OCCASIONAL PAPER No. 1

"Harm-Minimisation : Principles & Policy Frameworks"

Drugs and Crime Prevention Committee

PARLIAMENT OF VICTORIA

The views expressed in this paper do not reflect current or proposed Victorian Government policy, and they do not necessarily reflect the final position of the Victorian Parliamentary Drugs and Crime Prevention Committee.

Preface

Illicit drug policy, just like any other form of social policy, cannot be developed and implemented in an arbitrary and unsystematic way. It needs to be based upon and guided by rationally defended "first-principles" and ideals. The various programs and interventions that flow from drug policy also need to be implemented within a systematic, cohesive and goal-directed framework of activity.

There are differing views as to what the goals and purposes of illicit drug policy should be, and correspondingly different pictures of what an ongoing framework for implementing those policies would look like. It is not always the case, though, that these differing views are carefully elaborated, analysed or compared. The purpose of this document is to do just that. It seeks to clarify and refine what seem to be the most rationally justified "first-principles" and policy framework for an enduringly effective state-sponsored illicit drug strategy.

A goal of harm-minimisation is widely adopted in Australian drug policy, including the National Drug Strategy. This document endorses harm-minimisation as the most justified fundamental guiding principle for the development of illicit drug policy. There are different views, though, as to how harm-minimisation should be defined and what might be involved in realising it. This document refines and defends a particular conception of harm-minimisation, and it also outlines some of the characteristics of a systematic harm-minimisation framework for the implementation of drug programs, interventions and activities. The primary purpose of the discussion is to locate and identify certain key criteria that might be relevant to assessing the quality and progress of purportedly harm-minimising drug strategies. This accords centrally with the brief of the Victorian Parliamentary Drugs and Crime Prevention Committee to evaluate Victoria's "Turning the Tide" drug reform strategy – a strategy based on a goal of harm-minimisation.

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A number of people have made helpful comments on earlier drafts of this document, and their contribution is greatly appreciated. Any further feedback can be directed to the following email address:

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PART ONE:

HARM-MINIMISATION – THE CONCEPT

1: Drug Policies, Principles and Frameworks

A lot of effort is often put into implementing policies, programs and activities to deal with the social and personal problems associated with illicit drug use. The same amount of attention, though, is not always paid to the question of which "first principles" should guide and inform drug policy and practice. Many of the criticisms that are made about state and national drug strategies – for instance, that they are not efficient or cost-effective, are poorly coordinated, bring about inappropriate outcomes, and lack consistent direction – are made because the fundamental or primary goals of these strategies are not clearly defined nor sufficiently well thought-out. It is important to have a clear and justified conception of the primary goals of a drug strategy if policy-makers and practitioners are to develop and enact consistently effective programs.

A clear conception is important for evaluation, too, since well-defined and defensible goals can act as the fundamental yard-stick against which drug policy and practice can be rationally and systematically assessed. With the right primary goals in hand, the way will be clear for a sound and principled understanding of how good drug policy and practice should be developed, and also what criteria should guide their evaluation.

Just which primary goals are appropriate, though, is a question about which there will be varied and competing views. The whole issue of the aims of drug policy and practice is a hotly contested and deeply controversial one, both nationally and internationally. This controversy is all the more reason for becoming as clear as possible right from the start about what the best goals would be for a comprehensive drug strategy.

In doing this, it is important to keep in mind the difference between the primary goal(s) of a drug strategy as a whole, and the more local and immediate objectives of the particular projects, practices and initiatives that are the components of that strategy (Newcombe, 1992). These immediate local objectives may not be the same as the overarching goal(s) of the broad strategy as a whole. The reason for this is that there are often a wide variety of ways of achieving the same overall social result. For example, a drug strategy may include particular interventions whose specific purpose is, say, to provide accommodation support for users. Clearly, though, providing accommodation will not be the overall goal of the entire drug strategy. That goal will be something broader, which is served in some way by providing accommodation.

Given the great diversity of circumstances, client needs, and social and personal problems that prevail in relation to widespread drug abuse, it makes sense to have a comparable diversity of activities and interventions, each with its own specific methods and objectives (Erickson & Ottway, 1993).

The fact that different objectives operate at different levels of a drug strategy should not be a problem, as long as the strategy as a whole is integrated and the intended outcomes of the specific activities contribute effectively to the achievement of the strategy's underlying primary goal(s).

