THINK PIECE

The lure and the loss of harm reduction in UK drug policy and practice

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Abstract

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

Introduction

In 1988, the Advisory Council on the Misuse of Drugs published the results of its enquiry into the growing problem of AIDS and HIV in the UK. Contained within the council’s “AIDS and Drug Misuse: Pt 1” report (1988), was a sentence which proved to be more influential than any other in the history of UK drug policy. That sentence identified the need for a fundamental shift in drug policy and provision as a result of the belief that the “spread of HIV is a greater danger to individual and public health than drug misuse” (ACMD 1988: 17).

In the wake of that statement, the principal priority for services working in the drugs field, as well as for drug policy more broadly, became one of reducing drug users’ risks of acquiring and spreading HIV infection.

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

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

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

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

Some 10 years, after the publication of the ACMD report the ideas and practices of harm reduction have become a key part of the “drug treatment establishment” within the UK. The UK drug strategy “Tackling Drugs to Build a Better Britain,” published in 1998, identified the importance of harm reduction within the treatment pillar of the strategy:

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

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

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

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

Nearly all DAT area (97%) have harm reduction services and 87% provide access to drug prescribing services. (Updated Drug Strategy 2002: 52)
Within these terms, there can be little doubt that the ideas of harm reduction/harm minimization have had an enormous impact on the world of drug abuse policy and treatment within the UK. What I would like to do in the remainder of this article is to ask three related questions. First, was the ACMD right in asserting that AIDS and HIV represented a greater threat to individual and public health than drug misuse? Second, how successful have we been in reducing HIV and other drug related harms within the UK? Third, whether the time is right to shift the direction of policy and provision within the drugs field in the UK from reducing the harm of continued drug use to reducing the incidence and prevalence of drug use itself?

**AIDS and HIV a greater threat than drug misuse?**

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

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

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

The figures on the prevalence of HIV infection and AIDS amongst injecting drug users contrast markedly with the prevalence estimates for problematic drug use within the UK. Within England, Frischer and colleagues used the multiple indicator method to estimate a total problem and drug injecting population in 2001 of 287,670 (Frischer et al. 2004). From Scotland, Hay and colleagues used capture recapture statistical methods to estimate the prevalence of problem drug use (defined as heroin and benzodiazepine use) in 2003 to be around 51,582 (Hay et al. 2004). From Northern Ireland McElrath estimated the prevalence of problem drug use to be of the order of 828 (McElrath 2002). On the assumption that the prevalence of problem drug use in Wales (where there is no current or recently equivalent estimate) is on a par with that in England, the overall prevalence of problem drug use in the UK as a whole may be in the region of 356,000, i.e. some 80 times greater than the number of HIV positive injecting drug users within the UK. On the basis of these figures alone it is difficult to avoid the conclusion that it is problematic drug use, not AIDS and HIV, which is having the greater impact on individual and public health within the UK.

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

Reducing drug related harm

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

HIV infection

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

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

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

Hepatitis-C

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

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

Deaths

Data on drug related deaths in the UK are collated by the Office for National Statistics. In 2001, there were a total of 235 AIDS deaths in UK and 1192 deaths amongst drug users involving heroin, cocaine or methadone (Health Statistics Quarterly 13). Between 2000 and 2004 there were a total of 5551 deaths of drug users involving heroin, cocaine or methadone (Health Statistics Quarterly 29). On the basis of these figures there is little doubt that the level of drug related mortality within the UK attributable to HIV/AIDS is only a fraction of that associated with drug misuse more broadly. Whilst there has been a decline in the number of drug related deaths in England and Wales, with the number of heroin and morphine related deaths falling from 926 in 2000 to 744 in 2004, that reduction is hardly commensurate with a successful harm reduction campaign that still leaves hundreds of drug users dying prematurely each year (ONS: 2006). Indeed, for the period 1993 to 2000 (a key period in the impact of harm reduction ideas within the UK) deaths from heroin and morphine in England and Wales actually increased from 187 in 1993 to 926 in 2000 (ONS: 2002).
Overdose and life problems

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

Homelessness

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

Dual diagnosis

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

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

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

Children of dependent drug users

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

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

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

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

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

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

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

Information on the nature and the extent of drug related offending has been provided in the UK through a range of studies including work involving interviewing and drug testing arrestees. The ADAM and the New ADAM (Arrestee Drug Abuse Monitoring) programme in the UK has provided a means of systematically measuring the proportion of arrestees using illegal drugs and the extent of the link between drug use and offending (at least that element which involves a police arrest). Holloway and colleagues have produced an overview of the results of having interviewed and drug tested over 3000 arrestees in England between 1999 and 2002. In year 1 of their research 25% of arrestees tested positive for opiates ($n = 1434$), by year 3 this figure had increased to 28%. Similarly in year 1 15% of arrestees tested positive for cocaine, whilst by 2002 this figure had increased to 23%. In terms of the link between drugs and crime the New ADAM research team were able to report a number of significant reductions in drug related offending over the study period. For example, the proportion of cocaine users reporting one or more property crimes in the last 12 months fell from 59% in year 1 to 51% in year 3, overall the proportion of arrestees reporting property crime in the last 12 months fell from 53% in year 1 to 48% in year 3. The link between drugs and crime was very evident in this research with, for example, 17% of non-drug using arrestees in year three reporting one or more property crime in the last 12 months compared to 85% of those who had used crack cocaine or heroin.

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

Discussion

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

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

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

Another reason why existing harm reduction measures may have had only modest success in reducing the level of drug related harm may have to do with the degree to which these initiatives have been able to exert control over individuals’ injecting behaviour. A good illustration here may well be the provision of sterile injecting equipment to injecting drug users. This is an initiative, which, on the face of it, should reduce the risk of drug injectors acquiring HIV and other blood borne infections. However, if a sterile needle and syringe is used in a highly un-sterile environment (for example a toilet or derelict building) to inject highly toxic substances the drug user is likely to experience serious adverse health effects irrespective of the cleanliness of the injecting equipment used. For services to be successful in further reducing the risks of continued drug injecting it may be necessary to intervene much more directly in the injecting event, for example by providing advice on injecting technique, by supervising or administering injections to naive users, by providing drug users with a setting where they can use their street drugs under some level of medical supervision and ultimately by providing drug users with the drugs which they are injecting or using by some other means. At the moment, there are no services within the UK that are developing such an intensive array of harm reduction measures although in fact anything short of such an array may well leave considerable areas of injecting risk behaviour intact and leave substantial numbers of injecting drug users experiencing a range of harms associated with their continued drug use.

