. Bollinger unmistakably calls a spade a spade:

In my opinion, the only viable strategy is one of slow erosion... by the taking of small steps towards definite decriminalisation, practicable solutions pertaining to administrative law and the law regulating public health need to be found which are unobtrusive because they are unrelated to criminal law. Such examples are the medical prescription of cannabis, models of drug distribution by chemists or heroin rations ..., the toleration of ‘Coffee Shops', shooting galleries or drug-checking, certain permissible violations of the laws, aggressive information campaigns in schools and elsewhere, grass-roots organisations.
Ich Bin ein Frankfurter

US libertarian Ethan Nadelmann clearly has a generous travelling budget; he can be seen around the globe. For example, in 1997 he peddled his American-derived, Soros-financed philosophy at a conference in Frankfurt, Germany. (29) Ethan was obviously in rumbustious form. There was disagreement in the US, he said: ‘disagreement as to which aspect of the war on drugs was most disgraceful’. But there was, he said, agreement: that ‘you could blame illegality of drugs for almost all the ills the nation suffers’.

Proponents of restrictive drug policies often cited the 60% reduction in drug use between 1980 and 1992. Nadelmann said you can’t count that because the ‘War on Drugs’ didn’t start until 1986 (In fact, it started a good deal sooner with the parent movement rather than the government deserving the credit, having mobilised thousands of parents from the late 1970s onwards). Moreover, says Nadelmann, it was a poor outcome because it only affected the middle classes (No evidence is given to support this charge).

Most people don’t harm themselves in using drugs – his next point (But they do harm a lot of other people around them). Drugs won’t go away, he says (But the prevalence can be significantly reduced, evidence shows – both in relation to illegal drugs and, notably, to tobacco).

Methadone, says Nadelmann, is to heroin as nicotine patches are to smokers (The comparison is shaky; no deaths have been reported from use of nicotine patches. And the fact is that patches are used as a stepping stone to cessation of smoking. Far too often these days, methadone is seen as the permanent stopping place for users).

According to Nadelmann, who seemed to stray further from the middle of the road with every step, the government is to blame for crack cocaine through their unwillingness to agree to cocaine legalisation, just as they were guilty of provoking the making of ‘moonshine’ by prohibiting regular booze. In Ethan’s eyes, the Dutch are the true pathfinders of drug policy – a nation where ‘pragmatism’ counts for more than ‘moralism’. This conference was seemingly not the place to whisper the suggestion that a pragmatic policy does not have to axiomatically abandon morality – or vice versa – but then Nadelmann would not have heard it anyway, he was in full flight, heading for his Promised Land.

Some Final Thoughts on European Matters

This paper need not take space in repeating the developments in Switzerland, since most readers will be familiar with that disaster area - an avalanche of Harm Reduction. When looking for the reasons why Switzerland has gone downhill in the avalanche, one explanation may lie in the fact that the director of the so-called ‘Swiss Experiment’ of heroin prescription and assisted injection sites also happened to be the President of the Swiss branch of the International Anti-prohibition League.

Similarly, readers of this Journal can be assumed to know a good deal about the Netherlands. Their particular brand of Harm Reduction was visible for many years before drugs became the issue and cannabis cafes opened. Holland is also liberal in its approach to pornography and to the age at which sexual activity is legal (12 years of age). In the late 50s, this writer can remember walking in astonishment along Canal Street in Amsterdam, looking at brightly lit and decorated shop windows in which the ‘Item for Sale’ was not a washing machine; it was a human being. There were, it was said, ‘Harm Reduction’ procedures in place – condoms on the bedside table, regular health inspections for the ‘service provider’, and so on.

George Soros does not neglect Europe; in recent years Soros has placed some of his support and resources behind new organisations in Europe. The Soros-funded ‘Forward Thinking on Drugs’ group had a familiar figure on the bridge: Mike Trace, the disgraced UK ex-Deputy Drugs Tsar. Subsequently, another international libertarian body was created with Soros support - the Beckley Foundation, based in London. And its head? Mike Trace.

