

HARM REDUCTION IN SUBSTANCE USE AND HIGH-RISK BEHAVIOUR

International Policy and Practice

EDITED BY

RICHARD PATES, DIANE RILEY

 WILEY-BLACKWELL

Addiction **Press**

Harm Reduction in Substance Use and High-Risk Behaviour

International Policy and Practice

*This book is dedicated to Dominic Pates, Helen Jamet and Suzanne Pates, and
Gemma and Cleo Pates, all of whom have been my strength and support.*

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FOREWORD

The prevention of the spread of the human immunodeficiency virus among and from whole communities of people who inject drugs is no less than a public health triumph – one of the public health triumphs of the 20th century, as far as I am concerned. There is much history in this volume, about harm reduction, its antecedents, and other aspects of humankind's relationship with drugs and other fancies; and very welcome it is, because much of the extraordinary history of the current movement is in danger of disappearing. In this historical spirit, my own small involvement in this public health triumph came about relatively accidentally, in a way which introduced me to the predominant feature of the field: prejudice and discrimination, based on man's inhumanity to man.

Those who use drugs (of any kind, legal, illegal, anodyne or exciting) participate in one of the most useful tools for defining who's in and who's out, who's in power and who is not . . . I learnt this again when I ran a harm reduction workshop with WHO in the mid-1990s, in Guizhou in the south of China, for Public Security and Public Health officials from 10 Chinese Provinces. The Public Security officials traveled to the workshop straight from organizing the public executions which marked National Drug Control Day, executions of low level heroin user dealers and small time heroin traders. Each evening was marked with copious quantities of the local Maotai, 55-plus % alcohol, a slower but reliable form of execution. The extreme irony of celebrating the death of those using a pharmacologically pretty harmless drug by drinking large amounts of a severely harmful one brought home to me the utility of labeling people by the drugs they use, and selectively dealing with them on that basis. Using the drugs as an excuse, a cover, a blind to draw away attention, to effectively silence and subjugate the people.

The more I look at drugs, the more I see people. The more I look at people, the more I see a propensity to dehumanize so as to control. The more I look at the harm reduction movement of the last three decades, the more I see hope. Harm reduction drives towards re-humanizing the dehumanized, de-demonizing the demonized, normalizing and welcoming back to the human fold the outcast person, and the outcast behaviour . . . and reclaiming them as part of our humanity, so we can confront and deal with them in properly human ways.

The accident that happened to me, that I referred to above, was when I worked in the AIDS Branch at the Centers for Disease Control in the late 1980s. I was very supernumerary, and reputations were being made; territory was strongly claimed and fiercely guarded. But there was a bit of turf no-one wanted, and it was the scrap thrown to me – HIV among injecting drug users. I remember at the time, around 1988, noting that in an epicentre of the epidemic in the US, in the northeast states of New York and New Jersey, the number of people diagnosed with AIDS with histories of injecting drug use outnumbered those diagnosed who had histories of male to male sex – and yet there was no-one in the AIDS Branch at CDC, the home of the discovery of AIDS, the world leading public health institution, specifically studying this massive and devastating part of the epidemic. A first exposure to the depth to which prejudice permeates our institutions . . . and a surprise to a youngish public health practitioner, whose aspiration was to get the science right, and

had trouble seeing, let alone understanding, the basis on which some people with AIDS were worth more than others.

It has always seemed to me that there is a parallel between our drug policies and the practice of execution of deserters in war (who have always seemed to me far more heroic in their humanness than the adrenalin charged killer who wins the medal; perhaps only because I can completely identify with the former and do not for a moment understand the latter). The more dangerous we can make the use of a particular drug, by removing any possibility of quality control or regulation of access or informed use, the more likely are users likely to suffer harm from its use, so bolstering our initial proposal that its use is dangerous . . . if we do our job well enough, we might be fortunate in that a few will die, providing us with exactly what we need *pour encourager les autres*.

‘Harm reduction’ as a name may have started with HIV, but as we read in these pages as a concept it is co-contingent with humanity – it is in essence part of the definition of being human. Harm reduction is a normal human response to intractable, usually behaviourally-based, problems that allow no immediate solution – what could be more sensible than to ensure that the harm they cause is lessened to the extent possible? Is this not, indeed, simply good public health practice under a different guise? And again as we read within these pages, is not the best public health synonymous with human rights?