Shortcomings in the quality of harm reduction work

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

A lack in the quantity of harm reduction work

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

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

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

The impossibility of eliminating drug related harm

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

Conclusions

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

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

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

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

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

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

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References

The stick, the carrot, or both? Antithetical versus complimentary approaches in drug policy

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Though this paper is not without flaws, McKeganey has addressed a critical issue, namely what have been the consequences of adopting a harm reduction paradigm in UK drug treatment services, and what implications follow from this assessment for the continuation, modification, or replacement of this policy. While drug policy is often debated, the discourse, at least in the US, tends to be more ideological than data driven, and the type of broad, retrospective, empirical policy analysis that McKeganey attempts is all too rare in the substance abuse literature.
At the risk of oversimplifying his position, McKeganey’s argument about the shortcomings of harm reduction consists of two related parts. The first is that while harm reduction was adopted to prevent the potential spread of HIV among injecting drug users and their partners, that threat was over-estimated and never emerged. The second part is that the scope of negative public health and related consequences that have flowed from the adoption of harm reduction far outweigh its benefits. While he succeeds in making a case for the first contention, his case for the second is far weaker.

As to the first part of the argument, McKeganey marshals data indicating that HIV among injecting drug users was neither as high as asserted by those who championed the adoption of needles and syringe exchange, nor did it expand over the next decade or more. McKeganey then correctly raises the question of whether the lack of expansion can be attributed to the “success of the very harm reduction measures (needle and syringe exchange, methadone maintenance programmes, and advice on safer injecting)” that were adopted. He points out, however, that this is unlikely because there has been a sharp rise in Hepatitis C associated with injecting drugs over the same period.

McKeganey also presents data to support his second point that negative consequences associated with drug use have become unacceptably high. These consequences include deaths, overdoses, homelessness, dual diagnosis, the condition of children of dependent users, and crime. His argument, however, is weakened by at least two major problems. The first is that he fails to put the data into statistical perspective. The specific nature of this problem varies by the consequence being addressed, but includes failure to transform the data into rates, inappropriate use of time periods, confounding cause and effect, and failure to compare data for negative consequences among drug users to rates in a general population. As an illustration, consider his statement that “for the period 1993 to 2000 (a key period in the impact of harm reduction ideas within the UK) deaths from heroin and morphine in England and Wales actually increased from 187 in 1993 to 926 in 2000.” This absolute increase may or may not reflect an increase in the death rate, which depends on knowing the numbers of heroin and morphine users over the same period. McKeganey might have pointed out these problems and argued that, despite the limitations of the data, what matters most is their cumulative weight, but he does not. He has also missed an opportunity to use a careful inventory of the inadequacies of the available data to demonstrate the need for collecting better data in the future so that policy questions can rest on better empirical evidence.

The second problem undermining McKeganey’s argument is that he cannot show that the levels of these problems would have been any different if the harm reduction had not been adopted. Perhaps things would be much worse. This criticism isn’t entirely fair, since the absence of an appropriate comparison condition makes it impossible to determine what would have happened if harm reduction had not been adopted. I do think, however, that the author should have qualified his conclusions considerably more than he has.

Over the last several years in the US, fidelity of implementation has emerged as a central independent variable in evaluating the effectiveness of drug abuse treatment and prevention. In the Discussion section of the paper, McKeganey states that little is known about the quality of harm reduction programs. He also argues that the current attempts at harm reduction might be enhanced “by providing advice on injecting technique, by supervising or administering injections to naïve users, by providing drug users with a setting where they can use their street drugs under some level of medical supervision, and ultimately by providing drug users with the drugs they are injecting”. Earlier in the paper we also learned that in Scotland, few drug-using arrestees had prior contact with a drug treatment agency,
raising the question of whether harm reduction efforts are reaching the target population. So, if harm reduction may not be implemented as intended, and new elements could be added to increase its effectiveness, why should we be so eager to abandon it rather than to improve it?

My most serious criticism of the paper is directed at the idea that addressing drug dependency and harm reduction are antithetical. While needle and syringe exchange and methadone maintenance don’t necessarily lead to abstinence for injecting drug users, they promote the involvement of these users in a system of care and monitoring that can, in the short-term, mitigate at least some negative consequences of use, and that can, in the long-term, be shifted to encourage and support their abstinence. McKeganey would be quick to point out, and I agree, that the costs of adopting this dual approach to the user are likely to be high. It is equally appropriate to ask, however, what the costs of abandoning harm reduction and focusing on drug dependency might be. The answer must be speculative, but it seems safe to say that one effect would be that far fewer injecting drug users would be inclined to enroll in or stay in treatment, and this, in turn, might exacerbate rather than reduce the very negative consequences that McKeane sees as flowing from harm reduction. Policy reform could address this danger by attempting to drive people into treatment through new law enforcement measures, but experience in the US (where this has been the dominant paradigm for drug treatment) and the UK suggest that law enforcement carries its own large economic and social costs and may not be wildly successful in getting people into treatment or keeping them there until their addiction is cured. This dilemma can be posed as the choice between treating drug use as public health problem and treating it as a legal one. Neither choice dramatically reduces drug dependence or its negative consequences. A better alternative may be to construct a system of treatment that tries to make makes use of both the carrot and the stick, shifting the balance in these approaches for different users and at different times for the same user to get and keep them involved in a treatment relationship and then move them toward abstinence. I have little idea about how to achieve this balance. We do not know, after all, much about what treatment approaches work best for different users or for the same user at different times in their drug-suing career. Nevertheless, barring some major new breakthrough in treatment methods, recognizing the need for different approaches rather than a single narrow model of any kind, seems fundamental to making treatment more effective.