This suggests that the primary goal(s) of a drug strategy should be comprehensive enough to encompass the diversity of "lower-level" interventions, activities and objectives needed to address the range of problems that the strategy hopes to deal with. The goal(s) should also be comprehensive enough to be relevant to all domains of policy activity and practice in the drug world, such as health, education, law enforcement, justice administration, and so on.

2.1 : Harm Minimisation as the Fundamental Goal of Drug Policy

Increasingly, harm reduction or harm minimisation is coming to be viewed by many as the right primary goal for drug policy and practice (Hamilton, Kellehear & Rumbold, 1998). To decide if this view is indeed correct, it is important to explore two closely tied issues: firstly, what the proper definition or conception of harm-reduction should be, and secondly, whether harm-reduction, so understood, is in fact the most justified or rationally defensible primary goal for drug policy and practice.

The importance of a clear and coherent understanding of harm reduction or minimisation cannot be overstated. [Strang, 1993; Single, 1995; Lenton & Midford, 1996.]. As Eric Single points out, "Lacking a clear definition, the concept of harm-reduction or harm-minimisation is in danger of being co-opted by persons who have very different conceptions of what harm-reduction means in terms of policies and programs." (Single 1997).

Because we are in the business of discussing fundamental *goals* – that is, the things that are most worth achieving in drug policy and practice – the definition of harm-minimisation and its defence as a worthwhile goal will be closely linked. A simple dictionary definition of the words "harm-minimisation" will not do. We need to refine an *ideal* of harm minimisation that is fit for the purposes of guiding and assessing drug policy and practice.

Once we start talking in terms of policy ideals, we have moved into the realm of debate, argument and justification. This means that the particular ideal of harm-minimisation we settle on in the end should be the one that can be most successfully defended in the context of other possible conceptions of harm-minimisation. In refining and defending such an ideal, the following issues will need to be clearly and convincingly addressed:

- What should count as a drug-related harm?
- Should harm-minimisation be defined with the emphasis on its aims or on its outcomes?
- Should "harm-*reduction*" or "harm-*minimisation*" be considered the central goal of drug policy and practice?
- How are different drug-related harms to be compared and given priorities in line with their relative seriousness or urgency?
- How can the different methods of minimising drug-related harm fit

together to form a well-balanced and efficient harm-minimisation framework for drug policy and practice?

- What key criteria for evaluating drug policies and programs will be implied by the ideal of harm-minimisation that we settle on?

- How does a primary goal of harm-minimisation fit in with other policy principles, regimes and intervention approaches such as zero tolerance, abstinence-based programs, and legalisation, decriminalisation and prohibitionism?

The discussion in the rest of this document tackles these and related questions.

2.2 : Drug-related Harm

When talking of problematic drug use and responses to it, it is natural to focus on the idea of harm. Any major social policy program like a national or statewide drug strategy will need to be developed and implemented in a way that is sensitive to human rights. In a clear sense, human rights are simply rights against being harmed in certain ways, or suffering certain sorts of harm. The human rights orientation in social policy, therefore, will naturally suggest that the focus in drug policy should be on the reduction of drug-related harms. We really need to begin, then, with a clearer idea of what is meant by the idea of a “drug-related harm”.

It should be kept in mind from the beginning that the very notion of harm, whether it is drug-related or not, is a value-laden one. It is not a matter of mere fact whether something is “harmful” or not, but a matter that needs to be decided in the light of values and norms. It is a notion therefore which is subject to possible argument and debate (Newcombe, 1992).

Notwithstanding this, it is generally agreed that the harms associated with problematic drug use can usefully be divided into those experienced by individual users themselves, and those experienced by third-parties or by society collectively. The harms experienced by individuals will span a number of dimensions. For example,

health related harms such as:
- risk of death;
- serious injury and physical sickness;
- psychological/emotional problems;

economic harms, such as:
- foregone personal employment opportunities;
- heavy financial expenditures to support personal use;

personal/social harms such as:
- risk of drug related violence;
- family breakdown;
- breakdown of friendship and peer relationships and networks;
- stigma attached to criminal conviction;
- risk of incarceration;
- social isolation, stigmatisation and loss of personal dignity.