8. Taking Stock: Where Are We Now?

Definitely not where we want to be, that much is certain. Through a ‘combination of strong adversaries and weak friends’ (quoting Emperor Cicero - 106 to 43 BC), one can see the Harm Reduction Movement has already reached critical mass in several countries. Australia has taken Harm Reduction as the touchstone of its education, whilst in England many, perhaps most schools are adopting a Harm Reduction approach within their education, and the libertarian elite are well entrenched in the Education ministry’s corridors. A self-appointed and exclusive pressure group of educationists and related disciplines, the Drug Education Forum (based and serviced for most of its life in the DrugScope’s offices) seems curiously able to protagonise with impunity - a philosophy which effectively neuters prevention in our schools.

Prevention workers did their best to alert and galvanise those in control, and during his term of office they had several meetings with Keith Hellawell. But even a senior advisor like Keith, with all the experience of being a Chief Constable to stiffen him, found that changing the direction of our government officials was like boxing with cotton wool. It is small comfort – in fact no comfort at all - for colleagues such as those in Australia to say that the situation is even worse there and has been for at least a decade, with Harm Reduction education being the mandatory norm and cannabis decriminalisation a fact of life in some areas. This just paints a depressing picture of what the future might hold for other countries if prevention workers continue to be pushed aside.
9. How Did We Get Into This Mess?

Are the cuckoos in charge of the nest? It is a known fact of avian life that cuckoos, once in the nest, push everyone else out – hence one English language metaphor derived from the word ‘cuckoo’. The other common metaphor for ‘cuckoo’ is, quite simply, someone who is ‘not too tightly wrapped’.

George Soros seemingly recognises the first metaphor. In advancing his Open Society (which might be more accurately defined as a Half-Open Society), he does his best to see that his half of any argument has the major share of the resources. This determination even extended in 2004 to his funding Democrats to ‘cuckoo’ George Bush out of his White House nest.

There is, in truth, no shortage of cuckoos. Many people in a wide variety of fields are currently expressing concerns about the bizarre drift which is carrying Britain along in 2007. For example, over the last 12 months or so, the British national press has reported the following gems in the ‘Human Rights’ sector:

- Police declining to publish pictures of escaped murderers in case this infringed their Human Rights
- Health professionals suggesting self-mutilators should be given clean blades and helped by nursing assistants to cut themselves
- UK drug workers voting in favour of being drug users themselves, if they want
- National Lottery refusal of funding to lifeboats because they were not rescuing enough ethnic minority people
- Forestry Commission launching new recruiting campaign to encourage more gays to become lumberjacks

Prevention workers are always at the mercy of the cuckoos. The opposing forces, given the combined effect of their greater financial and personnel resources plus the majority Libertarian tendency in the media, have made the playing field so tilted and so slippery that ascent by prevention advocates is nigh on impossible.

The media tilt is very significant. It always used to be the case that British Prime Minister Blair, faced with a difficult issue, would ask, “What does the Mail say about this?” The counter-attack by libertarians has therefore been to steadily assassinate the character of the Mail. This contrasts with some years ago when it used to be the Guardian that was the whipping boy. Neither extreme attack was justified; the centre ground is, as ever, where a balanced view is more likely to be found.

A common thread in the libertarian media is to characterise prevention as punitive and oppressive of Human Rights. Neither is true, and the latter is particularly unbalanced in that it speaks only to the Human Rights of the drug user. The Human Rights of all those around the user – up to and including society as a whole – are not even entered, let alone entertained in this rhetoric.

What, then, is needed to produce balance? A much greater exposure of prevention for the health promotion value it embodies, a large reduction in the ‘Human Rights’ hyperbole, a rational approach to harm reduction which has cessation and abstinence as its ultimate goal and a balanced recognition of the Human Rights of all concerned – which of course includes the users. Cuckoos, too, deserve their share - but no more than that.

What Fertilised the Growth of Harm Reduction, the Ebb of Prevention?

In reflecting on the development of Harm Reduction, one stark contrast emerges. How was it that there are two virtually identical philosophies: one from only 20 years ago, operating under the title of ‘Responsible Use’ was quickly identified as ‘The Emperor’s New Clothes’ and kicked out, and yet here we are now, faced with Harm Reduction deeply embedded, its tentacles reaching everywhere – even into government? What caused the difference?

If readers of this Journal were to be asked to come up with one word as an explanation of the difference, that word would probably be ‘Soros’. In one sense they would be right; the money that he has injected into the libertarian movement, compared to that which Prevention workers can marshal, is like attacking their artillery with our cavalry. We British tried that once; it was heroic but futile.