I strongly agree with McKeganey’s call for a drug policy that emphasizes prevention as well as treatment. He isn’t specific about what prevention efforts should look like, or how much more prevention funding is needed. Nevertheless, preventing people from beginning use or convincing them to use substances more wisely (e.g. to avoid driving after drinking) is clearly a necessary component of effective drug policy. While the effects of enhancing prevention efforts may not be felt fully for many years, there is a growing body of research that indicates effective abstinence and harm reduction prevention programs exist. The most striking examples in the US are the long-term reductions in adult smoking and in the proportion of alcohol-related traffic fatalities and injuries.

As I did at the outset of this commentary, I want to emphasize the service that McKeganey has performed by taking on the difficult task of analysing the long-term effectiveness of a harm reduction strategy based on empirical findings rather than ideology. I hope McKeganey’s work will prompt more research on the consequences of harm reduction that will guide the improvement of drug abuse prevention and treatment policy in the UK and in the US.
How far did the pendulum really swing?

MIKE ASHTON

With admirable candour, in his article “The lure and the loss of harm reduction in UK drug policy and practice”, Professor McKeganey includes the caveats to his own arguments, but there are some I want to expand on. The key weakness is that he relies on the results of tick box exercises and statements in official reports about the priority that should be given to harm reduction to support his claim that the pendulum has swung too far from treatment and prevention. But did the pendulum really swing as decisively as he suggests in the first place? Did treatment services really close en masse and re-open as or get replaced by harm reduction services? If not, then the failures he identifies are as much failures of the ‘new’ direction he advocates (towards treatment) as of the one he questions (towards harm reduction).

Clearly, harm reduction is not a universal success. In our own magazine, we documented in detail the failure of needle exchanges to adequately control hepatitis C (Ashton 2003, 2004). But along with others (Canadian HIV/AIDS Legal Network 1999), we concluded that the “under-resourcing and marginalization of this work” had left it unable to match up to the increased scope required to control this virus compared to HIV.

Confirmation of this limited scope has come from reports on needle exchange provision in England (Abdulrahim et al. 2006) and Scotland (Griesbach et al. 2006). In the light of these new reports, it is no longer (in Professor McKeganey’s words) “difficult to accept that the level of investment within harm reduction has been so modest as to fall well short of that which would be required to bring about a major reduction in drug related harm”.

Investment clearly has been insufficient even to do the most basic thing needle exchanges are supposed to do – provide enough needles and syringes. For injectors no longer have to share purely by virtue of equipment shortages. Funding of paraphernalia supply is even more inadequate. Without these basics in place we cannot expect to control a virus so transmissible and widespread as hepatitis C.

Given these findings, the fact that the English national drugs strategy records that “Nearly all DAT areas (97%) have harm reduction services and 87% provide access to drug prescribing services” (Home Office Drug Strategy Directorate 2002) is revealed as the result of a tick box exercise, which bears little relationship to the adequacy of what happens on the ground.

And what of the other major arm of harm reduction pointed to, methadone maintenance services? That methadone services have expanded is beyond doubt. Whether, they have expanded at a greater rate than the problem they are addressing – and therefore whether they are now more or less adequate than they were – has yet to be demonstrated. Recent capture-recapture or multiple indicator estimates dominated by opiate problems (Frischer et al. 2001; Hickman et al. 2004; Millar et al. 2004; Hope et al. 2005; Hay et al. 2005; Holland et al. 2006) doggedly indicate drug treatment penetration rates (number of clients/potential clients) close to those recorded in the early 80s (Hartnoll et al. 1985), though some areas appear to be doing better (Beynon et al. 2004). Given improved monitoring
and the much greater incentive now for services and drug action teams to report users as in treatment, it is questionable whether in ‘real terms’ – in relation to the size of the problem – there has been the large expansion in methadone services, which Professor McKeganey postulates.

And even if there had been, would it be right to classify these as harm reduction services? In terms of doses (nearly two-thirds below the recommended 60 mg; Department of Health (etc.), 1999), formulations (just 1.6% of methadone is injectable ampoules), and the drugs prescribed (1% heroin; Metrebian et al. 2002), these services seem as committed to drug reduction as they do to harm reduction (Best and Campbell 2006). Services fully committed to harm reduction would be making higher doses and injectables more available, as indeed they used to. The move away from injectables is a clear sign that harm reduction objectives have become less not more salient in the decades since drug clinics were established, though in the early days the harm to be avoided was the expansion of the illicit market. In the 1980s the availability of injectable methadone prescribing in London and the role played by needle exchanges in helping their clients access it could have been the decisive factor in reducing HIV risk (Dolan et al. 1992, 1993).

In fact, British methadone services often adopt neither maintenance nor treatment/cure objectives, but some unclear mixture of the two. Not surprisingly, the doctors and nurses in them find it hard to abandon long-term cure objectives. Frustrated by the failure of English methadone services either to commit to treatment or to harm reduction, Gossop et al. (2001) called for a “clearer distinction between reduction treatments and the long-term, stable-dose maintenance treatments which are designed to achieve harm reduction objectives” – an admission that those objectives are by no means the clear guiding principle of Britain’s methadone services.

So while one major arm (needle exchanges) of the expansion in harm reduction services has been starved of profile and resources, the other (methadone services), rather than replacing treatment with harm reduction, is as justifiably seen as part of the expansion of the treatment system.

None of this is to argue against the need for more and more extensive and intensive rehabilitation services geared to overcoming dependence and achieving social reintegration. But if as Professor McKeganey argues the scale of the drug problem is such that harm reduction services cannot cope, then the same will almost certainly be true of rehabilitation services. In the current climate, it is simply not feasible that the resources will be made available to provide the decent housing, employment opportunities, family reconciliation, mental health, and all the other services needed to securely reverse years of accumulated disadvantage. In the years to come the money available per addict patient will be less, not more.

Even before the recent scaling back, over the same period (2002/03–2005/06), the National Treatment Agency foresaw a 28% rise in patient numbers (National Treatment Agency 2005), while according to the Prime Minister’s Strategy Unit, treatment spending would rise by only about 18% (Strategy Unit 2003). The latter figure takes into account inflation and the fact that much treatment spending is outside the central pooled budget, the increases in which look far more impressive.

