A Public Health Approach to Illegal Drugs

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Historians may date the beginning of the Harm Reduction movement from June of 1998. This is when the Secretary General of the United Nations opened a letter with 47 pages of signatures including 11 Nobel Prize winners, 7 heads of state, BC's Provincial Public Health Officer, and 13 Canadian Members of Parliament. The letter stated:

> *We believe that the global war on drugs is now causing more harm than drug abuse itself...every decade the United Nations adopts new international conventions, focused largely on criminalization and punishment. Every year, governments enact more punitive and costly drug control measures. Every day, politicians endorse harsher, new drug war strategies. What's the result? The illegal drug industry has empowered organized criminals, corrupted governments at all levels, eroded internal security, stimulated violence and distorted both economic markets and moral values. These are the consequences not of drug use per se but of decades of failed and futile drug war policies.* ***Scarce resources, better expended on health, education, and economic development are squandered*** *on ever more expensive interdiction methods. Realistic proposals to reduce drug related crime, disease and death are abandoned in favour of rhetorical proposals to create drug free societies.*

This is a reflection of a global change in how addiction is understood and treated around the world.

The goal of this talk is to examine this change both globally and in Vancouver. It is important to examine other countries as we can learn from their successes and mistakes. The policies of the USA have significant impact on how we structure our laws and we should try to avoid their errors.

Changing the way we deal with drugs. Our current approach is ineffective, expensive, and harmful to individuals, families and society. It also hurts services, the economy and can damage political processes.

The war on drugs

What is the effect of the war on drugs in the USA and Canada?

Social consequences of the "war on drugs"

1) Propaganda - difficult to get accurate information.
2) War restricts personal freedom - War Measures Act.
3) Canadian citizens become enemies (civil war?).
4) Promotes violence (police violence [1,2,3] gang violence. [4,5,6])
5) Promotes crime.
   - 60-80% of B&E's in Vancouver are to support habit.
   - $2000 worth of stolen goods + $200 cash to buy $20 worth of drugs.
   - In the first year of Prohibition crime leaped 24% in USA major cities.[7]
   - Vancouver had 3 pawn shops in the Downtown Eastside in 1980's now there are 45.
6) Promotes disrespect for the law (drug laws have been based on racism, smoking marijuana is a common crime).
7) Restricts religious practices. It took many years of litigation before the US allowed the Native American Church to use peyote legally, in accordance with their historical traditions.

8) Racist (The USA has the highest incarceration rate in the world with 468 of every 100,000 being in jail. The next two countries South Africa = 333 and Soviet Union = 268. In the USA Caucasians = 197 and black Americans = 1,534. (In Texas and Oklahoma it exceeds 2000 per 100,000). Canada is 143 per 100,000.[8,9] One in four black man in the USA in either in jail, on probation or parole.[10]
9) Prohibits beneficial use of some drugs (i.e. hemp paper, clothes, medicine).
10) Biases research and data collection.[11] "Out of the box" research is not supported. This prevents our exploration of possible beneficial uses of currently illegal drugs and does not allow us to fully understand drug using behavior in our society. We have difficulty distinguishing between drug use, abuse and addiction.
11) Observed wide spread violation of the law, weakens general respect for law and order. 72% of all drug offences are for marijuana. The majority of these 47,000 offences (in 1996) were for simple possession.[12]
12) Goes against free and democratic society.

Individual consequences of the "war on drugs"

13) Seizure of property in USA (profits go to police departments). Suspicion is enough to enact forfeiture. 80% never get charged with a crime they just loose their possessions. [13] Police Departments have requested more asset seizures from their officers due to low departmental budgets.[14,15]
14) Criminal acts are encouraged. As enforcement "pressure" goes up, drug smugglers and large volume dealers insulate themselves by increasing the "organizational levels" between them and the buyer. The larger the organization, the more people are drawn into the criminal lifestyle.[16]
15) Goes against concept of personal responsibility.
16) Promotes intolerance of others - discrimination/marginalization /disenfranchising.
17) Isolates people who could be more connected to others and services.

Health consequences of the "war on drugs"

18) Lack of pure drugs and clean needles are a health risk.
19) May lead to punitive pain management practices. [17]
20) Increases the spread of blood born diseases. IV drug users do not inject safely if they are not in a "health service" context.
21) Drug users die. No over-dose death has occurred in a supervised injection site.
22) Arial crop spraying in source countries damages environment and innocent people.[18] ("Plan Columbia" is the USA spraying coca plants)
23) Produces more concentrated (more addictive) drugs which are easier to smuggle.