HIV is just the starting point, the entry into the world of systematic discrimination and dehumanization. Harm reduction takes us through the door that HIV opens, a door to ourselves; and we betray it and our selves if we do not follow up, and confront the beast within.

This current book is as good a guide to this journey as it is possible to produce – a guide through personal experiences, from activists to users to educators and policy makers and police; a global guide, spanning the world as do the phenomena, the problems, the philosophy and the response; and a guide that takes us into the many paths that harm reduction, branching out from its beginnings with injecting drug use and HIV, is beginning to explore. It will serve us for many years, as textbook and inspiration.

Professor Nick Crofts
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Section I

Background

Chapter 1

INTRODUCTION

Diane Riley and Richard Pates

Harm reduction for psychoactive substance has been practised for centuries (see chapter 2) but harm reduction as we now know it was first developed in the 1980s, mainly as a response to HIV and hepatitis transmission among people who use drugs. There is now an extensive literature on harm reduction in academic journals and books and there are numerous publications aimed at advising and informing on best practice in many areas. We have come a long way since the days when all attempt at limiting the harm from psychoactive substances and high-risk behaviours simply involved prohibition, bans, and telling people not to partake. We know that the use of alcohol and other psychoactive substances goes back many thousands of years, sex work is called ‘the oldest profession’, and gambling has a very long history too. All of these have attracted opprobrium from the establishment in almost all countries and at most times in history, and attempts to recognise their inevitability and render them safer have been scant.

That harm reduction around psychoactive substances has been controversial is of interest in itself. If we look at another major cause of death and injury throughout the world, that of the motor car, we see a very different situation. It has never been seriously suggested that cars should be banned because of the number of deaths caused through their use (far more than heroin overdoses), but we have put in numerous harm reduction measures in an attempt to ameliorate these accidents. In terms of cars themselves we have introduced safer cars that stop more efficiently, that have greater protection for the occupants through stronger construction and crumple zones, and so forth. We provide seat belts and airbags so that in the event of an accident the occupants have a lesser chance of being injured. We have laws to limit the amount of alcohol people may consume before driving; we impose speed limits and enact a considerable amount of legislation to make the roads safer. We also make the motoring environment safer by constructing crash barriers, traffic lights, roundabouts and other physical changes to the infrastructure. These are all harm reduction measures designed to reduce death and injury on the road, and apart from some people feeling it infringes their personal liberty to be made to wear a seat belt or crash helmet, nobody really objects. The situation regarding harm reduction for psychoactive substances and gambling has been very different indeed.

This book covers a number of areas pertaining to harm reduction. The first section is an introduction by way of a history of harm reduction (which deserves a book in itself and is thus brief) and a discussion about the role of education in primary prevention, an attempt to remove the harm before it occurs. The second section looks at policy, offers a critique of various policy matters, examines law and policing, and raises questions about ethics and legalisation. The third section is centred around harm reduction for individual substances and behaviours, offering expert views on current best practice and ideas. The chapter on opiate harm reduction has been written from the ‘recovery’ perspective. There is much discussion elsewhere in the book about opiate substitution therapy (OST), so this is not included in this chapter, but current thinking is that the use of substitute medication such as methadone is necessary in the treatment of opioid problems but not sufficient, it

stabilises those dependent on opioids but is not a cure. In the UK and a number of other countries we have created a system for helping people stop using opiates but we have not really helped them become free of dependence (on both the drugs and the services that provide them). In some countries such as Canada, methadone is being given to users of Oxycotin, many of the young people, to help them discontinue use of the pain killer; the result has been an increase in methadone users who are also buying Oxycotin on the street. This is not an example of best practice in harm reduction.

The fourth section is a global geographical review highlighting what services have been available in all the continents and where the deficiencies lie. Whereas we are well informed about Western Europe, North America and Australia we are less well informed about parts of the world with large populations, increasing problems, and a marked deficiency of services. This comprehensive survey has highlighted how far harm reduction has come since the 1980s, from being a mainly northern European and Australian concern to being truly global and reaching some of the most disadvantaged people in the world.