The third-party harms and costs to society cover similar dimensions. For example,
- public nuisance;
- the social and economic costs of health-care provision;
- the costs of drug-related property crime;
- the costs of incarceration of serious offenders;

- other broader financial "opportunity costs" associated with money being spent on problematic drug use which could have been spent in other more socially productive ways (Collins & Lapsley, 1992).

These few examples are of harms that are widely recognised. However, drug use and the social and personal contexts in which it occurs are dynamic and changing, and the notion of a drug-related harm should be sensitive to this fact, as well.

With changing circumstances and social priorities, we may sometimes need to expand our conception of what counts as a drug-related harm, to include things that are not quite as tangible and quantifiable as most of the harms mentioned above. For example, the overall anxiety, concern, uncertainty and impotence a community may feel as the drug problem becomes increasingly widespread and seemingly intractable, surely counts as a significant harm. Indeed, this social anxiety and sense of impotence can sometimes threaten to be self-fulfilling, and to paralyse the collective will to rise to the challenge the drug problem presents for society. This example serves to reinforce the importance of remaining vigilant, and maintaining an open and inclusive dialogue about what should count as a drug-related harm.

2.3 : Reduce Harm or Minimise it?

Should the focus be on harm-*reduction* or on harm-*minimisation* when it comes to defending primary goals for drug policy and practice? A lot depends on exactly what "minimisation" is taken to imply. Reducing harm simply means decreasing it, even if only by a tiny bit. But if a tiny decrease in harm still counts as harm reduction, even when harms could easily be reduced to a much greater degree, then simply having harm-reduction as the primary goal seems too weak.

Minimisation, on the other hand, makes for a stronger primary goal because it asks for harms to be reduced as much as possible. Sure enough, it is much easier to know when harms have simply been reduced than to know when they have been reduced as much as possible. But still, it does seem true that if it is important to reduce harms at all, then it makes no sense to want to reduce them only a little and not as much as they could be. Minimisation, for this reason, is the better and more fundamental option.

So, in the following section on definition, the focus will be on clarifying the most plausible meaning for "harm-minimisation". By exploring and refining this concept, it will become clearer what is implied by harm-minimisation in practice. It is hoped, also, that a range of key criteria will eventually emerge as broad guides for understanding the nature and evaluation of harm-minimising drug strategies.

2.4 : Defining Harm-minimisation: Aims or Outcomes?

The importance of carefully refining the ideal of harm-minimisation is clear. Issues of definition have direct practical impact. What harm-minimisation is taken to mean or imply in principle will determine just what practices and policies are pursued in its name. If we get the principled understanding of harm-minimisation wrong, then we will get the practice wrong, and drug-related harms will not be minimised in the way they should be. In the discussion to follow, the meaning of harm-minimisation will be refined in a number of stages, leading to a full definition after questions about the justification of primary goals have been settled.

Before we go on, though, there is one further matter that needs to be clarified in connection with "reduction" versus "minimisation". It was said that harm-reduction is not demanding enough, and that minimisation is better in that way. But minimisation, understood in an unqualified sense, turns out to be too demanding. If harm-minimisation is taken to mean that harms should simply be reduced *as much as possible*, that will mean at any cost, or at the expense of everything else. Clearly, though, open-ended harm-minimisation like this will not be realistic. Many other social priorities have a legitimate claim to society's efforts and resources. There need to be plausible limits placed on harm-minimisation, to take this into account.

A more sensible conception of harm-minimisation will require the overall net level of drug related harms in society to be reduced as much as possible in the context of other competing social demands and limitations of resources. It is harm-minimisation in this qualified sense – more demanding than mere reduction but less demanding than minimisation at any cost – that will be the focus of the discussion to come.

What, then, are the central or defining characteristics of harm-minimisation? Should harm-minimisation policy and practice be defined by its aims, or by its actual outcomes, or by something in between? (Lenton & Midford, 1996). Because the whole language of drug policy and intervention development is a future-looking language – relating to what is anticipated to be effective – there is clearly something in the idea that if a policy or practice *aims* to minimise harm, then it should count as harm minimisation (Single and Rohl, 1997).