Family consequences of the "war on drugs"

24) Children and young teens become criminalized. In the USA the manditory minimum sentences apply to individuals age 18 and older. This results in adults finding children to deal and transport drugs.[19]
25) Children (and families) are victimized. In Vancouver children are apprehended for a few days during a "grow operation" bust.
26) Family members become enemies.

Consequences of the "war on drugs" on police and health services

27) Takes away police time from pursuing "real" criminals. Drug investigations are time and resource consuming. Our scarce tax dollars would be better spent dealing with crimes of force, fraud and public safety.
28) Is abusive to the police. To require the police to treat addicts as criminals creates job stress. Can be

a corrupting force within this service, which tarnishes their profession. [20,21,22,23]

29) Makes it difficult to provide health services (supervised sites, drugs on Rx).

Economic consequences of the "war on drugs"

30) Escalates price of drugs (so black market is well paid but price is not high enough to make unavailable).
31) Very costly (police, courts, jails).
    - Average jail time in U.S.A.: manslaughter = 12 months: drugs = 60 months. (More than kidnapping, robbery, arson, extortion, assault).
    - It costs more to send a man to jail than it does to send him to college (room, board, tuition and transportation). Prison bed cost $50,000 to $70,000 to build and $20,000 to $35,000 per year to fill. The per pupil cost at a well equipped American school is $15,000.[24]

Canada spends $400 million per year on drug enforcement which is approx 1000 MCF FTE's. Canada spends $4 on enforcement for every $1 it spends on health services in response to the problem of illegal drugs. [25]

32) Black market does not pay taxes. Various estimates for the black market range from $600 billion [26] to $100 billion.[27] The most commonly estimated size is $400 billion.[28,29] Canadian Federal Government collected $121 billion in taxes last year. Vancouver drug trade estimated to be $400,000 to $800,000 per day or approx 200 million per year (Werner Schneider, Illegal Drug Use conference Sept 2000).
33) Drug money destabilizes world markets.[30,31] the Economist has recommended drug legalization for this reason.[32]
34) Legitimate businesses are "scared away" from some neighborhoods.
35) There are direct and indirect costs from crime. The direct costs are the emotional and financial burden on the victims, and the societal costs of maintaining the justice system. The indirect costs are the increases in retail prices (to factor in shoplifting) and increased car and house insurance prices.
36) The value of real-estate near open drug scenes is devalued.

Political consequences of the "war on drugs"

37) People become suspicious of government. Many books have been written suggesting various conspiracy theories regarding the government's involvement in drug dealing.[33,34,35]
38) The drug war supports terrorism. Terrorists rely on "hidden" laundered money to operate which often comes from drug dollars.
39) Drug money destabilizes governments.[36,37,38,39,40] For example, Pablo Escobar killed many government officials in Columbia.[41] There are more guns in the drug armies in Burma than the government army[42]. Smugglers who have money and need protection join forces with guerilla armies who need money and have weapons. Joining forces = government instability [43].

The assumption of the war on drugs is that drug addicts (or drug users) are bad and need punishment and segregation from society (prisons).[44]

Do we have the "war on drugs" in Canada? In dealing with illegal drugs Canada spends four dollars on enforcement for every one dollars it spends on treatment and prevention.[45]

A good indicator that the War on Drugs is failing comes from a group of 50 American Federal Judges who, in protest to unfair mandatory minimum sentencing, announced that they would no longer try drug cases.[46]

Does criminalization stop drug use?

Being illegal does not mean they are not available:

- Easy to get delivered.
- Exist in all schools.
- Teens believe that drugs are easier to get than alcohol. [47]
- Bruce Alexander makes it clear that historically the law does not stop use most of the time.[48]
- Throughout the war on drugs drug price has gone down and purity has gone up. [49,50,51]
- Drug related emergencies have gone up throughout the war on drugs.[52]

Does decriminalization increase drug use?

If criminalization does not reduce drug consumption does decriminalization increase drug use? Eleven states decriminalized marijuana during the 60's and 70's and this did not increase consumption.[53,54,55] Amsterdam where marijuana is legal has half the consumption of the USA where it is illegal.[56,57]

Historical polarized debate does not offer solutions.

The debate in our society for the last 20 years has been legalization vs criminalization. The debate has not progressed as neither of these two polar opposites offers effective solutions.
If criminalization does not work what is the effect of legalization and promotion?

Alcohol \ tobacco model does not work (1&2 drug killers in our society).

