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HARM REDUCTION APPROACHES AND DRUG AND ALCOHOL POLICIES AND LAWS[1]

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In the context of illicit drug policies, a self-conscious harm reduction approach has its start about within the last 10 years, particularly in England and Australia. The initial primary emphasis was on the prevention of AIDS among intravenous drug users. The desperate threat of the AIDS epidemic, it was argued, justified desperate measures, even if they acknowledged and might appear to condone intravenous drug use. Prominent among these measures was making sterile syringes available to intravenous drug users, through needle exchanges and other measures.

This harm reduction initiative motivated by the priority given to preventing AIDS found common cause with some older approaches. Methadone maintenance, accepted since the 1970s in the U.S. but only accepted in countries like Germany in the late 1980s, has also been commonly viewed as a harm reduction approach. But what harm to whom was being prevented has changed by time and place. While the main policy motivation in the U.S. in the 1970s was to reduce the burden of crime on the community from illicit heroin users stealing to finance their supply, in Germany and elsewhere in the 1980s the provision of methadone has also been seen as a means of preventing HIV infection.

Another strand in the harm reduction approach has been the example of drug policy in the Netherlands, which has long adopted an approach of flexible policing and other policies which tolerates illicit drug use of limited kinds and in limited circumstance and seeks to minimize harm from the drug use. As those using harm reduction approaches have gathered in annual international meetings -- the next in Toronto on March 6-10 -- a coherent approach and ideology has emerged.

The approach turns out to be very much in the tradition of public health thinking. Public health agencies for instance, have long sought to limit the harm from sexuality, even if the particular sexual relations are illegal and the public health measures appear to condone the illegal behavior. Venereal disease clinics, for example, are an old public health tradition, and have long

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fought off attacks on their existence as condoning immorality. The public health stance has long been concrete and clear: it is appropriate to act vigorously to prevent immediate harm, even if the action may involve a diffuse risk of future harm.

In the specific context of illicit drugs, harm reduction also exemplifies a critique of conventional thinking about drug control, which has been in terms of a dichotomy of supply reduction and demand reduction. While a common rhetoric about drugs has been to push forward demand reduction approaches as an alternative to a focus only on supply reduction, a harm reduction perspective argues that both demand and supply reduction are focused only on the use of the drug, and refocuses attention on the harm caused by the drug use. In a harm reduction perspective, supply approaches and demand approaches are only part of a broader spectrum of approaches to reducing drug-related harm.

This perspective, it turns out, is congenial to common ways of thinking about alcohol. When attention turned to the prevention of alcohol problems in the U.S. in the late 1960s and early 1970s, many of us argued explicitly for what we called a problem minimization or harm minimization perspective on alcohol problems. This perspective opened up a much broader range of options than the usual thinking at the time, which was in terms of publicity campaigns, education about the signs of alcoholism and efforts to improve the public image of the alcoholic. Among the options, indeed, were controls on alcohol availability, a neglected topic at the time, but also efforts, as we put it, to make the world safer for drunks and safer from drunks -- seat belts and airbags in cars, "wet" hotels on skid rows, designated driver programs, and so on. In societies where alcohol is a licit drug, there is usually agreement that efforts to limit harm from drinking are an appropriate public health concern.

Harm reduction approaches have also been common for tobacco smoking. These have included the provision of filters and lowering the tar content of cigarettes, although it has become apparent that smokers often unconsciously neutralize the harm reduction effects of these measures by changing their pattern of smoking. More recently, Nicorette and other nicotine chewing gum and nicotine skin patches have exemplified a harm reduction approach by providing a supply of the main psychoactive substance, nicotine, while eliminating damage to the smoker's lungs -- and to others -- from breathing cigarette smoke.

Harm reduction perspectives have steadily been gaining currency in international thinking about controlled drugs. The 28th report of the WOrld Health Organization's Expert Committee on Drug Dependence, mentioned yesterday, adopted a harm reduction perspective, in line with public health traditions also reflected, for instance, in its 1974 report. The Board of Directors of the International Council on Alcohol and Addictions, the premier international nongovernmental agency in the field, recently provisionally adopted a policy favoring a harm reduction approach. It is clear that there is movement also at national levels: Canada, for instance, has adopted a harm reduction framework for its national Drug Strategy.

As harm reduction has matured from being something of an insurgent movement to being

closer to a mainstream consensus, there is beginning to be a more systematic probing of its premises and scope. Is the aim harm reduction or harm minimization, for instance? In an alcohol context, we accept that those who choose to drink often get pleasure from it, and that in limiting harm we should try to avoid taking away the pleasure. The aim is thus some kind of balancing of the risks of harm against the pleasures, which might be called a harm minimization approach, rather than an unrestrained effort to reduce the harm even if this took away the pleasure.

Then there is the issue of what is considered and counted as harm. The initial emphasis in harm reduction approaches such as needle exchanges was on harm to the user -- the risk of contracting AIDS -- and perhaps also to others in close contact with the user, such as sexual partners. But harm from drug use can come to others than the drug user him- or herself: to family members and friends, to an industrial enterprise (through loss of productivity from a drug-using worker), to the community faced with unsafe streets, etc.

It is commonly presumed that a focus on community-level harm will point to a supply-reduction approach, while harm reduction is more focused on individual-level harms. But this is not necessarily the case. A main argument in the U.S. these days for moving away from a focus on law enforcement to reduce the supply is that the violence associated with keeping a large market illicit imposes just too much of a burden of harm on the community. A similar argument about the need to reduce lawlessness and its harm to the society was influential in the Repeal of National Prohibition on selling alcohol in 1933.

As Bill McAuliffe noted yesterday, one effect of the U.S. policy focus on use of drugs as the problem has been that drug epidemiology, unlike alcohol epidemiology, has tended not to measure the actual experience of harm by drug users and those around them. But if we step back and ask the question, what are the main harms from the use of psychoactive drugs with which societies are concerned, the harms at the individual level seem to fall in four main categories: chronic health harm, casualties, psychological problems, and default of major social roles. A focus on harm, and a wider frame like WHO's which includes alcohol, tobacco and other substances outside international controls, will inevitably suggest a stronger emphasis on alcohol and tobacco. In any society where tobacco smoking is widespread and banalized, tobacco is likely to account for more deaths from chronic illness than any other substance. Where drinking alcoholic beverages is widespread and a part of daily life, alcohol will rival tobacco for deaths in terms of years of life lost from casualties and from chronic illness. Tobacco is not usually involved in default of major social roles, but this is at least as likely for the very heavy drinker as it is for the drug user.

Harm reduction approaches present some special challenges in documenting the international legal situation. Needle exchanges and marijuana bars (the Netherlands "coffee shops") often face a heavy weight of adverse international, national and often state or provincial law. Frequently, harm reduction initiatives have been taken at a local level, and have involved activities that are illegal -- needle exchanges often contravene U.S. state laws against distributing drug paraphernalia, for instance. Lacking legal status, often the proponents have instead sought

a modus vivendi with local authorities and the police, where there is an informal agreement that the police will not stand in the way or harass the effort. With the heavy load and long record of legislation at all levels of government in the drug area, we do run some risk of ending up with an archaeology of good intentions expressed as legislation which is often not applied in current real-life circumstances. Such sleeping laws can sometimes awake in a different era, as we have seen with U.S. temperance-era dramshop laws in the 1970s and 1980s, but in cataloguing such laws it will be important for us to establish how often they are used and in what circumstances.