It would be wonderful world indeed if the investment was there truly to give addicts with a decade or more of lost opportunities behind them a new start in life, or if we knew enough,
or were prepared to act on what we already know, to prevent such things happening in the first place.

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Prevention versus harm reduction as drug policy cornerstone

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Keywords: Prevention, harm reduction, drug policy, legalisation, cannabis

In this day it is difficult to express dissenting views openly when it comes to harm reduction as a panacea in drug policy and practice. So Neil McKeganey, in “The lure and loss of harm reduction in UK drug policy and practice”, demonstrates courage in addition to insight as he calls into question the efficacy of a harm reduction-focused drug policy. He sums up the core flaw in harm reduction as a practice – the assumption it makes that we can assert sufficient control over people’s behaviour to protect them and others from harm, as McKeganey says, “in the face of continued use”.

The most significant of McKeganey’s assertions comes, however, when he points out that a harm reduction-centred policy fails to address the incidence of drug use itself and that it “may be time to make drug prevention, rather than harm reduction, the key aim of drug policy and practice”. I cannot agree with McKeganey more. Therefore in this commentary I would like to discuss prevention as drug policy cornerstone, so to speak, around which we may build a solid drug policy that addresses the roots of drug problems, reduces incidence and prevalence, and still can meet people where they are while working with them toward healthier lives and safer and healthier communities. I will address two key issues. First, it is necessary to start in the present by unwrapping harm reduction a bit, looking frankly at how it has negatively influenced the demand and supply reduction drug policy pillars. We must do so if we are to begin earnestly to reshape drug policies. Second, I will address the advantage of prevention as policy cornerstone and describe some of the elements of a policy guided by prevention.

Harm reduction unwrapped

We would be wasting time in discussing drug policy if we did not pull into the open the fact that harm reduction ceased some time ago to be a policy pillar complementary to other pillars. It has come to describe a whole ideology. In asserting this I speak of the Canadian experience, but assume that the experience differs little in other countries, where it has overtaken drug policy. The harm reduction ideology encompasses a range of views, characterized by the belief that the focus of drug policy and practice should be on reducing drug related harms rather than drug use itself (Erickson et al. 1997). The value systems underlying this belief range from pragmatic to libertarian. The pragmatic harm reduction proponent holds that we cannot keep people from using drugs, so we should help them use them safely. The libertarian believes that drug use is no one else’s business but the user’s,
and/or that drug use is simply a lifestyle option – even a human right. The latter includes activists who strive to change or eliminate drug laws, and the lines between policy makers and activists often become blurred.

As harm reduction has grown to an ideology with its own value systems, it arguably has reshaped the other policy pillars. In particular, prevention has been affected. For example, in Canada’s Drug Strategy (Health Canada 2005), the emphasis of prevention is placed on reducing problematic drug use rather than incidence of drug use itself. If put into operation this policy would have weakened the meaning of prevention as it relates to reducing incidence. And once we lock onto harm reduction as ideology, we follow it to its absurdity, such as blaming the law rather than drug use for drug problems (e.g. Hankins 2000).

Much more could be said to dissect harm reduction in the hope of revealing its ideological grip and its subsequent effects on our ability to deal with drug issues. The point is, that it is not just a matter of increasing our focus on prevention, which is where McKeganey leaves off. We have not, I would argue, had the frank and open discussions required to open up drug policy and recognize that while harm reduction strategies may have their place with specific populations when linked effectively with vitalized long-term treatment, as drug policy ensign it ideologically skews and politicizes drug policy. Drug policies become less about reducing the burden of drugs on individuals, families, communities and society, and more on finding ways to help people have their proverbial cake and eat it too.

We require an ideological shift attainable only by accepting that the drugs issue is inherently value-laden and we must find and act on our national values around drug issues. By finding and acting positively upon these values, we can then de-politicize drug policy.

The good news is that prevention is a place to find these national values. Prevention makes sense epidemiologically because of the strong relationships between age of onset of drug use and later movement to other drugs and to addiction (e.g. Baumeister and Tossmann 2005). Reducing the number of youths who initiate and continue to use substances is of necessity the first place on which drug policy and practice should focus. But prevention is immensely more valuable than this. Prevention addresses the whole population. It involves communities. Prevention educates the public and gains its support. It builds strength in the rising generation. It supports parents. Prevention works with street addicts before they make the very initial choices that lead them there. Prevention is primordial; increasing prevention almost certainly is more cost effective than any other policy pillar. And prevention leaves room for and fits naturally with other policy pillars. Prevention, put simply, seeks proactively to make the world a better place. The above principles are neither conservative nor liberal. Drug policy need not be determined by federal elections.

Building drug policy around prevention

As we rebalance and depoliticise drug policy by affirming prevention as the central national goal, what then? Critics may say, oh, we have tried prevention, and it doesn’t work. Such is false. Largely, we have had a failure to implement prevention. Ever the topic of lip service, prevention traditionally has received little real fiscal, human and infrastructure support. What we can assess are the results of the lack of prevention. McKeganey notes the UK experience. Canada provides another example of the consequence of ignoring prevention. Rises in cannabis use among youths in Canada have followed the long void in prevention
messaging (Mangham 2001; McCreary Centre Society 2002; Canadian Centre on Substance Abuse 2004).

Tobacco provides an exception to the failure to implement prevention. Speaking of Canadian experience, tobacco is the one substance on which we have maintained a relatively consistent preventive focus. This prevention focus can claim at least some of the credit for substantial decreases in smoking over the past three to four decades, and reduced onset of smoking among the most vulnerable age group, youth (Health Canada 1999–2006; Mangham 1999). Tobacco use prevention provides a template, however imperfect, around which to frame a prevention-based policy and program.

A Prevention-focussed drug policy

I will use cannabis use prevention as an example. Cannabis recently has been affirmed as a drug with much more serious health and social impacts than popularly thought (Centre for Drug and Alcohol 2006, UNODC 2006). Early cannabis use is strongly associated with later heavy drug use patterns (Baumeister and Tossmann 2005). Placing harm reduction ideology aside, reduction of cannabis use onset is defensible as a drug policy goal.