We have assembled a distinguished group of experts to write this book, some well known and some less well known, but all experts in their fields. There may appear to be some gaps in the content and this is not accidental; there are some subjects that deserve more space than this long book allows and it is our intention to include them in another book. There is, for example, discussion of gender issues in a number of the chapters, but no specific chapter on girls and women. This is one example of a subject which needs more space than allowed here.

The chapter on Australasia is different in format to the other regional chapters. The author who was to write this was unable to do so due to unforeseen circumstances and we therefore gathered, at short notice, a distinguished panel of Australian and New Zealand authors to write a number of perspectives on these two countries.

Any book on a subject like this is only as good as its current content and we are aware that this is only a snapshot of harm reduction a decade into the twenty-first century. It is hoped that this will provide a useful resource for students, academics, policy-makers, law enforcement officers and all those interested in the reduction of harm. An attempt has been made to be comprehensive, but even in a book of this length there will be gaps. The subject of performance and image enhancing drugs was to have been included but again the authors were unable to deliver the chapter (for reasons beyond their control and not because of performance deficit) and it is hoped to devote another book to this increasingly relevant area.

Harm reduction has become part of accepted practice in many parts of the world. It is inevitable that new challenges will arise, new drugs that will cause moral panics and new political systems that will reject the libertarian ideas of harm reduction. What is important is that in both policy and practice the foundations have been laid to continue this work, to develop it, and to try to reduce the harm that is associated with the inevitable use of psychoactive substances and the other behaviours associated with human beings such as gambling and sex work.

Chapter 2

A BRIEF HISTORY OF HARM REDUCTION

Diane Riley, Richard Pates, Geoffrey Monaghan and Patrick O'Hare

The first few thousand years

Harm reduction has no doubt been part of the human behavioural repertoire since psychoactive substances were first used by our early ancestors. In most cultures which used such substances (and this appears to have been almost all), social rituals and religious codes often regulated consumption and associated behaviours. In many societies today these rites of passage, rituals and codes have all but eroded, leaving a void that risks and harms can fill. Until the industrial revolution, harms related to human-machine interaction (or collision) were, while still an occurrence (the arm caught in the grindstone, the leg in the plough), were not of such high risk to so many as to demand the regulations that we have today. In this chapter we give a brief overview of some of the historical underpinnings of harm reduction as we know it, including the role of police in reducing drug related harm.

Historical understandings of the risks of injecting

The practice of injecting substances into the body has been around for centuries. For example, Christopher Wren, in the seventeenth century, conducted experiments of injecting a dog with various substances including opium using a bladder and a quill as a form of syringe (Wren, 1665). He injected into the veins and reported that '*the opium, being soon circulated into the brain, did within a short time stupefy, though not kill the dog*', this probably being one of the first reports of the injecting of an opiate. He also reported '*that liquors thus injected into the veines without preparation and digestion, will make odde, commotions in the blood, disturb nature, and cause strange symptoms in the body*' (sic) indicating again an early example of the knowledge that injecting into a vein will produce sensations in the brain.

It was not until the invention of the hypodermic syringe in the 1850s that the practice of injecting became a popular and regular feature of medical treatment. The syringe as we now know it, with a barrel, plunger, hollow needle with a chamfered end was first produced by Charles Hunter (1858) who improved a design produced by Alexander Wood in 1853 (Wood, 1855) by adding a lateral opening in the needle. (For a full discussion of the history of injecting see Macht, 1916; Howard-Jones, 1947; Pates and Wichter, 2005.) In the latter part of the nineteenth century the use of injection to administer medication became increasingly popular especially for the injection of morphine. Kane (1880) in the preface to his classic text on the injection of morphia said that 'a physician of the present day without a hypodermic syringe in his pocket or close at hand would be looked upon as would have been a physician 50 years ago, did he not own and use a lancet'. But he went on to say 'There is no proceeding in medicine that has become so rapidly popular; no method of allaying pain so prompt in its action and permanent in its effect; no plan of medicine that has been so

carelessly used and thoroughly abused; and no therapeutic discovery that has been so great a blessing and *so great a curse* to mankind as the hypodermic injection of morphia.’ So within 30 years of introduction and widespread use there were already concerns about the use of the syringe.