However, focusing solely and simply on aims like this will not provide the whole story. (Single, 1995; 1997). What *actually happens*, and not simply what is intended to happen, seems to be just as relevant to the definition of harm minimisation. An example might show why. The recent precursor legislation requiring the reporting of suspect sales of amphetamine chemical precursors was designed to make amphetamine manufacture more difficult. As far as aims are concerned, this legislation might look harm-minimising since it seeks to considerably decrease the use of amphetamines and so minimise the harms associated with their use. In reality, however, the actual outcome of the legislation has been to increase the incidence of poor quality and dangerous forms of amphetamine, to encourage more dangerous routes of administration (ie., injecting), and to displace usage patterns toward cocaine (Australian Bureau of Criminal Intelligence 1996).

In other words, even though the central aim of the legislation was to reduce harm, its actual outcomes fell well short and probably increased harms, and for this reason there is some uneasiness about calling it an exercise in either harm-reduction or minimisation. So, actual consequences or outcomes seem to be relevant when it comes to deciding

whether a policy or practice is harm minimising or not.

The example above also serves to show that whether the intended outcomes of some intervention actually come to prevail depends very much on circumstance, and often on unforeseen and unanticipated factors. Just as the future can't be foreseen, the actual outcomes of policies and interventions can't be foreseen either. But now, if this is so, harm-minimising policies and interventions cannot be distinguished solely on the basis of their *actual* outcomes either, since these can only be known after the fact. As was said, we need a definition that is suited to the "future-looking" nature of policy and intervention development, and which allows us to say *now* whether the things *we are about to do* count as harm minimisation or not.

This presents the following question: If aims are important, but harm-minimisation can't be defined solely in terms of these, and if actual outcomes are also relevant but these can't be known in advance, how should harm-minimisation then be defined? Some middle-path is needed between aims and outcomes. But one that recognises or incorporates the role of both in some way.

It turns out that this middle-path might lie with the idea of a "reasonable expectation". Even if one can't unreservedly predict the outcomes of a policy or intervention, the *expectation* that certain consequences will actually come about in some specified circumstance can be either reasonable or unreasonable. There are degrees of reasonableness, though, and just how reasonable an expectation is will depend on the extent to which it is informed by, and based upon, the relevant evidence. A *fully* reasonable or justified expectation will be one that is formed in the light of the best available evidence. The policies and practices based on such expectations are those that are most likely to succeed in achieving their intended outcomes. These suggestions might provide the first elements of a possible definition of harm minimisation:

a policy or practice is ***harm-reducing*** *if it is fully reasonable to expect that it will reduce existing or future drug-related harm, given the particular context of its application;*

a policy or practice or strategy is ***harm-minimising*** *if it is fully reasonable to expect that it will reduce existing or future harm to the greatest degree allowed by the resources and conditions that prevail in the particular context of its application.*

By speaking in terms of expectations, the role of aims is recognised, and by speaking of expectations that are fully reasonable (and thus, outcomes that are highly likely), the importance of actual outcomes is reflected as well.[i]

Another important thing this working definition highlights is the fact that the success of a policy or practice in achieving its aim, and actually reducing or minimising harm, depends very much on the context and conditions in which it is applied. The very same policy or type of intervention might be successful in one context, but fail in another. For example, interventions that emphasise the harms to one's fellows of drug use (as well as oneself) may be very effective in Asian minority communities where bonds of kinship and loyalty are strong, but not so in a more individualistic anglo-mainstream cultural community.

The right question, therefore, is not whether a policy or practice or form of intervention is harm reducing or harm-minimising once and for all, but whether it is harm reducing or harm-minimising in this or that context. It might be fully reasonable to expect a certain practice or intervention to minimise harm in one set

of conditions, but not fully reasonable to expect it to under other conditions. Context is central to an understanding of what should count as harm-minimisation, and sensitivity to prevailing contextual factors is crucial to the intelligent development of drug policies and interventions. An expectation that some policy or intervention will be harm reducing or minimising will only ever be fully reasonable if that expectation has arisen through an accurate, evidence-based, understanding of the proposed context of its application.

3.1 : Minimisation of Harm or Reduction of Use: Questions of Justification

This working definition of harm minimisation is not complete, and will not be without some clarification of how the reduction or minimisation of drug *use* fits into the picture. This issue is perhaps best approached through asking how these two compare as potential primary goals when it comes to their respective intrinsic appeal, achievability, and comprehensiveness (Caulkins & Reuter, 1997).