A deeper explanation of why Harm Reduction flourished where Responsible Use failed in the push for liberalisation may lie elsewhere.

It was in the 1960s both in the UK and in the US that a sea change in educational approaches really took hold; morals-based education gave way to individual rights. Apparently disparate subjects such as reading, mathematics, history, geography and religious education fell victim to the excesses of an overheated individual rights approach in which some pupils could even decide whether to participate in classes or not. It goes without saying that lifestyle subjects such as sex education, drugs education and personal/social education would be swept along at the front of this wave.

One book which explores this phenomenon in more depth is called The Great Disruption by Francis Fukuyama. (30) Fukuyama concludes that there has been a major paradigm shift. Who created that shift?
It could be that the answer lies in a process known as Values Clarification, also associated with Outcome-Based Education. This concept originated in Wisconsin, USA, in the 1970s under the leadership of a man whom most people regard as one of the fathers of psychotherapy – Carl Rogers, together with Professor Sidney Simon and psychologist William Coulson. Rogers started with a very laudable concept, i.e., that pupils should be facilitated to discover and thus reach consensus on values which are beneficial to society. Sadly, within a short time the concept was diverted into one in which pupils were facilitated to discover values which were beneficial to them as individuals. External constraints were to be viewed as obstacles to the individual’s ‘Self-Actualisation’ – as Abraham Maslow, a contemporary of Rogers, termed it. Thus, the notion was advanced that:

... children should be left to create their own autonomous world, and that adults would be anti-democratic if they tried to pass their values to their children.

This was echoed by co-author Sidney Simon in the statement:

...the school must not be allowed to continue fostering the immorality of morality. An entirely different set of values must be nourished.

Similar approaches were observed in Gestalt-based education practices in Switzerland. A typical guiding assertion was that “Morals are regarded as obstacles which hinder the development of ‘my authentic self’, and the teacher has no right to impose his sense of values about what is right or wrong”. In Australia, classroom techniques resembling group therapy were deployed to produce changes in children’s attitudes and behaviour and challenge their previously held values.

Carl Rogers eventually expressed his own concern about the monster he had created, referring to it as ‘this damned thing’ and wondering, ‘Did I start something that is in some fundamental way mistaken, and will lead us off into paths that we will regret?’ But by then the wave had swept things beyond his reach. Britain now has a Journal of Values Education which invites school classes to discuss such questions as ‘Are drugs really bad for you?’, ‘What are the benefits and risks of drug taking?’ and ‘If adults drink alcohol why should I not take Ecstasy?’

Study of the Values Clarification process (31) and related movements helps explain how we have reached where we are today and why Harm Reduction has taken root when Responsible Use died off quickly after a first flourish of growth, having fallen on stony ground.

But one cannot blame Carl Rogers for everything that has happened in the last 20 to 30 years, anymore than one can blame George Soros. One is an idealist and the other an opportunist, but they both sowed seeds in grounds which we ourselves have made fertile.

External factors across and within society have, by their confluence, are some of the causal forces creating fertile ground for societal change. Emancipation of the young, their greater disposable income, disempowerment of traditional authority (including parents and teachers), a more materialistic society and a ‘me first’ outlook, dismantling of ‘community’, the highlighting of ‘personal rights’ at the same time as the downplaying of ‘responsibilities’, effects of structural unemployment and the need for a more mobile workforce (this last factor adding to the breakdown of the nuclear family) are some of the causal forces creating a ripeness for such societal change. The ‘contribution’ of the professions in being part of the problem rather than part of the solution is a major influence, as Professor Norman Dennis (32) makes clear. One could say more, but the picture is already clear...

The results can now be seen in undisciplined classrooms, in a police force which is perceived as sometimes more ready to arrest victims than criminals in order to reduce the harm to the latter, in drug workers campaigning to free colleagues who have apparently allowed drug dealing to be pursued on their premises and in Education Authorities that will not allow school nurses to issue Aspirin or Paracetamol for fear of a negative reaction but are receptive to the idea of issuing ‘morning after pills’ to young girls without their parents’ knowledge.

Harm Reduction is no more than an extension of this much deeper and wider cultural shift. Addressing only Harm Reduction in seeking to strengthen our society against structural collapse is an over-simplification that could prove disastrous.