By 1870 Allbutt became concerned about indiscriminate use of the syringe and complained that ‘patients are now injecting themselves daily or more than daily during long periods of time, for neuralgia, which are as far from cured as they were at the outset’. Levinstein (1878) also was concerned about the misuse of the hypodermic syringe and attributed the problems of morphine addiction to allowing patients to have access to the syringe allowing them to inject at will. A Professor Gaillard Thomas (quoted by Kane, 1880) stated that he would never teach a patient how to inject him/herself for fear of developing a morphine habit.

As early as 1862 there has been concerns about the accidental transmission of disease by injecting, a case of the possible transmission of syphilis as a result of a contaminated small pox vaccination was discussed in the *British Medical Journal* (Acton, 1862). Although no conclusion was reached the possibility was raised. One of Kane’s (1880) recommendations was that needles should always be thoroughly cleansed after using on syphilitic or carcinomatous patients and patients ill with contagious or infectious diseases.

Kane (1880) reports a number of cases of patients dying from tetanus following injections. He quotes cases back as far as 1867 as reported in the *Lancet* where a case was reported as being ‘due probably to the use of rusty needles’. He also quotes a case of a woman dying in 1871 where the syringes were in a very dirty condition apparently not having been wiped after use and that the steel needles were in a very rusty state. Three other cases of death from tetanus were reported in the *Lancet* following the injection of sulphate of quinine, again rusty needles being associated with the deaths.

Calvel (quoted by Kane, 1880) ‘collected many cases of abscess, traumatic fever and other accidents produced by hypodermic injection of morphia’, but believes they were all caused by ‘the state of the needle, improperly prepared solutions and to the cachexia produced by the morphia habit’.

It is clear that there has been concern about injecting virtually since the invention of the syringe and as will be seen later in the book (see chapter 11 on injecting) the risks associated with injecting are one of the main areas of concern in the harm reduction arena.

The eighteenth-century gin craze

Concern about the dangers of alcohol use has also had long historical precedents. In eighteenth-century London there was what is known as ‘The Gin Craze’. Daniel Defoe wrote in 1728 about the heavy drinking of gin especially among the poor, ‘common people get so drunk on Sunday that they cannot work for a day or two following. Ney [sic], since the use of ‘Geneva’ [gin] has become so common they cannot work at all, but run from one irregularity to another ’til they become arrogant rogues’ (Defoe 1728 quoted in Linnane, 2008).

The reasons for the excessive use of gin were partly due to the cheapness of gin and its availability. Duties on home produced spirits were very low compared to imported spirits and Britain was producing a huge amount of grain which was distilled into gin (Linnane, 2008). Duty was 2d per gallon and there was no need for retail licences to sell it and it was therefore sold in thousands of premises across the capital. Men, women and children all drank gin, using it as an anaesthetic to quieten starving children and as a food substitute for starving parents.

Over the next 22 years a number of Acts were passed in an attempt to control the gin craze (and the consequent harm). In 1729 a licence fee of £20 was imposed for retailing spirits and duty was raised from 2d to 5 shillings per gallon. By 1733 these were repealed as they were apparently unworkable and further drunkenness and disorder occurred. In 1736 another Gin Act was

introduced requiring those retailing spirits to pay a £50 licence fee. Spies were paid to inform on people circumventing the Act and this led to rioting and the stoning to death of some of those informers. In 1751 the Gin Act suppressed some retail outlets and initiated further increase in taxes so that within a few years the annual consumption of gin fell from 11 million to 1 million gallons. This was clearly an attempt to reduce the harm being done to London's poor and eventually worked through legislation, taxation and through the use of paid informers.

The history of policing and harm reduction

The historical literature on police services in Britain contains a number of examples of laws, programmes and practices which fall neatly under the rubric of harm reduction. Of course, British police services prior to the late 1980s did not use the term to describe these programmes and practices but few would now disagree that they were formulated and underpinned by similar considerations as their modern-day examples; namely the reduction of harms caused by infectious diseases, alcohol and drug misuse and sex work and a desire to divert some offenders, particularly young people, alcohol and drug misusers and sex workers away from the criminal courts. Indeed, some of the so-called modern or new approaches have their historical links to policies and programmes which stretch back decades; at least one practice dates back some four hundred years.