We can't ignore the problem.
Needle park as an attempt to not criminalize and not actively deal with the problem.

Zurich - Switzerland
No penalty for use in one area
1000 user daily
1986-1994 closed after open for 8 years
Increased violence, HIV, robberies, gang violence, drug deaths
Black market thrived.[58]

What is Harm Reduction?

Harm reduction appears to be the best solution:

Harm reduction asks the Question: How do you reduce the harm to individuals and society given the fact that some individuals will use drugs.
We currently use harm reduction theory for many issues:
Cars kill people: safe driving courses / seat belts / stop signs / speed limits are all harm reduction strategies.
For young teenagers who are sexually active: while we disapprove, we also engage, provide services and give accurate information (and prescriptions). We understand the strict abstinence based messages alone would result is more pregnancies.

Eric Single (1999) examines three definitions of harm reduction:

1) That which applies to individuals who continue to use drugs.
2) All inclusive definition which includes all Addiction Services as all programs want to reduce harm.
3) Those programs which can be demonstrated empirically to reduce harm to users and the larger

society (including marginalization of users, social and personal costs).[59]

Harm reduction theory recognizes that there is a continuum of drug use from problematic to non-problematic.[60]

Harm Reduction is not the same as the criminalization, legalization debate.

Not just about legalization of drugs - it's a whole philosophy/set of values.
Not a Trojan horse for legalization.
Drug addicts are seen in the larger social context of poverty, family abuse, social isolation, marginalization, and not just criminals in need of punishment.

This is a different model which is driven by:

- Medical/public health/treatment.
- Business, and economic think tanks (RAND, Fraser Institute).
- Human rights.
- Coroner (Vince Cain in 1995 recommended drugs by Rx, in Heroin OD report,[61] Larry Campbell, recently retired believes we need to discuss drug legalization).
- Compassion not punishment.
- Parents (Grief to Action).
- Police, are one of the main drivers in the UK.[62,63]
- There is a global transition occurring where previously under powered groups are gaining power. Women, aboriginals, gays, children, racial minorities are all slowing gaining in power around the planet. This transition is just starting to affect drug abusers.
- An increasing societal reluctance to criminalize "moral" issues (e.g. homosexuality, abortion, prostitution).
- Initial driver behind this model was HIV/Aids (if you say "just say no" to sex = HIV spreads/ if you teach people about safe sex techniques HIV declines in a population) HIV transmission graph. (IDU drop could be due to saturation of those at risk, more methadone, more smokeable cocaine, needle exchanges are spreading).
- Heroin overdose deaths (1999=277, 2000=256) in B.C.
- The internet. The Canadian Foundation for Drug Policy and the Lindesmith Center present easily accessible research, studies, and commentary which is available to anyone. It is not surprising that the US government is trying to suppress Internet discussions on drugs. (Wired News: Aug 6/99)
- 30% of Vancouver's IDU population is HIV positive and IDU is for approx 45% of all new infections.[64]

"Just say no" to drugs does not stop people from using drugs.

What do we offer people who choose to use (or people who "just say yes")?

Most services are for people who want to stop.
Need a range of services (that are client centered) for people at each stage of abuse/use.
Services to users are not incompatible with services to those who want to quit.
In order to engage addicts we must "meet them where they are".

"Drug policies must be pragmatic. They must be assessed on their actual consequences, not on whether they send the right, the wrong, or mixed messages".[65]

Eight Legal Options

Harm Reduction theory recognizes that there are many options in between the two poles of legalization and criminalization.

We have eight legal options available to us and each of these options produces different benefits and harms.