10. What Should Be Our Rational Response?

This paper is focused on history - on yesterday and today rather than tomorrow – nevertheless, some indication of possible future options learnt from history may be in order. Sample initiatives include the following:

- Become more pro-active, more guided by structural planning, less preoccupied with responding to what ‘the Other Side’ does

- Continue doing what you are doing, but get better at it
Improve your international networking and cooperation (How many hundreds of signatures have you collected in support of the ITFSDP Resolution, first tabled at the conference in Brussels in February 2005 and addressing what is known as 'so-called Harm Reduction'?)

Find the prevention-funding equivalent of George Soros

Study and learn from the processes that have brought us to where we are today (This paper attempts to contribute to that understanding.) In this context, a studious read of the full paper by Michael J Ard (13) could be a good use of your time.

Keep up with the changes – this arena is volatile, not static. For example, even as this paper was being put to bed, a British national newspaper (Independent, 10 April 2007) ran a feature arguing that Afghanistan’s poppy crop should be purchased outright by Western nations such as Britain and the US which, they argued, would cut off the opium flow to Europe at a stroke, undermine the Taliban and correct a current shortfall in supply of opium for Western nations' medical purposes. (A broadly similar proposal a few weeks before this by SENLIS was enough to provoke the Afghan government into closing the SENLIS office in Kabul) This writer suggests that an appropriate name for such a project would be 'Poppycock'.

Recognise that there is a place for some methods of reducing harms from drug use, but that place is downstream of onset of use – a part of the treatment process, always open to assessment and practice review and always with the eventual goal of abstinence.

Learn from the comparisons between preventive policies and Harm Reduction. Dr Lucy Sullivan gives an exemplary report (33) of the comparison between Sweden and Australia.

Understand that the Media are not just passive observers – they contribute to social and cultural change through what they choose to write in their columns and editorials, what the adverts show, what they say on TV, radio and movies and what they write in their blogs and websites. It is incumbent on all of us to make relationships with the media and make them not just listen to our views, but use them.

You will not like every media contact you make, but that is less important than their liking your story. In the early days of the New York Times, they posted a motto ‘All the news that’s fit to print’. In our present age the rock mag Rolling Stone parodies this by offering ‘All the news that fits’ – i.e., if it doesn’t fit with their prejudices, it won’t get onto the page. Don’t be put off – try them anyway and all the others.

Create your own memes!

It has been said that those who do not learn from history are condemned to repeat it. American judge and educationalist Robert H. Bork might have been thinking about the history of so-called Harm Reduction when he wrote:

One of the uses of history is to free us from a falsely imagined past. The less we know of how ideas actually took root and grew, the more apt we are to accept them unquestioningly, as inevitable features of the world in which we move.
11. And in Conclusion ...

Society exists and expands through the building of structures. Some structures are physical – the concern of architects and engineers. Others are organisational or behavioural – the concern of a very diverse range of people. Structures are known to sometimes over-stress or even collapse if the stress is great enough. In the case of drug misuse (or abuse), our society today can be seen to be severely stressed – but there is no structural unity in our remedial works. For some participants this is quite intentional, whilst for others it is no more than ‘unintended consequence’.

By studying the provenance and practice of harm reduction, as encouraged by this paper, it is possible to identify more clearly what best to do to achieve more unity in our response and to generate consequences that are ‘intended’ rather than accidental.

Perhaps the single most seminal point this writer can offer in concluding this paper is that all behaviours – including abuse of drugs – are influenced by the ‘culture’ that surrounds them. This is, in effect, the confluence of the many and varied factors around drug abuse and misuse.

Some cultural factors like health awareness and morality are society-wide. Others are mostly confined to specific groups – youth, adult, employers, leisure, sports, arts, advertising, music and so on. This writer took an earlier ‘sounding’ of these cultural aspects in his paper (34) to the Fifth International Drug Prevention Conference in Rome (2003).

Clearly, many of these factors range widely and are independent of specific behaviours like drug abuse/misuse. It is therefore essential that anyone seeking to influence drug policy is alive to these important external factors.

The topic of this paper was the ‘history’ of Harm Reduction. In exploring the subject, it became apparent that there was as much ‘mystery’ as ‘history’ – or perhaps, more appropriately, ‘mysticism’ which the dictionary defines as:

A belief characterised by self-delusion or dreamy confusion of thought, especially when based on mysterious agencies
How true that seems of Harm Reduction. And some of the agencies are more mysterious than others.

Biography

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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