Alternatives to prosecution for offences involving alcohol and other drugs

For decades, the most widely used alternative to prosecution in Britain has involved the use of the *formal caution*. Following the introduction of Home Office Circular 30/2005, the *formal caution* is now referred to as a *simple caution by* Home Office officials and police services in order to distinguish it from *conditional cautioning*.

The practice of using the simple caution has its origins in the discretion given to police whether or not to initiate a prosecution when an offence is disclosed; a point reinforced by Lord Denning in delivering his judgment in the case of *R. v. Metropolitan Police Commissioner ex parte Blackburn*:

Although the chief officers of police are answerable to the law, there are many fields in which they have discretion with which the law will not interfere. For instance, it for the Commissioner of Police or the chief constable, as the case may be, to decide in any particular case whether enquiries should be pursued, or whether an arrest should be made, or a prosecution brought . . . He can also make policy decisions and give effect to them, as for instance was often done when prosecutions were not brought for attempted suicide.

MPS records show that something akin to simple cautioning was being used in 1833 (Steer, 1970) causing the Commissioner to issue the following instruction during that year:

In some returns of charges refused, when the charge has been preferred by a police constable for disorderly conduct, the reason alleged by the Inspector for not taking the charge is 'Dismissed upon promising not to be guilty of such conduct for the future'. The Commissioner altogether condemns such practice.

Regarding the specific practice of using the simple caution for adult drug offenders, there is a widely held belief that this practice has its origins in the Home Office Circular of 26/1983 which laid down the Attorney General's Guidelines on the criteria to be applied by all persons or agencies who had to decide whether these should be a prosecution in a particular case. Some believe that it was a practice first introduced by the Merseyside Police, England, in the late 1980s as part of the 'Mersey model of

harm reduction’. Neither supposition is correct. As in the case for other offences, the practice has a long history. Although no precise date can be assigned, the practice dates back to at least the sixteenth century. A book entitled *Quacks of old London*, published in 1928 (Thompson), recounts how one John Halle ‘a worthy doctor of Maidstone’ described the quacks – known as ‘counterfeit javels’ – who thronged to that town in 1565. Among them was John Bewley, a notorious quack from London, who having been arrested in Maidstone was brought before the local justices: ‘He was let off with a caution, and advised “to leave such false and naughty deceits and begone”.’

The following examples, drawn from MPS prosecution and policy files, and police service Annual Reports to the Home Office, clearly show that simple cautions were administered for a variety of drug offences, including those which are now defined as ‘drug trafficking offences’, over one hundred years before the Home Office Circular 26/1983:

- In October 1877, the Registrar of the Pharmaceutical Society issued ‘caution letters’ to some twenty offenders for offences under the Pharmacy Act 1868.
- In 1903, a chemist received a simple caution by the MPS for offences relating to the unauthorised sale of opium tincture under the Pharmacy Act 1868.
- In 1926, a man appeared at the Greenwich Police Court, London, for offences under section 5 of the Poisons and Pharmacy Act 1908. The summonses were dismissed but a caution was nevertheless administered by the magistrate.
- Two chemists and one other person received simple cautions by Manchester City Police in 1926, for offences contrary to the Dangerous Drugs Acts 1920–3.
- On 30 July 1931, a MPS police inspector administered a simple caution to a woman by for attempting to obtain 36 grains of morphine by means of a forged prescription.
- In September 1932, the daughter of the Dean of Exeter, received a simple caution by the MPS (following advice from the Director of Public Prosecutions) for two offences of supplying drugs.
- On 19 October 1932, Mrs Leonie Fester was cautioned by the MPS (following advice from the DPP) for unlawfully obtaining prescriptions, and in turn unauthorised supplies of morphine, from two doctors.
- Of the 118 persons arrested by the MPS Dangerous Drug Squad in 1965, 45 (38%) were cautioned at the request of the DPP.

It is also worth noting that in some cases the drug involved would now be described as Class A drugs – i.e. the opium tincture and morphine. Since administering simple cautions to drug offenders is thought to avoid the stigmatisation and the damaging effects a conviction can have for an offender, numerous commentators view the practice as an important component of police services’ harm reduction policies (O’Hare, 1992; Kaal, 2001; Task Force to Review Services for Drug Misusers, 1996). And, over the years, this is how the British police services have come to see the practice.