Clearly enough, reducing or minimising problematic use and minimising harm are both worthwhile aims. But which is ultimately more defensible as the primary and fundamental drug strategy goal? There are a number of general reasons – conceptually-based reasons as well as pragmatic ones – for thinking that harm-minimisation ought to be considered the more fundamental goal. These reasons can be listed as follows:

Harm-minimisation is more conceptually fundamental: What is it that is problematic about drug use, when it is problematic? In answering this, it is hard to avoid the conclusion that it is the *consequences* of problematic drug use, i.e., the harms that it creates, rather than the mere activity of using itself, which is the problem. If the primary goal of drug policy and practice were simply and solely to reduce or minimise use, then interventions into drug use would be fulfilling their purpose even when they either create harms or leave existing ones unresolved. Clearly, though, something crucial would have been overlooked with this.

The upshot of these observations is that, as far as priorities of importance are concerned, it is the drug-related harms rather than the drug use itself that appears to matter fundamentally. If the reduction of drug use is important in drug policy and practice, it will conceptually presuppose the prior and more basic goal of reducing or minimising the harms of that use.

A goal of harm-minimisation will recognise important differences that are overlooked by a goal of reducing use: If the goal of drug policy and practice is simply to reduce the level of drug use – that is, to reduce the total number of people using drugs or the overall amount of drugs being used – then issues about the type of drug that people use, or whether they use it in a high risk or a low risk way, or how heavily they use, will not be a central concern of public policy (Caulkins & Reuter, 1995). Differences between, say, the injecting use of heroin and the smoking use of heroin will not register as important from the mere point of view of use reduction. The difference is only important from a point of view where drug-related *harms* are a concern.

Similarly, if all that matters is reducing the total number of people using drugs, the heavy and problematic user of heroin will be viewed as being on the same

footing as the occasional, casual user of heroin. According to pure use-reduction criteria, each will count for the same – as a person whose drug use needs to cease – with neither greater nor lesser priority being given to one over the other when it comes to policy and intervention (Caulkins & Reuter, 1995). There is, however, an important difference between problematic and casual heroin use, a difference which ought not be overlooked in drug policy and practice. When the level of harm produced by drug use is considered fundamental, this important difference will be recognised.

Again, in a policy regime geared simply and solely toward minimising the number of users, policy and intervention activity will focus greatest attention on those whose use is most easily stopped or deterred. In other words, efforts will be directed at light or recreational users (Caulkins & Reuter, 1997). Clearly though, it makes better sense to focus on exactly the opposite – on those whose use is heavier and involves a greater risk of harm to themselves or others. Such a focus would be maintained by a policy regime whose fundamental guiding principle is the minimising of harm. When it comes to registering significant differences between drug using patterns, behaviours and priorities, harm-minimisation is a much superior goal to use-reduction.

Harm-minimisation is more comprehensive as a primary goal: Any foundational goal for a drug strategy needs the capacity to comprehensively integrate the different domains of activity in the world of drug policy and practice, such as public health, education, law enforcement, justice administration, and so on. A goal of harm-minimisation has a natural capacity to inform the range of activities that often occur in the areas of treatment, rehabilitation, and public health.

Reduction of use, although it sometimes has a role to play, seems to have limited capacity to provide impetus and direction to many of the interventions typically employed in these areas. For example, public health programs designed to deal with drug related blood-borne diseases are more naturally motivated and conducted under the umbrella of harm-minimisation rather than use-reduction. Similarly, with treatments such as methadone and alternative pharmacotherapies, the immediate aim is to reduce many of the harms associated with drug use (eg, to stabilise lifestyle, reduce the need to resort to criminal activity, etc.).

Drug law enforcement and administration of justice have traditionally been seen in terms of the aim of reducing use. However, harm-minimisation still has a key role in these areas. It is often thought, for instance, that law enforcement and police activity in the drug world is more acceptable and effective when it is conducted in a "harm-sensitive" way. That is, in a way that seeks to minimise the harms that may possibly arise from these use-activities (eg., making sure that street-level policing does not deter users from accessing needle-exchanges). Similarly with the administration of justice through legislation, the courts, sentencing and the corrections system. Although deterring drug use is a central goal in these areas, harm-reduction still has a key part to play. This is evidenced by the increasing emphasis on court diversion practices, and drug treatment and rehabilitation options as components of bail sentencing and correctional orders.

Harm-minimisation seems to be more comprehensive to the extent that it has more potential to guide a greater range of drug interventions and activities than mere use-reduction. Certainly, reduction of use has a role to play, but it is a role

that does not speak to as great a diversity of activities as harm-minimisation.

