DRUG & ALCOHOL FINDINGS *Hot topic*

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GO Harm reduction: what's it for?

The answer to the title question seems self-evident – to reduce harm. But what counts as harm, and whose harm? Is intoxication a harm, or a benefit? If people are offended by drug use, is that a harm we need to place in the balance? What if magnifying the user's harm from drug use deters others from turning to drugs – good or bad?

According to the UK Harm Reduction Alliance, harms may take the form of health, social or economic impacts, and may affect individuals, communities, or whole societies – a formulation which permits opposing stances in the name of harm reduction, from prioritising the health of drug users, to sacrificing this to promote other social objectives and reduce the financial burden on the state. Ambiguity of objectives within harm reduction is nested within a policy frame which may see any form of harm reduction – if acceptable at all – as a gateway to the overarching goal of stopping illegal drug use, an activity seen in and of itself as simply wrong, and/or one whose harms are so extreme that 'no use' is the only justifiable strategic objective. As Pope Francis put it in 2014, from this perspective, "Drugs are an evil, and with evil you can't give way or compromise." For the leader of the Catholic world, harm reduction in the form of prescribing substitute drugs was just such a compromise: "I would like to say with great clarity: drugs are not defeated with drugs! ... Substitutive drugs, then, are not a sufficient therapy but a veiled way of surrendering to the phenomenon."

These opposing agendas have from the advent of harm reduction led to a shifting balance between seeing it as acceptable only in the service of the greater good of reducing or eliminating drug use, versus seeing harm reduction as the overriding objective, one which should never be sacrificed to the anti-drugs agenda. This hot topic traces such shifts in discourse and policy since the time when in the early 1980s realisation of HIV's injecting-related spread shook up British drug policy and British drug services.

HIV roots of harm reduction

When in the 1980s harm reduction emerged in Britain as a distinct strategy, what it was for was clear: to stop the spread of HIV among injectors, and even more so from injectors via risky sex to the rest of the population. Sometimes reluctantly, its proponents accepted that prioritising this objective meant de-prioritising others, including treatment of addiction itself and the drive to achieve abstinence amongst the patients. In reaching this for many uncomfortable position, it may have helped that HIV was also spread sexually, and on this front harm reduction rather than abstinence seemed both more natural and given the lessons of UK history, more effective.

Though it did not seem it at the time, in hindsight the turning point came in 1986 in the report of a committee set up by Scotland's chief medical officer, prompted not by a drug treatment field focused on addiction and abstinence, but by a coalition of medical and public health forces. Using the newly available test for HIV, in 1985 an Edinburgh GP had discovered that half his injecting patients were infected with the virus. The committee was drawn largely from outside the drugs field and led by Brian McClelland, director of the Edinburgh and South East Scotland blood transfusion service. For several years he had been at the forefront of moves to prevent this at first unidentified infection spreading through blood donated by infected donors, especially drug injectors and homosexual men.

His committee saw preventing injecting-related spread through the eyes of infection control specialists, relegating to side issues reservations deriving from the dominant philosophies of addiction treatment, then focused on abstinence and away from the long-term maintenance prescribing of the 1970s. For McClelland's committee, saving lives was the name of the game. Since "Infection with HIV poses a much greater threat to ... life ... than the misuse of drugs," they straightforwardly concluded: "On balance, the prevention of spread should take priority over any perceived risk of increased drug misuse."

> *Infection with HIV poses a much greater threat to ... life ... than the misuse of drugs*

What that meant in practice was that injectors who won't stop injecting must be given clean injecting equipment and counselled against sharing it, and that maintenance prescribing was seen as a way to reduce injecting and maintain contact with injectors, not primarily as a step towards detoxification and abstinence. In a context where it was feared that confiscation of injecting equipment by Lothian's police had aggravated the epidemic, even enforcement was to be subjugated to the new HIV agenda: "Police policies in relation to individual drug misusers should be reviewed to ensure so far as possible that they do not prejudice the infection control measures recommended."