Three key elements characterize tobacco prevention and are transferable to any case. These are consistency, comprehensiveness and endurance. Consistency means consistency of messaging. With tobacco, our message remains the same, as it was decades ago – don’t smoke, and if you smoke, stop. Inconsistent messages hurt prevention. What are young people to believe when the parents and the law say one thing – don’t use the drug – while politicians, newspapers, everyone it seems, has a conflicting message, or if the law bows to libertarian desires? Comprehensiveness means a blend of strategies (education, social marketing, policy, addressing social, cultural and economic factors). Endurance means sustaining prevention over time. This may be the single most important element. In the past we have expected immediate changes of single prevention programs. We need to consider that tobacco-related changes have come not through any single program, but by a slow process of shifting the normative climate surrounding tobacco use, achieving the “tipping point” or threshold mentioned by McKeganey in another context.

Without ensuring these attributes in prevention policy and practice, we would be simply returning to the previous status quo – piecemeal prevention, treatment, and enforcement, none sufficient to the task. With them, we will invigorate drug policy. Our aims will be clear.

McKeganey’s insights hopefully will contribute to a collective realization of the serious limitations of harm reduction. Far from being a panacea, inadvertently or otherwise it has skewed drug policy wherever; it has linked up with ideology. We cannot have a drug policy ideologically attached to harm reduction and also achieve the vital goals of prevention. We face a choice. And in democracies we do have that choice.

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Harm minimization, prevention, and abstinence: Adversarial versus co-existence approaches. Commentary on “the lure and the loss of harm reduction in UK drug policy and practice”

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Professor McKeganey is fast becoming the Don Quixote of the UK addiction world – or at least one of the ‘grumpy old men’ – constantly tilting at windmills. In recent weeks he has been prominent in tilting at two of these, arguing against methadone maintenance; and calling for addiction services to alter their focus from the identified client with problems with their own use and onto their children and the effects that parental substance misuse has on them. And now he is tackling another of services’ core values: Harm minimization.

I have a number of problems with his argument, which I will outline below. But it is important to state that, even by simply asking the question, that he has done the addiction world a service. Someone has to question accepted ideas, and it is only through such questioning that we can move forward and start to clarify whether such ideas have passed their ‘sell-by’ date.

However, it is one thing to pose the question, and another to answer it coherently; and as far as this present tilt at harm minimization goes, I am afraid that Professor McKeganey’s answers do not stack up.

The first serious problem with McKeganey’s arguments is that he confuses two distinct ideas: That of stopping people who have never done something (used drugs, drank alcohol, had sex, gambled on the horses, etc.) from starting versus minimizing the harm that people might do to themselves and others once they do start.

McKeganey’s article posits a simple juxtaposition between ‘prevention’ and ‘harm minimization’ and asks whether we should make just one of these ideas the ‘key aim of drug policy and practice’. 
It seems to me that the much more obvious thing to do is to do both! – aim for prevention with non-drug-users; aim for harm minimization with existing drug-users. McKeganey states in this article that the focus in the UK is primarily on harm minimization, but this is a false argument – it is clear that current UK drugs policy and practice does do both prevention and harm minimization: There is work in schools etc to prevent use, and work with existing drug users to minimize the harm that they might do to themselves or others. It is not difficult to discover that this is what UK drugs policy states. The Home Office website affirms that the “strategy comprises four strands of work: preventing young people from becoming drug misusers; reducing the supply of illegal drugs; increasing the number of individuals accessing effective drug treatment; and reducing drug-related crime. These are covered in more detail in specific sections on this website” (http://www.drugs.gov.uk/drug-strategy/).

And in the “Young People’s” section it states: “preventing today’s young people from becoming tomorrow’s drug misusers is a key target within the Government’s Drug Strategy”. Although they do use the term “misuse” as opposed to “use”, they go on to talk about “Government targets for preventing young people from taking drugs”, making it relatively clear that they are actually talking about preventing use and not just misuse. Further on in their “Young people’s substance misuse strategy” (http://www.drugs.gov.uk/young-people/) they state that a “key aim...is to encourage that: young People choose not to take illegal drugs”.

So, it is clear that English drugs policy does aim to both prevent use, and minimize harm. It seems that McKeganey’s dissatisfaction is with having prevention as ‘A key target, as opposed to prevention being the only aim. I find this confusing: is McKeganey arguing that we should only undertake prevention, and abandon those with whom a prevention approach fails?

A second major problem with McKeeganey’s article is that it emerges that the paper is not in fact actually about prevention at all. McKeeganey does not really discuss prevention in the article, and nowhere examines any of the available evidence about what does and does not work in drugs prevention (e.g. Lloyd et al. 2000, Cuijpers 2003, McGrath et al. 2006). It emerges that the thrust of the article is not about juxtaposing harm minimization with prevention; it is about treatment services (i.e. dealing with those people for whom a prevention approach has not worked), comparing a harm minimization approach with an abstinence approach.

This again is an extremely important idea – that we should cease to try to minimize harm in those who do use drugs, focussing instead on abstinence, as is more usual in (say) the USA. Unfortunately, McKeeganey does not cite any evidence from countries such as the USA, which do focus on abstinence, to show that abstinence-oriented services are more successful than ones aiming for harm minimization. Instead the reason that McKeeganey gives for making this suggestion is his assertion that the harm minimization (HM) approach had not worked.

Unfortunately, here again his arguments lack logic. His historical analysis of the growth of HM services in the UK is accurate, and he correctly states that the reason for the growth of the HM approach was the concern that, without such an approach, HIV cases would rise significantly. But to argue (as he does) that the fact that the feared rise in HIV cases did not materialise demonstrates that the HM approach was wrong is an odd one. An alternative explanation is that the HM approach has been exceptionally successful, with the falling numbers of HIV cases demonstrating that people have heeded this HM advice. Of course, it is difficult to be certain why the feared HIV epidemic did not occur (this is always a problem with prevention – if prevention works, then the lack of the very thing that has been prevented is often taken as evidence that the initial prevention activity was not needed!), but it is logical...
to argue that the lack of this epidemic must have been, in part, because of the harm minimization work that was being undertaken. Indeed, figures which McKeganey cites (e.g. that the percentage of HIV+ cases in London has dropped from 13% (1993) to 2.3% (2004), instead of rising exponentially as had been feared) demonstrate how effective something (which might well have been the HM approach) clearly was.