Harm-minimisation is a more pragmatic and achievable goal: Few would disagree that a world completely free of drug use would be a virtually unattainable goal, if current and historical experience is anything to go by. Despite continuing efforts to stop the use of illicit drugs in this country, that use continues to grow. And even at a more personal level, the goal of complete abstinence for individuals is, in many cases, a very difficult one to achieve. Given this, a pragmatic policy approach would recommend that an achievable goal such as reducing the harms associated with use is better (Strang & Farrell, 1992; Mugford, 1991)

Harm-minimisation can encompass use-reduction: Harm-minimisation can be thought of as a more fundamental goal than use-reduction in the sense that harm-minimisation can *include* use-reducing activities as a means. If pursued sensitively, policies and interventions designed to reduce use can be a very effective way of reducing drug-related harms (Caulkins & Reuter, 1997).

However, the only use-reducing activities that can fall under the umbrella of harm-reduction or minimisation will be those that are pursued in a harm-sensitive way. They must attempt to reduce use in ways that can be reasonably expected to reduce or minimise current or imminent harm, and to not create other "collateral" harms, so that the outcome would be an overall net reduction of harm. Clearly, not all instances of activities designed to reduce current or future use are harm-reducing in this way. For example, intensive policing near needle-exchanges, incarceration of minor drug offenders, saturation policing, and so on, all tend to either increase the risk of harms or fail to reduce them in the long run. Such use-reduction activities are not compatible with a framework governed by harm-minimisation.

It would be fair to say, at this stage, that the preceding paragraphs strongly suggest that the minimisation of harm is preferable to the other leading candidate – the reduction of use - as the primary goal for drug policy and practice.

3.2 : Integrating use-reduction - "use-targeted" and "use-tolerant" harm reduction

Some of the last few points highlight the fact that use-reduction and harm-reduction can coexist within the one framework of drug policy and practice, as long as the use reduction is harm-sensitive in the right way. In fact, it may even be useful to talk of "use-targeted" forms of harm-reduction. That is, activities which it is fully reasonable to expect will successfully reduce harm through reducing use. The other side of this coin is that there will be cases where harms can only be effectively reduced by *avoiding* efforts to reduce use, or by recognising that reduction of use or abstinence is unachievable in the circumstances. Refraining from policing around needle-exchanges is an example of this, as is educating at-risk adolescents about safe methods of drug use. In these cases harm-reduction does not require the discouragement, reduction or ceasing of drug use, and in the first case actually requires that such attempts be avoided. It may be useful, then, to speak of "use-tolerant" forms of harm-reduction, as well as use-targeted ones.

These last few observations throw some light on how our conceptual refinement of the principle of harm-minimisation

should be completed. It was seen that use-reduction policies and programs which are harm-sensitive (ie., use-targeted forms of harm-reduction) are compatible with harm-minimisation. But an equally important observation is the fact that harm-reduction or minimisation can also be use-tolerant. It does not necessarily involve attempts to reduce or eliminate use (Wodak & Saunders, 1995). This point can be factored in to finally complete the definition of harm-minimisation as follows:

> *a policy or practice is* ***harm-reducing*** *if it is fully reasonable to expect that it will reduce existing or future drug-related harm given the particular context of its application, without necessarily requiring the reduction or elimination of drug use;*

> *a policy or practice or strategy is* ***harm-minimising*** *if it is fully reasonable to expect that it will reduce existing or future harm to the greatest degree allowed by the resources and conditions that prevail in the particular context of its application, without necessarily requiring the reduction or elimination of drug use.*

One important thing to keep in mind with this is that not every particular policy, practice and intervention within a harm-minimising strategy or framework needs itself to *minimise* the harms that it targets. Paradoxically, the goal of minimising the overall net balance of drug-related harms across society might, in some circumstances, be better achieved if certain policies or interventions within the strategy actually refrain from seeking to minimise the harms they target and only seek to reduce them. For example, attempting to minimise (as opposed to simply reduce to some degree) the harms connected with blood-borne virus infection might prove so great a drain on the resources available to a drug strategy that it would stifle the reduction of other harms, which reduction might collectively have a greater impact on the overall net minimisation of harm across society.

So, a well-balanced harm-minimisation strategy will efficiently target some harms for minimisation and others for reduction in a way that is sensitive to the prevailing conditions, and which makes it most likely that the overall net harm will be minimised across society.

