



## Harm Reduction: What's in a Name?



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## **Abstract**

Harm reduction has become one of the most contentious issues in drug use policy. The initial clarity and simplicity of the phrase "harm reduction" has evolved into an emotion-laden designation that has polarized groups with a common goal and is interfering with opportunities to engage high-risk populations and the implementation of a range of substance abuse services and supports. The purpose of this paper is to examine the concept of "harm reduction" and to work towards an approach that seeks to bridge the gap between opposing philosophical positions so as to maximize the benefits of programs for drug users and minimize the harm created through misperceptions of what constitutes "harm reduction". Policy makers and practitioners are urged to advance evidence-based programs, policies and interventions regardless of the label applied to them and to work towards implementing a comprehensive system of supports and services for dealing with substance abuse.

## **Background**

The use of illegal drugs is a serious public health and social problem in Canada. It is estimated that in 2002, illegal drug use accounted for 1,695 deaths and 352,121 hospital days. The economic burden on health care and law enforcement, the loss of productivity as a result of premature death and disability, and the overall social cost of substance abuse was estimated at \$8.2 billion in 2002 (Rehm et al., 2006).

Injection drug use (IDU) presents a particular issue of concern, not only because of the severe impact of this behaviour on the lives of individual users, but also because of the broader public health impacts associated with the transmission of blood-borne pathogens such as HIV and hepatitis C and the threat to the overall safety of communities.

Over the past 25 years, a variety of measures have been implemented to deal with the immediate threats to public health associated with high-risk drug use practices such as IDU, including needle exchange programs, methadone maintenance programs, and supervised injection facilities. Because such approaches emphasize the minimization of adverse consequences associated with IDU rather than the cessation of drug use per se, they are often referred to collectively as "harm reduction".

In its most general sense, "harm reduction" refers to any program, policy or intervention that seeks to reduce or minimize the adverse health and social consequences associated with drug use. This broad perspective would include virtually any drug policy, program or intervention since at some level, the objective of all such measures—including enforcement and abstinence-oriented programs—is to reduce the harmful consequences of drug use in some manner. A narrower definition of "harm reduction" focuses on those policies, programs and interventions that seek to reduce or minimize the adverse health and social consequences of drug use without requiring an individual to discontinue drug use. This latter definition recognizes that many drug

users are unwilling or unable to abstain from drug use at any given time and that there is a need to provide them with options that minimize the harms caused by their continued drug use to themselves, to others, and to the community, including overdose, infections, spread of communicable diseases, and contaminated litter. This approach does not exclude discontinuing drug use in the longer term and can serve as a bridge to treatment and rehabilitation services.

It is the latter definition of "harm reduction" that has created the polarization of groups within scientific, public health, clinical, and social policy communities. It would appear that on the one hand, there are those who view "harm reduction" as a way to help drug users minimize the damage they cause to themselves and others through their continued use of drugs. On the other hand, a "zero-tolerance" perspective on illegal drugs views "harm reduction" as an approach that encourages drug use and appears to provide thinly-veiled support for the decriminalization or legalization of drugs.

Strongly-held opinions on both ends of the "harm reduction" spectrum have caused a rift between people who should be working together to improve the lives of drug users and reduce societal problems. This ideological argument is unproductive and threatens the credibility of scientists and practitioners and, more importantly, hinders the implementation of well-intentioned and effective policies, supports, services, interventions, and treatments aimed at protecting all people from the adverse health and social consequences associated with drug use. Programs should neither be accepted nor rejected on the grounds of ideological perspective, but rather on the basis of an objective assessment of their effectiveness.

## Key Principles of Harm Reduction

The following are key principles of harm reduction as outlined by the CCSA National Policy Working Group (1996):

- *Pragmatism*: Some level of drug use in society is to be expected. Containment and amelioration of the drug-related harms may be a more pragmatic and feasible option, at least in the short term, than efforts to eliminate drug use entirely.
- *Humane Values*: No moralistic judgment is made about an individual's decision to use substances, regardless of level of use or mode of intake. This does not imply approval of drug use. Rather, it acknowledges respect for the dignity and rights of the individual.
- *Focus on Harms*. The extent of a person's drug use is of secondary importance to the risk of harms resulting from use. The first priority is to reduce the risk of negative consequences of drug use to the individual and others. Harm reduction neither excludes nor presumes the long-term treatment goal of abstinence. In some cases,

reduction of level of use may be one of the most effective forms of harm reduction. In others, alteration to the mode of use may be more practical and effective.