Drug treatment in police stations

In Britain, the practice of providing controlled drugs such as dihydrocodeine and methadone to detainees held in police stations so as not to disrupt their treatment regimens or to help them stave off withdrawal is longstanding. According to MPS archives, morphine was occasionally prescribed to detainees held in London police stations as long ago as the 1930s. Certainly, dihydrocodeine (in the form of DF 118 tablets) was often prescribed to heroin addicts held in London police stations in the 1980s and the early 1990s. Arrestees who were able to prove that they were entitled to receive

methadone on prescription would also be prescribed the drug if their time in police detention was expected to be lengthy or s/he exhibited signs of withdrawal distress. In accordance with medical guidelines and rules governing the treatment of persons in police detention, methadone could only be administered to a detainee under the direct supervision of a ‘police doctor/surgeon’ (or Forensic Medical Examiner as they were later called).

Drug referral schemes

Long before Drug Referral Schemes were established and evolved into the well-defined programmes of the late 1990s, British police services had been experimenting with the idea of referring drug misusers to appropriate drug treatment programmes. In general terms, the idea of intervening at the point of arrest in order to divert offenders thought to have problems relating to their use of alcohol or other drugs can be traced to the latter part of the nineteenth century following the passing of the Inebriates Act and the Habitual Drunkards Act in 1879, and the twentieth century saw sporadic initiatives aimed at introducing ‘detoxification centres’, safer alternatives to police cells for people under the influence and schemes aimed at providing information about services. Specifically, the origins of DRS can be traced back to a letter dated 11 September 1934 from a Home Office civil servant to the Assistant Commissioner, Crime, at New Scotland Yard, suggesting that ‘drug addicts . . . in many cases’ could be coerced into treatment as an alternative to prosecution.

The history of two different systems

In the first 3 decades of the twentieth century there were very different responses to the problems of opiate addiction in the UK and the USA. In the late nineteenth century opiate addiction in America was legal although stigmatised (Courtwright, 2001). A series of laws beginning with the Smoking Opium Exclusion Act (1909) and culminating in the Harrison Act in 1914 made access to legal opiates very difficult. Although opiates were not prohibited the Harrison Act made physicians and pharmacists and others who dealt with narcotics register with the US Department of the Treasury, pay a tax and maintain records of the narcotics they dispensed. The Act also demanded that physicians who prescribed narcotics followed certain provisions. However, there arose the question as to whether they could prescribe opiates to ‘maintain’ an opiate addict’s habit and the Treasury and courts refused this provision. Physicians who did continue to prescribe were harassed and prosecuted and this led to the majority of the clinics established to treat and supply addicts were closed (Courtwright, 2001).

In contrast in the UK questions were being raised about prescription and control of narcotic drugs for addicts (Spear, 2002). In 1923 an Assistant Under Secretary of State, Sir Malcolm Delevingne, wrote a letter to the Minister of Health asking ‘for an authoritative statement on the prescribing of morphine to an addict’. This eventually led to the establishing of a commission under the Chairmanship of Sir Humphrey Rolleston, then President of the Royal College of Physicians to examine the question. The main conclusions of the Rolleston report (Ministry of Health, 1926) which established what came to be known as the British System were as follows:

There are two groups of persons suffering from addiction to whom the administration of morphine and heroin may be regarded as legitimate medical treatment, namely:

- a. Those who are undergoing treatment for the cure of addiction by the gradual withdrawal method.;
- b. Persons for whom, after every effort has been made for the cure of addiction, the drug cannot be completely withdrawn, either because:
 - i. Complete withdrawal produces serious symptoms which cannot be satisfactorily treated under the ordinary conditions of private practice; or where
 - ii. A patient, who while capable of leading a useful and fairly normal life so long as he takes a certain non-progressive quantity, usually small, of the drug of addiction, ceases to be able to do so when the regular allowance is withdrawn.

So while in the USA maintenance of addicts became difficult and virtually disappeared until the mid-1960s, when the early methadone clinics researched by Dole and Nyswander in New York started, in the UK maintenance, a firm plank of harm reduction, has been continued for more than a century.