1) **Free market legalization:** The current capitalist "free market" system can be used to sell drugs. This would include promoting, advertising and finding creative ways to maximize sales and use of these substances.
2) **Legalization with "product" restrictions:** Under this model restrictions would be aimed at the "merchandise". "Product" restrictions can be aimed at manufacturers, packagers, distributors, wholesalers and retailers. Drug packaging, marketing, and method of sale would be specified. Advertising and promotion would be prohibited. Drugs would be sold in plain packaging with standardized weights. Retail outlet location, days and hours of operation would be controlled. The strength, formulation, method of use, and retail price of the drug would be regulated.
3) **Market Regulation**: This model is legalization with "product" and "customer" restrictions: It would include all of the "product" restrictions as outlined above, and would also restrict purchasers. Restrictions could include:
   - age of purchaser,
   - volume rationing,
   - proof of "need" in order to purchase,
   - registrations of purchasers,
   - proof of residency with purchase.
   - limitations in allowed using locations.
   - Using this option, a health care worker (e.g. nurse, counsellor, social worker) could assess the "customer" on a variety of factors including degree of addiction, documented need, residency and age. These "consumers" could then be registered and allowed to purchase a rationed amount to be used in designated spaces (i.e. supervised injection facilities, consumption rooms, home use). An active integrated prevention/public health education program integral to this model would also restrict customers.
4) **Allow drugs to be available on prescription:** Physicians could be allowed to prescribe currently illegal drugs for medicinal or maintenance purposes.
5) **Decriminalization:** The existing laws can be changed to remove legal sanctions. Under this option criminal prosecution is not an option for dealing with drugs. This term is often confused with the term legalization which specifies how drugs can be legally available. The term decriminalization is limited in it's utility as it only states what will *not* be done and does not explain what legal options *are* available.
6) **De facto decriminalization or de facto legalization:** The existing laws can be ignored. For many years the Netherlands have maintained the laws prohibiting the possession and sale of marijuana while allowing both of these in practice.
7) **Depenalization:** While existing laws are maintained the penalties for possession are significantly reduced. Penalty options under this option are; discharges, diversion to treatment instead of jail for significant charges (possession of large amounts and trafficking), and "parking ticket" status for possession of small amounts of drugs for personal consumption.
8) **Criminalization:** All existing laws prohibiting currently illegal drugs can continue to be enforced.

A significant issue to be explored is the effect that each of these options has on the black market. This criminal process spawns significant social pathologies and is very effective at distributing drugs in our society. The black market is created and maintained with criminalization, defacto decriminalization and decriminalization. It is diminished with prescription availability, and reduced or eliminated with

the legalization options.

Drug consumption from the legal market is increased with legalization and promotion or reduced as you progressively criminalize.

Lessons from Europe
Swiss study -prescription of narcotics: 1994 – 1996

- 1146 in total, 800 heroin users were given free IV heroin at 16 different sites (morphine and methadone were given to the rest).
- Participants would inject onsite up to 3 times daily with nurse present.
- No overdoses, no diversion to the black market.
- Improvements in physical health, mental health (depression, anxiety, delusional disorders) housing, employment doubled, contacts with the drug scene decreased, and criminal acts dropped by 60%.
- 83 of the subjects voluntarily choose abstinence during the study.
- Most were self limiting in dosage.
- Difference between heroin and methadone were: heroin was better at recruitment, retention and compliance. Heroin also had fewer side effects.[66]

In a 2001 follow-up, 1969 subjects were examined and the following conclusions were reached

- 22% had chosen abstinence treatment
- physical health (22% to 13%) and mental health (37% to 19%) improved.
- Homelessness dropped (18% to 1%).
- Criminality dropped (69% to 11%)
- Contacts with the drug scene dropped (59% to 14%)
- Cocaine use dropped (29% to 5%)
- Unemployment dropped (73% to 45%)[67]

Since harm reduction initiatives (heroin in trial status, low threshold living, day care projects, work place integration, counselling, needle exchanges, increased medical care, outreach workers, self help groups) have been introduced in Switzerland drug related deaths dropped.[68]

Amsterdam
In Amsterdam the Dutch have had marijuana available for many years.

- Goal is to make drugs boring.
- Part of an integrated social policy.
- Per capita use is less than the USA today. Increase in use when it first became available (use curves matched American use curves) but this dropped off to a lower per capita level. Now the per capita ratio of Netherlands to the USA is half.
- The Dutch use the word normalization to describe the goal of reintegrating addicts into the mainstream society. This is one of their primary goals.

The Dutch believe that repressing marijuana increases the use of heroin and cocaine. There is evidence that this is true. The soldiers in Vietnam initially smoked marijuana and when this was repressed (sniffer dogs, etc.) heroin use escalated, when pressure was applied to reduce heroin use IV use increased, as the drugs became less pure and more valuable[69]. David Smith of the Haight Ashbury free

clinic notes that after "Operation intercept" (Nixon 1969) the availability of heroin increased markedly.[70]

Global Change

Frankfurt

Frankfurt, Germany, in 1992 started practicing harm reduction in response to an open drug scene. They started a process where all the involved administrators started a dialogue about this open drug scene. They increased low threshold methadone, shelter beds, needle exchanges and harm reduction education. They opened supervised injection sites and multi-service crisis centers. Crime, OD's, HIV rates, and public drug users[71] all decreased.