To a considerable extent, just which harms should be minimised and which reduced on any occasion will depend on the particular conditions that prevail at the time. So, no "once and for all" recipe exists for this. However, there are some general things that ought to be taken into account in making that decision:

(i) whether some sorts of harm are generally more worthy of attention than others, and

(ii) whether some components of a harm-minimisation regime are worthy of more effort and resources than others (for example, prevention & early intervention, as opposed to supply-interdiction, as opposed to treatment & rehabilitation).

These issues will be taken up in the next few sections.

While the discussion so far has mostly been about the concept or principle of harm-minimisation, the discussion to follow will turn to what the basic structure of a harm-minimisation *framework* for drug policy and intervention activity might ideally look like. In other words, how the principle of harm-minimisation (as we have defined it) should be reflected within a complex scheme of activity.

PART TWO:

HARM-MINIMISATON - A FRAMEWORK FOR ACTIVITY

4: *Relative harms: comparisons and priorities within a harm-minimisation framework.*

The sorts of harms associated with problematic drug use are widely discussed. What is less widely discussed, however, is the question of which sorts of harm are more important to address than others. Arguably, not all types of drug-related harm are equally serious or urgent. Most would agree, for instance, that drug-related death is worse than the inability to maintain employment due to drug use. If society is to expend social resources and effort in the most effective harm-minimising way, it needs to at least address the issue of what priorities should exist between the different types of drug-related harm, and what criteria might underlie those priorities. This is made all the more important by the fact that different stakeholders in the drug area weight different harms (and benefits) differently [Hawks & Lenton, 1998].

In deciding whether to devote more resources to employment programs for users, for example, or to family and peer support, or to retraining programs and re-education initiatives for users, policy makers and implementers need to make judgements about the relative seriousness of the harms that these interventions target. Is the loss of users' employment more serious than the deterioration of their family and friendship networks, or the deterioration of their cognitive capacities? Similarly, legislators are increasingly called upon to make judgements about the harmfulness of occasional cannabis experimentation among young people compared to the social stigma and life disadvantages associated with a criminal conviction.

Also, in order to efficiently target their efforts at intercepting the supply of harmful drugs, police and customs need to compare the relative harmfulness of different drugs. Is it more important to curb the supply of crack cocaine because of its tendency to cause users to become violent, or more important to intercept heroin and amphetamines with the dangers associated with their intravenous use. And again, the harms experienced by individual users sometimes need to be measured against harms or perceived harms to the broader community. For example, which of the following harms ought to carry more weight in policy decision-making: the health risks to a limited number of individual users who regularly inject in an alleyway, or the possible apprehensions and objections of a large number of local residents at the presence of a safe injecting facility in the community?

The question of how these types of harm are to be compared and "measured" against each other is a difficult and intractable one. Sometimes it is relatively clear that some harms are more important than others. As was said, few would disagree that fatal overdose is more serious than the unemployment of users. But it is much less clear whether deterioration of cognitive capacity is a worse harm than the deterioration of friendship networks or the stigma of a criminal conviction. Sure enough, the number of people who are in need of

particular interventions or services and the degree to which they need them will be relevant to determining where policy and resource priorities should lie. But this calculation of need cannot be the whole story, since the question still remains as to which needs are more important and which less, when different needs compete for attention. And this, again, is a normative and value-laden question.

The issue of the measurement and comparability of drug-related harms is a difficult one, and no easy answer has so far presented itself. Certainly, some harms do seem clearly much more important to address than some others. But what is still elusive is some reliable way of completely and consistently ranking and assigning priorities between *all* drug-related harms.

In the absence of criteria for completely ranking drug-related harms, the following pragmatic 'next-best' options suggest themselves:

Make the most informed and justified decisions possible: Even if there is an element of controversy and uncertainty as to how to completely organise priorities between different interventions addressing different harms, decisions about priorities still need to be made. The element of controversy or uncertainty should not be allowed to paralyse decision-making. It is important, however, that the decisions that are made about which activities to give more attention to and which less are made in as rational, informed and justified a way as possible.

Give precedence to harms that can be readily addressed. An underlying focus with harm-minimisation is the pursuit of realisable, practical goals. It makes sense that the degree to which a harm can be successfully addressed should play a role in determining its priority for attention.