The twentieth century

Harm reduction as we know it is a social policy with respect to drugs which has gained popularity since the 1980s, primarily as a response to the spread of Acquired Immune Deficiency Syndrome (AIDS) among injection drug users. Although harm reduction can be used as a framework for all drugs, including alcohol, it has primarily been applied to injection drug use because of the pressing nature of the harm associated with this activity (Riley, 1993; Riley and O'Hare, 2000).

Harm reduction has as its first priority a decrease in the negative consequences of drug use. This approach can be contrasted with abstentionism, the dominant policy in North America, which emphasises a decrease in the prevalence of drug use. According to a harm reduction approach, a strategy which is aimed exclusively at decreasing the prevalence of drug use may only increase various drug related harms, and so the two approaches have different emphases. Harm reduction tries to reduce problems associated with drug use and recognises that abstinence may be neither a realistic nor a desirable goal for some, especially in the short term. This is not to say that harm reduction and abstinence are mutually exclusive but only that abstinence is not the only acceptable or important goal. Harm reduction involves setting up a hierarchy of goals, with the more immediate and realistic ones to be achieved in steps on the way to risk-free use or, if appropriate, abstinence; it is consequently an approach which is characterised by pragmatism.

The main characteristics or principles of harm reduction are (Riley, 1993; Riley et al., 1999):

- *Pragmatism*: Harm reduction accepts that some use of mind-altering substances is inevitable and that some level of drug use is normal in a society.
- *Humanistic values*: The drug user's decision to use drugs is accepted as fact, as his or her choice; no 'moralistic' judgment is made either to condemn or to support use of drugs, regardless of level of use or mode of intake. The dignity and rights of the drug user are respected.
- *Focus on harms*: The extent of a person's drug use is of secondary importance to the harms resulting from use.
- *Hierarchy of goals*: Most harm reduction programmes have a hierarchy of goals, with the immediate focus on addressing the most pressing needs.

The roots of harm reduction as we now know it are in the United Kingdom, the Netherlands and North America.

Liverpool, United Kingdom

In the mid-1980s, there was an influx of cheap brown heroin on Merseyside. It was estimated that there were about 20,000 drug users in the Region in a population of about two and a quarter million people (O'Hare, 2007). Liverpool, Wirral and Bootle had high levels of heroin use. Parker, Newcombe and Bakx estimated that there were about 5000 heroin users in the Wirral out of a total population of about 300,000 (1988). In 1985, John Ashton of the University of Liverpool Department of Public Health and later Mersey Regional Director of Public Health and Howard Seymour, Head of the Health Promotion of the Mersey Regional Health Authority (MRHA) had been developing the ideas of the New Model for Public Health, bringing together the old ideas of environmental change, prevention and therapeutic interventions but adding the importance of 'those social aspects of health problems which are caused by life-styles. In this way it seeks to avoid the trap of victim blaming' (Ashton and Seymour, 1988: 21). They were interested in applying it to the emerging public health problem, drugs and AIDS, using a strategy, which involved political organisation, market research of groups at risk, creative use of mass media, activism, the involvement of the risk groups in programmes and community support.

This resulted in the implementation of a harm reduction approach to drug use in the region, especially the threat of HIV through the sharing of infected injecting equipment, based on public health principles that influenced the later historic recommendations of the UK's Advisory Council on the Misuse of Drugs (ACMD) 1988 report. Services were created from 1985 involving the consumer, which gave drug users the information and the means to protect themselves, especially those drug injectors most at risk.

A crucial part of the strategy was the opening of the Mersey Drug Training and Information Centre (MDTIC), which later became HIT, which was a drop-in centre whose brief was to give honest information to anyone who requested it and training to the public and professionals. It was next door to the Liverpool Drug Dependency Unit (LDDU), which prescribed methadone and, in a few cases, heroin. It was part of the New Public Health approach, oriented to prevention rather than treatment and based 'on the premise that this can best be achieved through involving the population at risk in the solution to problems of public health (being consumer-led); that they be informed of the risk and be able to make healthy choices' (Eaton et al., 1998: 309).