In response to the Swiss study on Heroin Prescription, the Dutch[72] the Germans[73] and Spanish[74] have agreed to launch a heroin prescription program study. This is being discussed in Canada, Denmark[75], Luxembourg and Australia[76] . Heroin is available in England, Netherlands and Switzerland.[77] Medical use of Marijuana has passed referendums in seven states. Drug users groups are becoming a legitimate voice in the discussion in Europe. Germany, Switzerland, Netherlands[78] and Australia have supervised fixing sites (consumption rooms). Testing for the purity of drugs is available in the Netherlands, Switzerland, France and Spain.[79]

Dirk Chase Eldredge, a right wing conservative republican wrote *Ending the War on Drugs*. He states:
In 1997 the federal government spent $1.4 billion on interdiction with little, if any, tangible impact on the drug problem. If that money had been spent on anti-drug education and treatment, not only would Americans have received real value for their tax dollars but also many would enjoy a much improved quality of life [80].

Supervised Injection Sites

Spain, Germany (13 sites), Switzerland (17 sites), Netherlands (16 sites), and Australia have supervised fixing sites (consumption rooms).

- Staffed by public health nurses, doctors, health care workers
- All fixing is observed but no assistance is given
- Clean and comfortable, safe needles, bleach, safe sex information, other health promotion programs are promoted, easy to educate as people are accessible
- Some social space is provided
- Often connected to other services (showers, medical, food, counselling, etc)

The main goals of supervised injection sites are:

- Preventing overdoses
- Preventing the spread of blood born diseases
- Providing a gateway to education, treatment and rehabilitation
- Provide "normal" contact with service providers
- Reduce injection damage (as clients are more relaxed than they are when "street fixing")
- Provision of basic medical care to reduce use of hospital facilities

The main concern voiced by local residents is the "honey pot" effect. It is claimed that supervised injection sites will attract drug users to the area and create more chaos in the area. The evidence is clear that this does not occur. The community response after these sites are established is either neutral

or positive as there is a reduction of street disorder.[81,82,83]

So far studies[84,85] evaluating supervised injection sites have shown that:

- Public nuisance decreases
- Criminal activity decreases
- Public drug consumption drops
- Expropriated public space is returned
- Health care costs decreased
- Police can focus efforts on the supply side of the problem
- Court time and incarceration costs are reduced
- Overdose deaths decrease (no deaths have occurred to date)
- Utilization of emergency and hospital resources decreases
- Safe sex practices improve
- Injection practices improve
- The number of discarded syringes on the streets decreases
- HIV (and other blood born infections) decrease
- Marginalized users are contacted
- Users connect with abstinence based treatment
- Referrals to "high threshold" recovery services occur
- Contact with users (social integration, referrals, etc) is easier than contact at other services like needle exchanges as users relax and are not "taking care of business".

Dr Perry Kendall stated "the evidence from other countries is very, very convincing and more robust than the evidence we had when we started putting in needle exchanges.[86]

After a supervised fixing site has been open for a number of years the average age of the users goes up. (Werner Schneider 2000).

Banner Statement

The Harm Reduction parade has a banner that states: A*ddiction in our society needs to be seen as a Public Health problem, not a criminal justice problem.* This conclusion can be found from the following two very different perspectives.

In England the physicians were not limited in what they could prescribe (as they have been in USA and Canada) up until 1965. After that there were specific clinics to deal with addicts. Dr. John Marks took over a clinic, which was prescribing heroin with the intention of closing it. He evaluated it and found that the patients were free of AIDS (he expected 15-20%), in good health, and most were employed. The local police tracked 100 of his patients and found a 94% drop in theft, burglary and property crimes. The most significant finding was that convictions for illegal possession in the community dropped immediately after the clinic opened. Marks concluded that the demand curve for drugs is U shaped. If drugs (or alcohol) are too freely available or if they are prohibited - you increase consumption. The bottom of the U appears to be drugs available on prescription[87]. The bottom of the U curve also includes using public health tools and viewing addiction in the light of the social determinants of health.

Using John Mark's U curve we observe that society's treatment of illegal drugs needs to move to the centre to reduce demand. Alcohol has historically been on the other high end of the curve (legalize and

promote). Our society is changing by moving toward the centre with restrictions on advertising, server training programs, designated driver programs, prevention and public education programs, etc.