McKeganey makes a further illogical claim. He argues that because drug use (and drug problems) are rising, and because there are many more people with drug problems than there are with HIV, “it is difficult to avoid the conclusion that it is problematic drug use, not AIDS and HIV, which is having the greater impact on individual and public health within the UK”. This is a strange conclusion to arrive at: it is based on an assumption that the harms caused to individuals and to public health from drug misuse and from HIV are equivalent. It clearly is the case that, if these harms were equivalent, then problem drug users should be our priority, as there are more of them. But McKeganey offers no evidence to corroborate this assertion of equivalent impact. There are very many commentators who would argue that the impact on self, family or society of being HIV+ is generally far greater than the impact of having a drug problem. Further, McKeganey also ignores the fact that, in the context of this discussion, the HM approach is aimed not at the general population, but at a subsection of the drug misusing population – those drug misusers who might also go on to become HIV+. Therefore, it is not a comparison between the impact of drug misuse versus the impact of AIDS (where one could try to argue that the impact of one is greater than the impact of the other): it is patently obvious that problem drug use plus AIDS is a hugely worse situation than problem drug use alone.

Yet another logical inconsistency arises when McKeganey looks at drug-related deaths and concludes that because deaths have risen (from 187 in 1993 to 926 in 2000), this demonstrates that HM is not successful. If the number of drug misusers had been constant over that period, then he might be correct; but in fact this 5-fold rise in death rates is less than the overall rise in drug prevalence: In terms of a percentage of deaths per numbers of misusers, death rates have fallen slightly. It is true that such a very slight fall is not a sign of a successful HM approach, but (as McKeganey himself acknowledges) the HM approach was aimed at HIV prevention (rates of which have fallen significantly), not at reducing death rates. And it is also the case, of course, that changes over the years in how drug deaths are recorded and reported could also have contributed to this rise in numbers of deaths: The ‘true’ fall as a percentage of prevalence rates may be even greater.

Similarly, the list of problems McKeganey cites as associated with drug misuse is well known: HEP-C, overdoses, life problems, homelessness, dual diagnosis, links between drug use and crime. But citing statistics about these problems does not inform his key question: should we move away from a HM approach and towards an abstinence-based one. Indeed, one could use exactly the same figures and lists of problems to make a completely contrary argument to McKeganey’s one: instead of suggesting a move to abstinence, this list of problems could be taken as evidence that illicit drugs should be legalized and controlled through licensing. In fact, “Transform” (http://www.tdpf.org.uk/) do use this same information to make exactly that argument – if people could buy drugs legally and therefore more cheaply they would not be forced into crime to fund the high prices that the illegal market brings; and if they were legal, drugs could go through strict quality control procedures which would vastly reduce drug-related deaths, which are usually caused by overdose due to uncertain levels of purity.

McKeganey’s conclusion that, “in the light of the previous section (i.e. this list of drug-related problems) one would have to say that the harm reduction approach within the UK appears to have had only modest success in reducing the breadth of drug-related harms” is
an unfair one, resting (it seems to me) on two logical errors. First, the aim of the HM approach was to reduce HIV rates, and rates of sharing needles (later expanded to reducing rates of sharing any injecting equipment), not to address these problems. Therefore, the past period cannot be seen as a “test” of harm reduction’s power to reduce other types of harm. Second, McKeganey cites the increases in the various harms and problems that have accrued over the past 15 years, and argues that these are a testament to the failure of harm reduction approaches over this period. But this ignores the fact that there has been a huge investment in a wide range of approaches over this period: certainly in harm minimization, but also in prevention, access to treatment, the range of treatments available once services have been accessed, and a major rise in resources expended on enforcement. To take prevention (the area that McKeganey suggests has been ignored over this period) as an example, the late 1980s onwards coincided with a major investment in drugs prevention activity, first through the Drugs Prevention Initiative, and later through the Department of Health and the DFES. To argue that the last 15–20 years can be seen some sort of test of harm reduction policy in isolation from the huge investment in all these other interventions is just plain wrong.

In my view, the main problem with McKeganey’s article is that it is a polemic, not a reasoned argument presenting various viewpoints and reaching measured conclusions. It reads as if he has a point which he wishes to make, and has selected some evidence which he hopes will help him make it. As I state above, I do not think he has done that particularly well, but even if he had, the arguments here are far too one-sided, and he sets up too many binary choices (prevention or treatment; harm minimization or abstinence).

This is a particular problem in that underneath these one-sided views are some good ideas. It is the case that too few services challenge drug users to change their behaviour. It is the case that drug services rely too much upon giving people drugs (methadone and benzodiazepines) instead of intervening therapeutically to help people change. It is the case that much more needs to be done to reduce drug-related deaths. It is the case that our HM approach needs to change, away from a major focus on HIV prevention and towards a much greater focus on HEP-C prevention and on reducing drug-related deaths. It does sometime happen that problem drug users are not encouraged to aim for abstinence, even when they wish to. We do need to work to ensure that the quality in drug services (including within injecting equipment ones) is uniformly high and not variable as at present. It certainly must be the case that harm reduction approaches should be open to criticism and change. But a change of focus is not the same as stopping our attempts to reduce harm.

When HM first became fashionable I argued myself (Velleman and Rigby 1990) that this was in fact not a new idea, and was simply one borrowed from the alcohol treatment field, where HM in various forms (e.g. controlled drinking, not drinking and driving, designated drivers, lower alcohol content beverages, etc.) was well-established. I suggested then that HM needed to be incorporated within a range of treatment responses, as opposed to becoming a mantra, which stopped people from offering a wide-range of treatment options. I think it is the case that, because of the drive to engage drug misusers in treatment and the fear of them dropping out, services have often become less challenging, and too acquiescent.

Again, one could look at the alcohol field: There, although HM continues to be well established within alcohol treatment circles, few people suggest that the most effective way to treat people with alcohol problems is to provide them with free alcohol on prescription. Although engagement of clients with alcohol problems is seen as vital, this does not stop staff from actively working with people’s motivation, ambivalence to change, and the sheer difficulty of making changes. And (thankfully) in the UK most alcohol treatment services find the co-existence of harm minimization approaches (such as controlled drinking) with abstinence-based approaches (if that is the client’s choice or is majorly indicated by other
reasons) an easy one. The adversarial approach of a forced choice between abstinence and HM is much more reflective of the far more punitive approach taken within the USA in alcohol and drug services.