McClelland's radical reversal of priorities was never fully accepted within government. The report was cited the following year when the UK Conservative government's Norman Fowler announced the establishment of pilot needle exchange schemes to test if they could combat this deadly new infection, but in a statement which also clung to traditional aims to "reduce the extent of drug misuse" and "explain [its] dangers" to "misusers". More trenchantly, in response to McClelland, former Scottish Health Minister John Mackay likened issuing needles to addicts to offering prospective murderers "good weapons so that you'll murder them efficiently and quickly, and they won't suffer much ... heroin addiction is wrong ... we ought not as a government, as a country, be encouraging it by giving people the means."

Also in 1987, harm reduction surfaced as a coherent philosophy promulgated to the British drugs field. In the face of HIV and an increasing drug problem, it was "High time for harm reduction", argued Russell Newcombe in the field's house magazine. He itemised its theoretical and pragmatic foundations, among which was that "Rather than viewing drug use simply as a 'deviation' to be rectified ... In many cases, even 'dependent' drug use can be reconstrued as just another example of the basic human desire to repeat pleasurable activities." Across drug policy from prevention to treatment, a focus on "controlled use (rational choice, care and moderation)" would displace the focus on abstinence.

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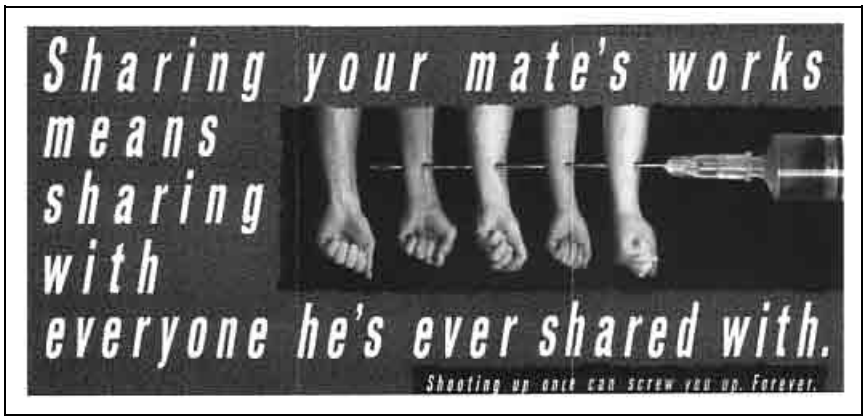
The year after this revolutionary call, in 1988 the UK government's official drug policy advisers echoed the McClelland committee, asserting that "The spread of HIV is a greater danger to individual public health than drug misuse." Like the Scottish committee, for the Advisory Council on the Misuse of Drugs this meant "services which aim to minimise HIV risk behaviour by all available means should take precedence in development plans." However, abstinence remained the "ultimate goal", if one that must be shelved when it conflicts with preventing the spread of HIV. They urged that "The different goals for drug misusers must not be seen as in competition", but in fact they were. HIV could only be curbed by accepting drug use rather than primarily trying to stop it.

Hedged about as it was, at first this reversal of priorities from tackling drug misuse to tackling HIV was not fully embraced by government, which seemed keen to maintain its existing policy thrust and tack on an element of HIV prevention at the edges rather than making this the dominant theme. The Scottish government was openly dismissive of the chapter in the report calling for urgent action north of the border. However, in England by 1989 a national campaign poster was forefronting the risks of sharing needles with only the small print seeking to reduce injecting ▸ illustration. On public billboards, it symbolised the priority given to reducing the spread of HIV, a move away from the explicitly anti-drug "Heroin screws you up" campaign of a few years before, though still one seen as stigmatising drug users.



Street poster from England in 1989.

Subjugate to recovery?

Today in the UK there remain radically different interpretations of the priority to be given to harm reduction and of its role in the response to drug problems, each self-evidently valid to their adherents. From in the 1980s it seeming obvious that harm reduction must take priority over combating drug use, now to some influential figures, the reverse seems equally obvious.