- *Balancing Costs and Benefits:* Some pragmatic process of assessing the relative importance of drug-related problems, their associated harms, and costs/benefits of intervention is carried out in order to focus resources on priority issues. This analysis extends beyond the immediate interests of users to include broader community and societal concerns. This rational approach allows the impacts of harm reduction to be measured and compared with other interventions, or no intervention at all. In practice, such evaluations are complicated by the number of variables to be examined in both the short and long term.
- *Priority of Immediate Goals.* The most immediate needs are given priority. Achieving the most pressing and realistic goals is usually viewed as first steps towards risk-free drug use or discontinued use.

## Harm Reduction in Practice

There are numerous examples of policies, programs and practices for dealing with high-risk drug use, including injection drug use. These programs provide a range of services to a variety of drug-user groups, the primary objectives of which are the reduction of adverse consequences associated with injection drug use. Some of these are outlined below. This is not a comprehensive list; rather, it is intended to provide examples of a range of programs and services available.

*Needle Exchange Programs.* Needle exchange programs involve the provision of clean needles and syringes to injection drug users. The primary purpose is to prevent the spread of blood-borne pathogens and help reduce the incidence of infection and other harms associated with the use of damaged, non-sterile or shared syringes. Needle exchange programs are in place throughout Canada and exist in a number of different operational formats. For example, variations include restrictions on the number of syringes that can be distributed, the requirement to exchange used syringes for clean ones, stationary versus mobile sites, and distribution through pharmacies or "vending machines".

Research has demonstrated beneficial effects of needle exchange programs, including decreased rates of high-risk injection practices such as syringe borrowing, lending, sharing and re-use (Kral et al., 2004; Wood & Cooney, 2004); decreased rates of HIV, hepatitis C and B infections (Wood & Cooney, 2004); increased likelihood of entering detoxification (Strathdee et al., 1999); and increased rates of treatment uptake and retention (Wood & Cooney, 2004).

*Supervised Injection Sites.* Safer or supervised injection sites are specialized facilities that provide injection drug users with a clean, safe, unhurried environment. Sterile injection

equipment is provided and health care and social service professionals are available to deal with health issues, provide counselling, and facilitate access to detoxification and treatment programs. Supervision is provided by professionals trained in low-risk injection techniques and overdose intervention. The only supervised injection site in Canada is located in Vancouver.

Although there are challenges associated with the evaluation of the overall impact of supervised injection sites, research has shown that clients using these facilities demonstrate increased awareness of high-risk injection behaviour and increased adoption of lower-risk alternative practices (Hedrick, 2004; Kerr et al., 2005). Supervised injection site use has also been associated with entry into detoxification services, which is associated with increased use of follow-up addiction treatment services (Wood et al., 2007).

*Methodone Maintenance.* Substituting oral methadone for illegal opiates is a recognized approach for reducing reliance on illegal opiates often administered by injection. Methadone maintenance helps to establish a level of stability among users necessary to build the personal and social resources needed to allow the individual to approach a new lifestyle free from the use of injectable opiates. The program also provides the opportunity for users to connect with health care, treatment and social services. Methadone maintenance programs operate across Canada.

Traditional methadone maintenance programs require users to undergo detoxification and be abstinent from opiate use as a condition of acceptance into the program. Injection drug users often lack the social and economic supports or the motivation necessary to engage in detoxification and treatment to achieve abstinence. The process of withdrawal and detoxification presents a very real barrier to accessing methadone maintenance programs. Low-threshold methadone maintenance provides opiate users with a means of stabilizing their lives without requiring complete cessation of illicit drug use. There are fewer requirements for urine testing and counselling than traditional methadone maintenance, but the opportunities for health care, social services and treatment remain.

Methadone maintenance therapy is the most well-researched and evaluated intervention for opioid dependency. Demonstrated impacts include reduction in the use of opiates and other illicit drugs; reduction in drug-related criminal activity; improvement in physical and mental health; improved social functioning; reduced risk behaviour for, and actual transmission of, blood-borne diseases; and reduced mortality (Health Canada, 2002). In addition, other studies have shown those in methadone maintenance therapy have increased legitimate earnings, have health problems diagnosed earlier, and are more likely to receive counselling and referral to other services (World Health Organization, 2004).