The War on Drugs is primarily driven by the U.S.A. which is a country which has a difficult time finding the middle ground on issues which they see as being "moral". The two extreme poles are free market capitalism vs. demonization. Their response to gambling is either prohibition or Las Vegas. Their debate about drugs is either "war on drugs" or libertarianism. The U.S.A has had greater difficulty controlling multinational corporations which sell alcohol and tobacco.[88]

RAND Study (1994) compared the effectiveness of four types of drug control. Source control (attacking the drug trade abroad), interdiction (stopping drugs at the border), domestic law enforcement (arresting and imprisoning buyers and sellers) and drug treatment. The researchers asked "how much would the government have to spend on each approach to reduce cocaine consumption by 1%". They devised a financial model with over 70 variables. Treatment was seven times more effective than law enforcement, ten times more effective than interdiction and twenty one times more effective than attacking drugs at their source. The most cost effective way of reducing drug consumption in society of to provide treatment/prevention services.[89]

Models of Support for Harm Reduction

The **Health model** offers prescription of drugs but is limited to the physical aspects of addiction.
The **Legalizers** strength is human rights and clarity about the failure of the war on drugs but they miss the treatment and prevention issues.
Traditional treatment models do not include the human rights or comment on the punitive societal model.
The **Public Health model** takes the best of all of the above as this model includes prevention, treatment, drug prescription, and the understanding of the broader social determinants of health which include empowerment of addicts who are willing to challenge the punitive model.

The Future of Harm Reduction in Vancouver?

What could harm reduction mean for Vancouver?

- More Methadone[90] and lower threshold methadone[91,92] (e.g., methadone bus, no urine tests, increased accessibility).
- Prescribing heroin, cocaine, amphetamines.[93]
- More needle exchanges, throughout Vancouver.
- Supervised injection sites.[94]
- Less stigma (more political power) to addicts. Groups of drug users are organizing, and gaining in political power. Vancouver examples are VANDU, the Consumer Board, the Compassion Club. The advantage of this is a greater connection between addicts and mainstream population.
- More detox and treatment options, more prevention programs.
- Selective non enforcement of laws.[95] The police are changing and starting to behave more like social workers (Through a Blue Lens - Dec 99, CBC TV).
- Drug testing in raves.[96]

Vancouver City Hall produced report (Nov 2000) calling for a "four pillar" approach, which attempted to balance treatment, prevention, harm reduction and enforcement. Having supervised fixing sites, drugs available on prescription and drug testing was all discussed in this report. After this was released Ujjal Dosahjh (provincial premier) stated that he believes that supervised fixing sites are not enough and drugs need to be available on prescription.[97]

Harm Reduction across Canada

What does it mean nationally? The Canadian Association of Chiefs of Police and the RCMP support decriminalization for possession of marijuana.[98] The Senate in April 2000 agreed to from a committee to review Canada's anti-drug legislation. In their terms of reference it states that their goal is "develop a national harm reduction policy in order to lessen the negative impact of illegal drug use in Canada...focusing on use and abuse of drugs as a social and health problem."[99] The first federal paper, (on Canada's strategy for dealing with IDU's) produced by **both** justice and health perspectives was been released in March 2001. The goals are:

- Injection drug use should be regarded first and foremost as a health and social issue.
- People who inject drugs should be treated with dignity and have their rights respected.
- Services should be accessible and appropriate and should involve people who inject drugs in all aspects of planning and decision making.
- Programs and policies should take into account diversity among the injection drug using population such as gender and culture, and polydrug use.
- The community and stakeholders should be involved in the responses.

This paper also discusses supervised fixing sites and making heroin available on prescription.[100]

Alan Rock (Federal Health Minister) has given his support for heroin trials and supervised injection sites.

Implications for treatment, prevention, enforcement and the larger society

Harm reduction implications for treatment:

- Abstinence is only one of many goals.
- Cutting down, using less dangerous drugs or methods, are legitimate goals.
- More focus on improving social/vocational functioning.
- Increased attention to "normalization" or social reintegration.
- Relapse would not mean treatment failure.
- Need to provide services for users who want to continue using (like supervised fixing sites).
- Users play a legitimate role in defining service structure and function.
- More medical involvement is needed. Drugs of abuse need to be available on prescription.

Harm reduction implications for prevention:

- Abstinence based messages are appropriate for youth who have not yet used drugs.
- Credibility needs to be maintained by not exaggerating drug dangers, (tell the truth).
- Drug prevention messages would be part of a larger package including issues like communication skills, family functioning, assertion and other health promotion material.
- Reducing harmful drug using practices, for those who use drugs, is legitimate prevention practice.
- Increasing social integration is a vital prevention practice.