Finally, as is often the case when Professor McKeganey raises thought provoking suggestions, he seems not to recognize that there is also a major negative side to his ideas. I am sure that most commentators would agree with the idea that the prevention of problem drug use is much better than waiting until people develop problems and then trying to help them overcome them. But, if we were to follow his exhortation and focus primarily on that end of the continuum, and if we were only to offer abstinence-based treatments to the drug casualties, what would happen to those people with drug problems who do not wish or do not feel capable of abstaining? To say that we should simply cease to try to help them, and to stop trying to minimize the harm that they might do to themselves, their families and to society, unless they prove willing to abstain, is I feel irresponsible: It would cause untold damage to many more people.

McKeganey argues that the very success of the HM policy in preventing HIV is a reason for stopping it, which is nonsensical. He correctly states that there are still many problems associated with drug use, but he provides no evidence that a move towards abstinence-based treatments would help this, as opposed to a different focus for a harm minimization approach, or even a push towards legalization. He argues for renewed focus on drug prevention when there is already a huge focus on this within schools and youth programmes. And although he suggests that we should “renew our focus on drugs prevention”, he presents no ideas at all as to how we might become more successful at doing this, in the light of increasing levels of drug use across most of the world.

So, I believe that there does need to be some re-balancing: moving treatment services more towards challenging clients, using the range of approaches developed within the alcohol-treatment world to increase individual’s motivation and their external social support for change (e.g. UKATT 2005); moving HM so that it focuses more on HEP-C, drug-related deaths, etc; developing the concept of HM in more psychotherapeutic ways (e.g. Tatarsky 2003); developing improved drug prevention interventions with our young people so that fewer go on to use drugs in the first place. But pushing the debate into a simple either/or of prevention versus treatment, harm minimisation versus abstinence, is a significantly retrograde step.

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References

The lure and loss of harm reduction a response to the commentaries

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I am very grateful to colleagues for having taken the time to read and respond to my article “The lure and loss of harm reduction in UK drug policy”. I wholeheartedly agree with Wayne Harding in lamenting the lack of empirically based discussions of drug policy within the UK and elsewhere. One of the reasons for that lack is the absence of empirical data of a kind that allows us to assess the impact of policy on the drug problem both globally and within countries. For example, it is striking that only in 2006, we are undertaking research in UK to provide an overall assessment of the prevalence of problematic drug use. As a result, we simply do not have the necessary time series prevalence data with which to assess the degree to which drug problems are changing in the light of global and national drug policies (UNODC 2006).

In addition to the lack of data in key areas, I think there is also something of reluctance within the addictions field itself to address some of the big questions within our field. Rarely, for example, do we ask whether we have the right balance in our drug policies and services between, for example, abstinence and harm reduction, or whether treatment has focussed too much on the needs of the individual user at the expense of his or her family and the surrounding community, or the likely nature of the drug problem we may face over the next 10 to 15 years. These are all important questions, but they are rarely asked in a discipline that tends to focus instead upon a smaller set of issues. One reason for that reticence may be the fear of being seen in Richard Velleman’s words as “tilting at windmills” – addressing questions that may seem consequential, but which, in reality are ephemeral. My own view however, is rather different, in that I do not see how our discipline can progress unless we are prepared to turn a critical eye towards the assumptions underpinning our knowledge and practice.

Harm reduction is one of the big ideas within the addictions field. Indeed, it could be said to be just about the biggest paradigm shift to have occurred within the addictions field in the last 20 or so years. Therefore, it seems right to ask some fairly basic questions as to how successful we have been in reducing many of the harms associated with continuing illegal drug use during the period when the ideas of harm reduction have been most influential.
It is not difficult to see the appeal of the paradigm shift that occurred in the late 1980s, when the ideas of harm reduction were first mooted. Working with dependent drug users to help them overcome their drug dependency must be one of the hardest jobs imaginable. The successes are few and often long in the coming; and when they do come the individual may be more inclined to ascribe their recovery to their own efforts, or the efforts of those around them, than to the contribution of service providers. Within a context of such difficulty in getting people off drugs, it is hardly surprising that the addictions world received the ideas of harm reduction with such evident enthusiasm. Here was a paradigm that enabled drug workers to engage with drug users on a much broader front than that of exhorting them to cease or reduce their drug use. In the earliest formulations of the harm reduction approach, it was expected that services would work with drug users to move them from reducing their risk behaviour to becoming drug free. It was never, though, spelt out how services were to achieve the almost magical aims of both facilitating drug users continued drug use (through for example, providing advice on safer injecting techniques) and encouraging drug users in becoming drug free.

Richard Velleman has interpreted my article as a call for the focus on harm reduction to be dropped and replaced with a focus on drug prevention. In fact, as I pointed out in the concluding section of my article, the drug problem in the UK has spread so widely that we need effective harm reduction services more now than at any time in the past. The key question though, underpinning my article, is why our existing harm reduction services have largely failed to reduce the harms of continued drug use and whether it is now time to make drug prevention rather than harm reduction the cornerstone of drug policy and practice.

Richard Velleman has also questioned my suggestion that problematic drug use has had a greater impact on individuals and families than HIV infection. It is difficult, of course to weigh up the effects of different harms but when you compare the number of drug users dying from drug related causes with the numbers dying of HIV related illnesses there is simply no comparison. In looking at the impact of problematic drug use on families, Marina Barnard has shown, how such drug use often hits these families like a tidal wave creating a debilitating amalgam of confusion, guilt, anger, fear, and recrimination on the part of family member. For thousands of relatives up and down the country the ever-present fear is that of the knock on the door bringing the news that their loved one has died of a drug related overdose. Would these families feel any more bereft at the loss of a loved one to an HIV related illness? I suspect that when confronted by the death of one's child, sibling or parent, it is not the cause of the individual's death, which is the uppermost in the family's minds, but the numbing sense of loss at a life prematurely ended. In these terms the sheer scale of the loss associated with problematic drug use is so far beyond that associated with HIV that it is indeed the case that it is problematic drug use rather than HIV that is most affecting these families.