*Drug Substitution.* Drug substitution programs provide users with legal substances to replace their reliance on illegal drugs. The goal is to reduce recourse to criminal activity to support the purchase of illegal substances, to control the quality and dose of substances used, to provide participants with safer-use practices, and to provide access to health and social services. Providing heroin users with pharmaceutical-grade heroin has been ongoing in the U.K. for many years. In Canada, the North American Opiate Medication Initiative (NAOMI) trials are funded by the Canadian Institutes of Health Research (CIHR) to study the extent to

which heroin-assisted therapy can improve treatment outcome for treatment-resistant chronic heroin users. Prescription dexamphetamine has been used as a substitute for cocaine.

*Peer-administered Naloxone.* Overdose mortality deaths among opiate users can occur because those witnessing an overdose are often reluctant to seek medical assistance for fear of enforcement intervention. Naloxone is a fast-acting opiate antagonist, reversing the effects of opiate overdose within minutes. Overdose mortality rates can be reduced by making naloxone more readily available. Peers and outreach workers trained to administer naloxone can be a source of this life-saving intervention.

*Street Outreach Programs.* Marginalized drug users often have limited access to even the most basic services. Many are reluctant to contact any form of health or social service agency for fear of public identification and/or stigmatization. Street outreach programs take health and risk-reduction services such as clean syringes, sterile swabs and bottled water to drug users. Marginalized populations are often best reached through peers familiar with how and where to access the target population and who can build relationships of trust based on the credibility of personal experience.

*Safer Crack pipe programs.* The distribution of safer crack pipe kits is intended to reduce the transmission of blood-borne pathogens associated with the sharing of crack pipes and to reduce the harms to the user associated with the use of unsafe equipment. In addition, through the distribution of the kits, the use of injection as the route of administration decreases, thereby reducing injection drug use and the associated adverse consequences (Leonard et al., 2007). The distribution of kits also provides an opportunity to place users in contact with health and social services and to provide education on reducing the risks associated with the use of crack cocaine and other high-risk behaviours.

It is important to recognize that each of these programs or interventions is unique and responds to a specific need. Each program is a discrete, stand-alone entity that is not dependent on any of the others. Unfortunately, there has been a tendency to view all approaches under the "harm reduction" banner as part of a package. But implementing a harm reduction approach does not necessarily imply that all initiatives and interventions must be used. Although each program has a general objective of reducing harms, they vary considerably in their focus, target group, specific objectives, and intensity. The harm reduction approaches adopted need to be appropriate to the extent of need in the community.

## **Harm Reduction in Other Areas**

To advance the issue further, consider that programs and policies to protect the individual and society from the harms associated with high-risk behaviours are not restricted to illegal drug use, but are routinely used in other areas of health and safety. For example, in medical practice, Type II diabetes is a chronic medical condition that threatens those who are obese and have a sedentary lifestyle. Few would object to providing medication such as insulin to

those so affected. Nevertheless, medication does not cure the condition; the primary goal is to reduce the likelihood of secondary disease conditions such as cardiovascular disease, retinopathy, neuropathy, and/or nephropathy. Although losing weight and becoming more active are often recommended, not everyone is successful in their attempts to adopt a healthier lifestyle. The use of medication to manage and control the secondary complications of Type II diabetes does not necessarily require the individual to change their behaviour.

Similarly, the distribution of condoms to prevent unwanted pregnancy and the spread of sexually-transmitted diseases among high-risk populations (including high school students) is an example of a public health measure that could also be labelled as "harm reduction". Such programs attract a degree of controversy; nevertheless, they continue because they address the reality of high-risk sexual activity. They are not intended to prevent the behaviour, but rather, to help reduce the negative consequences associated with it.

"Harm reduction" measures are also commonplace in the field of injury prevention and control. Seat belts, air bags, helmets for bicyclists and motorcyclists are all examples of measures taken to reduce the severity of injuries in the event of collision or upset. These measures neither prevent crashes nor attempt to reduce the high-risk behaviours that lead to negative events. Once again, the primary goal is simply to reduce the likelihood and severity of injury. Not only have such measures proven effective and garnered widespread support, in many jurisdictions they have become legal requirements.

The types of programs described above are examples of what is commonly referred to as secondary prevention. Whereas primary prevention is intended to prevent the occurrence of a disease or high-risk behaviour in the first place, secondary prevention focuses on early detection of the condition or disease with the goal of preventing its progression and the emergence of serious medical complications and threats to the health of the individual. The common factor in all these examples from various fields is a focus on reducing the adverse consequences associated with high-risk behaviours without an expectation that they will necessarily lead to a reduction in the antecedent behaviours. These programs, policies and interventions acknowledge that the behaviour is likely to persist and they do not pass judgment on individuals for poor lifestyle and/or behaviour choices. They accept that high-risk behaviour occurs and is often chronic and resistant to change. Hence, the focus is to minimize the negative consequences of the behaviour.