Harm reduction implications for enforcement:

- The harm of marginalization of drug users needs to be understood and acted on.
- Enforcement staff need to adopt the public health vision of drug abuse and form linkages with the public health service.
- Enforcement (pertaining to illegal drugs) needs to be focused on crimes of force (e.g. violence and B&Es) and fraud (e.g. money laundering) and public safety concerns from drug use (e.g. drinking and driving).
- Police would get to redeploy staff from consuming drug busts for possession and utilize staff to deal with dealing and other crimes.
- All source control efforts are stopped.

- Clean needles, methadone and condoms (etc.) need to be available in jails.
- Enforcement workers would provide linkages to treatment and prevention services.

Implications for the larger society

- When people see reduction in open drug use, dealing, discarded needles, and crime they will support harm reduction initiatives.
- Drug use (including alcohol) is controlled in a society by the rituals and norms which develop around using practices[101]. These social controlling norms need time to develop.
- Harm reduction is an incremental process. It will take time for society to learn how to control drug use using public health initiatives, increasing communication and decreasing isolation.
- It will take time for critical mass of the public to think "health problem" not "criminal problem" when confronted with drug use.
- Addicts need to be seen as "Canadian citizens who use drugs".

Regional control is important.[102] DTES needs it's own ability to regulate as the needs of this community are unique. The Health Canada report suggests we challenge international drug control agreements.[103]

Drug courts: An incremental step in the right direction. Treatment not incarceration is the goal.

Social Factors leading to a reduction of drug consumption

If criminalization does not reduce drug consumption, what are the factors, which do result in drug reduction in society?

1. Social and family integration. The largest drop in consumption of alcohol in North America (since Columbus) was not prohibition but settlement, adoption of family life and increased social cohesiveness.[104,105] Aboriginal communities around the world who have been marginalized and have poor internal support, have high abuse rates.
2. Widely shared public opinion. Reduction of cigarette use in recent times has been "agreed upon public pressure" which has been followed by smoking space and sale restrictions.
3. Availability of treatment (The RAND study, John Mark's U curve).
4. Prevention programs are an effective way of changing public opinion.
5. Prohibit advertising as this increases drug (alcohol and tobacco) consumption.
6. Employment (with a future).
7. Age. Recreational drug use in North America has been dropping as the baby boomers mature. This is contrasted with the steep rise in addictive drug use (DAWN hospital admissions).
8. Urban vs Rural.
9. Perceived health risk.[106]
10. Family modeling and clarity about expectations.
11. Ritualistic use controls drug use in a society.[107]
12. Level of poverty, family violence, and abuse.
13. Normalization.

The Dutch vs the Swedes

Social factors are more important indicators than criminal sanctions in determining levels of drug abuse. This conclusion is apparent in the debate between Sweden and the Netherlands. These two countries are the two extremes in Europe. The Dutch are the most liberal and the Swedes are the most repressive in their drug policies. Both countries have very low addiction rates (the Netherlands are slightly lower[108]) in spite of their contrasting policies.[109] Both countries are wealthy welfare states and have a high degree of social cohesion. It is predictable that they would both experience limited

problems. One of the most significant differences between these two countries is the Swedes have an overdose rate which is 3 time higher than the Netherlands (1.6 vs .5 per 100,000 pop).[110] In Amsterdam drug use is decreasing in Sweden drug use is increasing.[111] The Netherlands have the lowest rate of drug injection in Europe.[112] The Swedes have the highest HEP C infection rate in Europe (92% of IDU's).[113] The Netherlands used to be the radical amongst the Europeans and now that most of Europe is changing, Sweden is now the radical of this group.[114]

Economic savings

Harm reduction has to be an integrated social policy not just legalization/decriminalization of drugs. Addiction must be seen as a treatable illness and treatment and prevention is the most cost effective way of dealing with this problem. A study done in California found that for every dollar spend on treatment $7 was saved in crime and health care costs. Another study found that one dollar spent on treatment resulted in $11.54 savings in social costs.[115]

Abstinence

Harm reduction can increase the chance of abstinence.

1) Public Health nurses and counsellors are more likely to promote abstinence than dealers.
2) Harm Reduction programs increase sense of personal power, which is needed to believe that life can be better without drugs.
3) The black market would be smaller and drugs from this source would be less available. The reduced availability of drugs would increase abstinence.
4) If we saw drugs as a health problem and not a criminal justice problem this would free up money to be put into treatment beds and prevention programs. Increased availability of immediate treatment and increased prevention efforts would increase abstinence.
5) Harm reduction services can take away the "excitement" of the process of buying and using drugs which is attractive to some addicts.
6) Increased contact with service providers leads to increased "normalization" or social integration which reduces drug use.
7) Harm reduction programs provide links to abstinence based services.
8) If funds were redirected from enforcement to the social determinates of health (poverty, abuse, violence, etc) our society would target the issues which actually reduce drug consumption.