> *It is self-evident that the best protection against blood borne viruses is full recovery*

In 2012 the UK government's 'roadmap' to a recovery-oriented treatment system subjugated "All our work on combating blood borne viruses" to the national strategy's "strategic recovery objective", arguing that "It is self-evident that the best protection against blood borne viruses is full recovery". What 'full recovery' entailed was never spelt out, but what it did *not* entail was clear: out of the mix was remaining in methadone or other maintenance prescribing programmes, and the continuing drug use whose consequences are addressed by harm reduction services such as needle exchanges.

For the UK Harm Reduction Alliance and co-signatories including the UK Recovery Federation, the roadmap's interpretation was not at all self-evident. Their response transformed the government's *Putting Full Recovery First* title to *Putting Public Health First*, challenging what they characterised as an "ideologically-driven hierarchy" which places full recovery at the top, with "any other achievement marked as inferior".

> *Harm reduction is the goal – not a step along the road to recovery*

That theme was uncompromisingly taken up by the Australian Injecting & Illicit Drug Users League. Concerned that their nation's harm reduction orientation was under threat from UK-style "new recovery", they attacked the UK government's roadmap, insisting that "Harm reduction is the goal – not a step along the 'road to recovery' or the path to 'freedom from dependence' " – a formulation derived from their core belief that harm reduction is the "principle paradigm upon which drugs policy should be based. All other approaches (eg, demand reduction, supply reduction) can have validity only where there is strong evidence that they are appropriate, practical and equitable means of reducing drug-related harm." Like the home-grown attacks on the same document, they reversed the primacy order so self-evident to the UK government, subjugating treatment and recovery to harm reduction, not the other way round.

Methadone maintenance – life-saver or life-limiter?

These polarities are endemic in debates about methadone maintenance and allied approaches for heroin addiction, seen as both treatments for dependence, and harm reduction while dependence continues. In 2012 a UK attempt to reconcile these objectives complained that "the protective benefits [ie, harm reduction] have too often become an end in themselves rather than providing a safe platform from which users might progress towards further recovery." This expert group drawn largely from the drugs field was prepared to see recovery pursued even if it "will sometimes lead to people following a potentially more hazardous path, with the risk of relapse". At the same time, "preservation of benefit" was seen as a legitimate reason for continuing treatment; not least among those benefits is the preservation of life and health. Again the attempt was made to mount horses galloping in different directions – possible at a clinical level, but at a policy level, choices have to be made.

For some prominent drugs field figures, the harm reduction benefits of remaining on methadone are a clinching argument in its favour, and a warning that an evangelistic recovery agenda will cost lives. Others think the risks worth it, arguing that "Leaving the protection of methadone maintenance treatment may increase the risk of death. But it might also be the way to a brand new life beyond your wildest dreams, where you find jobs, homes and friends." Leaving methadone is a dangerous business, but a proportion of former patients will swim rather than sink, and for some on the banks, the sight of those 'recovered' swimmers leaving methadone and addiction behind seems worth the loss of others.

Different games

In these debates the fundamental question is whether harm reduction is a primary goal, a second-best outcome when recovery is for the moment unattainable, or valid only as an engagement strategy and platform for recovery. The answer flows down to operational issues, such has how to weight the alternatives when harm reduction gains are threatened by trying for 'full recovery', riskily entailing the end of substitute prescribing and treatment exit. Another dilemma addressed by needle exchanges since their inception in Britain is how energetically and persistently (if at all)

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exchange staff should pursue treatment entry and drug use reduction objectives for their clients, if this risks deterring some visitors who just want to collect equipment and go. The reverse risk is missing opportunities to make greater risk-reduction gains through treatment and cessation of injecting.

Peacemakers try to gloss over the divides with, 'We are all in the same game in the end, aren't we?', posing harm reduction and abstinence-based recovery as ends of an unbroken continuum of helping the patient, to which all can sign up. But in reality these are different games, their rules and aims deriving from differences in what we value most and how we see drug use: as always bad, or only bad if it causes harm.

As so often, science will never settle these issues, but it can clarify the consequences of deciding them one way or the other. Run this search to find analyses which address harm reduction as an intervention goal.

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