The realisation that HIV could be contracted through sharing contaminated injection equipment was met with an immediate pragmatic response based on public health principles. If the danger was infected equipment, clean equipment had to be made available. A syringe exchange service was started in 1986 in a converted toilet at MDTIC. Methadone was used to attract people to come to services to find out how to reduce risk and to get clean equipment. If there were still people who had not come in to services, the services had to go out to where they were. User friendliness was a key concept. It had to be easy to access (low threshold), open at the right times with a committed non-judgmental staff.

The target group was identified. Making and maintaining contact with that target group and delivering specific interventions to that population at risk, the 'population' rather than an 'individual' approach, was the method used. Cooperation was sought from the target group, the public, professionals (which was indeed the hardest group to convince with many doctors using their clinical freedom to provide what they thought was best for their patients) and the police. The objectives were very simple: to reduce sharing of injection equipment; to reduce injecting drug use; to reduce street drug use; to reduce drug use; and if possible you increase abstinence. This was presented as a hierarchy of objectives. The emphasis was very much on the more achievable aims of reducing risk behaviour rather than reducing drug use. Needle exchange, prescribing mainly of

methadone, outreach and the provision of information were the instruments used. Service uptake was rapid with 733 people making 3,117 visits to the Syringe Exchange Service in the first 10 months. In the first 2 years, 1090 people attended the Drug Dependency Unit. Hitherto, 200 people per year coming to a traditional agency would have been the norm. Soon the Maryland Centre was opened to provide basic health care as well as HIV prevention services. This all became known as the Mersey Harm Reduction Model.

The police were becoming disillusioned with arresting the same people time after time. They recognised the new approach's potential to reduce this and made the decision not to target drug users coming to services, to stay away from the vicinity of services and to refer drug users they arrested to those services. They didn't use possession of injection equipment as evidence of drug use and referred people to needle exchanges and saw public health as part of their role alongside public order. 'Consequently, as a Force, we support the needle exchange schemes and have a non-prosecution policy with regard to possession of used needles that are to be exchanged' (O'Connell, 1990).

It is interesting to contrast the approach of the police with the approach of Liverpool City Council, which was controlled by the Labour Party and which was vehemently against the policy. They saw methadone as the 1980s version of the 'opium of the people' and were a constant thorn in the side of everyone involved with the project in Liverpool. The local Labour Party position also contrasted with the attitude of the right wing central government led by Margaret Thatcher, which made a substantial amount of funding available to roll out the approach across the country.

The approach resulted in behaviour change; there was a reduction in sharing of needles and syringes and use of street drugs. Many more people were attracted into services who had never been before. Some people who had been injecting heroin for 25 years made their first appearance at a drug service. A range of physical problems relating to injecting drug use were found and dealt with. The drug using population of Merseyside became healthier and more knowledgeable. In the late 1980s, Liverpool was responsible for about one third of the methadone prescribed in England. Contact was made with over 50% of the high-risk population. An HIV epidemic did not happen among injecting drug users in Mersey. By 1996 there had been 20 people who had contracted the virus through injecting drug use and some of these seem to have contracted the virus before moving to Liverpool.

In 1988, the British Advisory Council on the Misuse of Drugs stated: 'We have no hesitation in concluding that the spread of HIV is a greater danger to individual and public health than drug misuse. Accordingly, services which aim to minimise HIV risk behaviour by all available means should take precedence in developmental plans.'

In 1990, the harm reduction approach was applied to the new phenomenon of the use of MDMA (Ecstasy) with the publication by MDTIC of the milestone leaflet, *Chill Out*. Key features of this leaflet were that it was culturally attuned, attractive, non-judgmental and user friendly. This leaflet created a controversy with the Director of MDTIC being attacked on the front pages of the *Daily Star* and the *Sun*. MRHA decided that the leaflet was in line with their strategy and decided it should be defended against accusations of encouraging drug use and so the director also appeared on national television programmes. However, its publication was a turning point in the public's understanding of harm reduction in that a debate about the issue took place on Merseyside and nationally, with a favourable outcome in terms of public opinion (McDermott et al., 1993).

The first conference on the reduction of drug related harm was organised by Pat O'Hare and colleagues in Liverpool, UK, in 1990. The conference has taken place every year since then in cities around the world with attendance by representatives from more than 80 countries.