The fact that Harm Reduction programs increase abstinence is found in studies of needle exchange programs. In one study of 720 NEP clients over half requested help to enter treatment[116]

Youth

What does harm reduction look like for youth? It is useful to understand that harm reduction is only useful for youth that are involved with drugs. Abstinence based messages are appropriate for youth who are not involved with drugs.

The Safety First program (Lindesmith Centre) suggests that cautionary honesty is the best approach. If the money was redirected from the criminal justice system into the treatment/prevention services youth would have more exposure to programs which were designed to assist them to make healthy choices. The Dutch believe that scare tactics increase drug consumption in youth and they embed drug prevention material in a larger health promotion context. A comprehensive harm reduction approach would reduce the adult dealers in our society, which would mean fewer drugs would be available for youth.

Cocaine

What does harm reduction for cocaine look like? A weak oral solution has been used by aboriginal people who have had no problems with chewing leaves. There are many examples of the fact that people will choose weaker drugs if given a choice. During prohibition people just drank whisky and rum, now the majority of sales are beer and wine. Most cigarettes sold are filtered not unfiltered and expresso the strongest coffee is not the most popular. If offering a weak oral solution was not sufficient to attract "hard core" IV drug addicts a continuum of method use could be established for each user. Offering less harmful ways of taking the drug would be beneficial. The path for an individual who uses cocaine of unknown dosage and purity, with unclean water (puddles) with an unclean needle in an unsafe setting, could start with using a clean needle with known dosage and purity, clean water in a safe setting. Shifting to smoking, snorting, and oral use may be subsequent steps on the road to abstinence. Bruce Alexander has written a paper concluding that stimulant maintenance is feasible in Vancouver.[117]

Alcohol and Tobacco

What does harm reduction mean for alcohol and tobacco? Using John Mark's U curve we observe that society's treatment of illegal drugs needs to move to the centre to reduce demand. Alcohol has historically been on the other high end of the curve (legalize and promote). Our society is changing by moving toward the centre with restrictions on advertising, server training programs, designated driver programs, prevention and public education programs, etc.

Benzodiazepines

What can we learn from our experiences with benzodiazepines? While we have significant social problems with these drugs, it could be worse. Using John Marks U curve we note that problems would increase if we legalized and promoted, or if we criminalized. Either of these two other options would increase consumption. Advertizing increases drug consumption and the black market, which is produced by prohibition, is very good at distributing drugs. At present youth do not have easy access to these drugs as they are controlled by the medical profession and therefore not available for sale in school yards. If we criminalized this would produce a black market would increase access to youth. We can work within the existing model, and apply public health education techniques to patients, their families, physicians and pharmacies. Doctors are accessible, dealers are not.

12 Step community

The 12 step community which has been historically resistant to Harm Reduction is now starting to change it's perspective. The book *Heroin* by Fernandez is published by Hazelden Press and it provides a scathing review of why the War on Drugs is failing.

Enabling

What is the difference between enabling and harm reduction? This word has two definitions the dictionary definition and the therapeutic definition. From the therapeutic perspective *enabling* is supporting the denial process to assist in continuing addiction and all the connected negative behaviors. This definition of enabling consists of avoiding, shielding, taking over responsibilities, rationalizing and rescuing. It denies addiction and avoids honesty. Harm Reduction deals directly with the addiction, with no denial. The individual is supported to take personal responsibility and make better choices around both the addiction and related harmful behaviors. As harm is reduced in the addicts life and he/she becomes "normalized" (through increased contact with health care providers, counsellors, etc) and empowered and physical/psychological health improve. Enabling deals with one factor alone,

the support of addiction. Harm reduction deals with all aspects of an individual's life as it deals with issues from poverty to parenting. From the therapeutic perspective harm reduction is not enabling as enabling is about denial, harm reduction is about honesty.

According to the dictionary *enabling* simply means "to help" and from this perspective Harm Reduction is enabling as it's goal is to help someone to live.

Sound bytes for change

In our media driven society change is usually driven by specific sound bytes, like the following:

- The war on drugs creates more harm than drug use itself.
- Addiction is a Public Health problem not a criminal justice problem.
- The war on drugs is actually a war on people.
- Humanize don't demonize.
- Just say "no" to the war on drugs
- The war on drugs is a problem masquerading as a solution.

March 20, 2002

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