Mike Ashton's response to my article raises an important issue namely the degree to which drug treatment services and drug policy have embraced harm reduction ideas within the UK. This is an entirely legitimate question to ask although it seems to me to imply that any discussion of the successes and failures of harm reduction should only be confined to services that have delivered an idealized version of the harm reduction model. In reality, of course, one can hardly do other than to consider the achievements and the failures of harm reduction services as they have been articulated, however imperfectly, in the areas in which they have been developed. In Glasgow, for example, a city-wide network of needle and exchange clinics have been providing drug users with millions of needles and syringes since they opened in the early 1980s. And yet within that single city around 60% of injecting drug users have become Hepatitis C positive. If this is not a palpable failure of our harm reduction
services then I do not know what is. Mike Ashton may feel that we ought to have been providing needles and syringes in their tens of millions, if we were serious about reducing drug users needle and syringe sharing behaviour. But if we had done that what kind of city would we have had with that level of saturation coverage of injecting equipment and would we not thereby have created massive further harm associated with discarded needles and syringes?

In the light of such high levels of infection associated with persistent needle and syringe sharing, it may be time to recognize that our capacity to limit drug users’ risk behaviour in the face of their continued drug use is actually fairly limited. Further, it may only be through achieving success in drug prevention that we may ultimately claim success in reducing and eliminating drug-related harm both for the individual and the wider community.

Colin Mangham has usefully identified three key elements of an effective prevention paradigm: consistency, comprehensiveness, and endurance. If these are the elements of a successful campaign then, I think we face a major challenge in relation to drug policy, which within the UK at least is based upon an assessment of the variable harm associated with different drugs. Taking Mangham’s case for smoking prevention, here we have a drug (tobacco) which causes serious and in some cases irreversible harm, even at low levels of consumption. The public health message in relation to tobacco has been consistent, comprehensive, and enduring in stressing the benefits of cessation and prevention. In relation to drug policy, the opposite has been the case. Take, for example, the case of cannabis policy within the UK, which could hardly have been less consistent, less comprehensive or less enduring. The trouble here of course is that in relation to UK drug policy, we have sought to structure our response to different drugs in terms of calibrating their individual harm. So cannabis is seen as less important than heroin and cocaine, which are seen to be the drugs causing the greatest harm. However, a focus upon the harm associated with individual drugs is further compounded by the fact that the nature of that harm itself is likely to vary depending upon the strength of the drug being used, the amount of the drug used the age of the user, the presence of any other drugs that may be used in conjunction with any particular drug and the situation within which the drug is being used. We have in effect almost limitless and changing levels of harm associated with each individual illegal drugs such that it becomes virtually impossible to devise a prevention approach targeted on any individual drug that is consistent, comprehensive, and enduring. Indeed to produce a consistent, comprehensive, and enduring prevention paradigm in relation to illegal drugs would necessitate that we shift from assessing the harms of individual substances and treat illegal drug use itself as a preventable corpus. However, to do that would mean shifting from the harm reduction focus of UK drug policy to a focus upon drug prevention.

Wayne Harding is surely right in wishing that my stocktaking exercise had identified not just the bald figures of continuing drug-related harm, but the rates of harm associated with continued drug use. Unfortunately, much of the data through which one might have been able to construct such rates are simply not available and one is left, on more occasions than one would wish, with the bald figures of continuing harm. Harding has also raised the issue of whether harm reduction and abstinence are indeed antithetical goals in drug policy and provision. At a philosophical level it is easy to see the complementarity of these goals and yet it is far from clear how services are combining the goals of abstinence and harm reduction in practice. At the International Harm Reduction Conference in Belfast in 2005, for example, there was barely a single paper focussed on the issue of drug users becoming drug free. Similarly, when in 2004 I reported the results of research on whether drug users were
contacting services to become drug free or to receive harm reduction advice, Robert Newman, one of the leading harm reduction clinicians in US, commented that:

Addicts who embrace an ultimate goal of enduring abstinence should be assisted in every way possible, but they must be advised with brutal frankness of the low prospect of success – and the grim, potentially fatal, consequences of failure. (Newman 2004)

Such a statement could hardly be regarded as a ringing endorsement of the value of encouraging drug users to become drug free. Whilst I do not doubt that it is possible to combine the aims of harm reduction and abstinence, I think that we need to do much more than to take that claim at face value. It is by no means clear, for example, how needle and syringe exchange services are successfully managing to discourage drug users from injecting at the same time as providing them with access to sterile injecting equipment. There will be those who say that needle and syringe exchange clinics should not be seeking to discourage drug users from injecting. However, injecting is by a considerable margin the most dangerous way of using illegal drugs and remains so, whether the equipment used is sterile or not. There is a strong case then for why needle and syringe exchange clinic staff should be seeking to move injecting drug users away from injecting although hardly any evidence as to how these two somewhat competing aims are being achieved.

Finally, there is a further reason why it may be necessary to make drug prevention rather than harm reduction the cornerstone of drug policy, which has more to do with the impact of serious and problematic drug use than the limitations of the harm reduction approach itself. At the moment, we tend to think of the UK as having a large drug problem. In reality, of course, our drug problem is tiny involving only around 1% or approximately 350,000 of the adult population. The impression of a large drug problem is because of the fact that problematic drug users generate a vast array of problems absorbing something of the order of £13 billion of government expenditure each year and tying up our prison service, health service, police service, and social work service as well as a huge array of services in the voluntary sector. If that 1% were to increase over the next 10–15 years to 2% or 3% (an increase, which is commensurate with that which has occurred over the last 15 years) one would have to wonder at our ability to cope with a drug problem at that level. Whilst we may feel that society will always be able to cope with its problematic drug use problem (whatever level of prevalence of that problem), in fact, society may struggle to cope with a drug problem much greater than its current level. If that is the case, there may well be an urgent need to make drug prevention rather than harm reduction the major thrust of policy and practice within the drugs field, irrespective of the limitations of the harm-reduction approach.

References