Others might refer to measures that typically fall under the banner of "harm reduction" or "secondary prevention" as a form of risk management. This phrase is often used in business and natural-disaster situations and reflects the need to control the adverse outcomes of a negative event. Whatever label is used to describe these types of programs, policies and interventions, each individual measure should be assessed objectively in terms of its effectiveness in reducing the negative impact of high-risk situations or behaviours on the individual, the community and society at large.

## **Conclusion**

In a recent discussion paper, Antonia Maria Costa, Executive Director of the United Nations Office on Drugs and Crime, pointed out that the 1988 UN convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances urges countries to adopt appropriate measures aimed at eliminating or reducing demand for illicit psychotropic substances with a view to reducing human suffering, including interventions to counteract the social and health consequences of drug abuse. In addition, the International Narcotics Control Board (INCB) acknowledged that harm reduction measures have a role to play in a demand reduction strategy. Success in reducing the adverse consequences of drug abuse and halting the epidemic of blood-borne diseases requires a three-part strategy: preventing drug abuse, facilitating entry into treatment, and establishing effective measures to reduce the adverse health and social consequences of drug abuse.

Misconceptions abound and to a large extent appear to be linked to a lack of clarity and a common understanding of what constitutes “harm reduction”. There exists a wide range of interventions, supports and services that can be included under the banner of “harm reduction”. For some, harm reduction has evolved into a philosophy for dealing with drug abuse and addiction. We would argue that “harm reduction” is not a single entity, but consists of any number of programs, policies and interventions that seek to reduce the adverse consequences of drug use, be it alcohol consumption, smoking or injection drug use. The focus of disagreement on “harm reduction” appears to be related to the type of drug use behaviour being targeted and the specific nature of the measure. For example, few would object to the use of nicotine patches, whereas supervised injection sites can evoke strong negative reactions. This situation illustrates that individual tolerance for “harm reduction” is not dichotomous, but varies along a range of interventions. The key issue, then, is not whether “harm reduction” is good or bad, or whether one is for or against it, but rather the extent to which we are able to accept specific, individual interventions, supports and services for dealing with problems of drug abuse.

The controversy surrounding "harm reduction" exists not only because it relates to the “social evil” of illegal drug use, but because of the mistaken perception that the phrase is a euphemism for increased drug use, decriminalization and/or legalization. The once-obvious clarity of the phrase “harm reduction” has been hijacked by the strong opinions voiced by those on both sides of the issue. The often vitriolic debate has only served to focus attention on the ideology of extremes at the expense of improving the lives of those individuals and families affected by drug abuse as well as the communities in which they live. To discontinue programs, policies and interventions simply because of an ideological objection to the term “harm reduction” and all of its perceived meanings would be a travesty of extraordinary proportions. Similarly, to adopt a measure simply on the basis of its being lauded as “harm reduction” would be equally fallacious. Rather, the merits of any intervention should be based on an objective assessment of the scientific evidence of its effectiveness and its appropriateness when weighed against a range of policy and program options.

The interests of individual and public health might well be better served by removing the term “harm reduction” from our collective lexicon and establishing a moratorium on the rhetoric. In its place, we need to engage in a discussion of the merits and limitations of specific, individual programs, policies and interventions that fall within the domain of secondary prevention.

The argument is sometimes made that harm reduction is far more than a term or a sampling of interventions drawn from its menu, but rather that it constitutes a philosophy. Adopting what is often positioned as an “all or nothing” approach simply reinforces the fears of those opposed to endorsing an open-ended definition. If this remains as a precondition of agreement on harm reduction measures, then we can despondently project little change for the future. It is time to break free of strongly held positions and to commit to understanding harm reduction measures as part of a comprehensive continuum that also includes prevention, education, detoxification, treatment and follow-up.

Drug abuse and addiction are truly chronic, multifaceted societal problems that require a range of policies, programs and interventions. However reasonable or objectionable certain measures may be to some people, our collective endorsement of specific programs should be based on objective, scientific evidence of effectiveness, with an appreciation of the intent of the intervention and whether it is the best course of action for specific problems. We should neither unilaterally accept nor reject measures because of where they fit within our ideological perspective or because of the way the term “harm reduction” colours our perceptions of their intent. We urge policy makers and practitioners to advance evidence-based programs, policies and interventions regardless of the label applied to them and to work towards implementing a comprehensive approach for dealing with drug use based on their demonstrated effectiveness.

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