There should be open and continuing dialogue about drug-related harms and their relative importance. As was pointed out earlier, the notion of a drug-related harm is a value-laden and contestable one, as is the question of what criteria ought to be employed to determine the priorities and urgencies that exist between harms. Given that social attitudes change and different values emerge and become ascendant over time while others decline, it is important to keep the debate about harms and their priorities open and ongoing. It is important also, to ensure that this dialogue is as socially inclusive and informed as possible, including the perspectives of users themselves.

A substantial emphasis should be placed on efforts at *prevention and early intervention.* If it is not always clear which drug-related harms deserve the most attention when they arise, it makes sense to ensure that as few harms as possible arise in the first place. That is, if the problem can't be solved when it arises, do your best to make sure the problem doesn't arise.

With this emphasis, the question of priorities becomes that of determining and targeting those personal and social factors that are known to pose the greatest risks to either beginning problematic drug use (primary prevention), or progressing to more problematic drug use (secondary prevention and early intervention).

5.1 : The structure of a harm-minimisation framework

Effective harm-minimisation will seek to reduce harms through a comprehensive range of means, spanning all three of the harm-reducing dimensions of a harm-minimisation strategy – supply reduction, demand reduction, and treatment and rehabilitation.[ii] It will involve appropriate law enforcement, supply interdiction and criminal justice administration, as well as early intervention, education, prevention, and treatment and rehabilitation. All of these means will be supported by research, evaluation, appropriate training and planned and coordinated action. It is useful to picture the structure of a harm-minimisation framework in terms of an archway (see Figure 1), where achievement of the goal of harm-minimisation (the roof) rests on the three strategically placed pillars of supply reduction interventions (law enforcement), demand reduction interventions (prevention and early intervention), and treatment and rehabilitation interventions. Those pillars, in turn, are embedded and supported within foundations of coordinated action, and research, evaluation, and training.

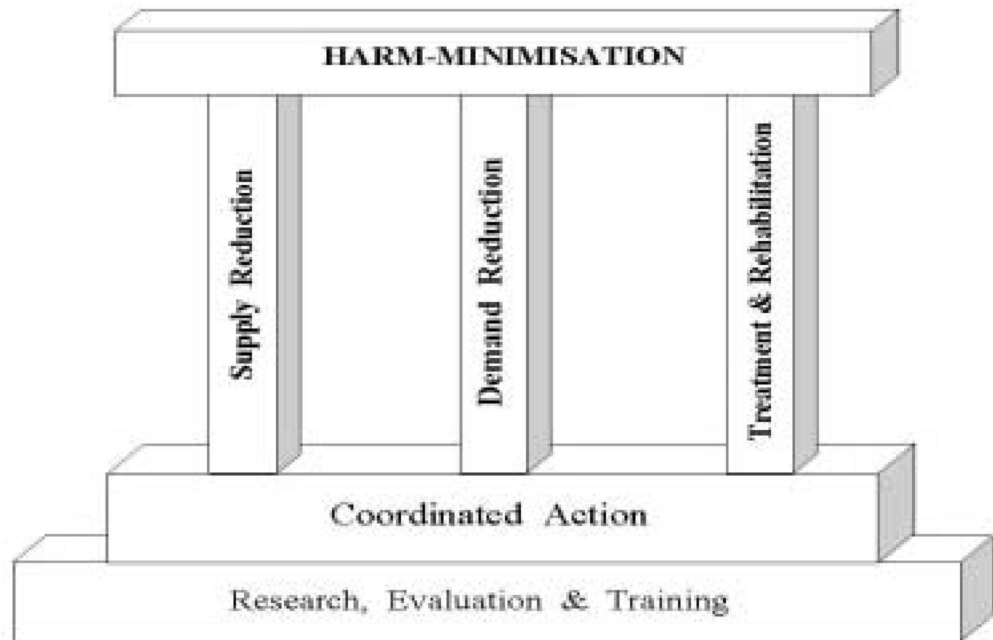

Figure 1: The Harm-minimisation archway

5.2 : Balance of effort in a harm-minimisation framework. Targeting harms and coordinating action

This idea of an archway is a useful way of depicting how the different components of a harm-minimisation framework are related to each other. However, it doesn't throw much light on another important question, the question of what the right balance should be between those components. How much effort should be thrown behind law enforcement and supply interdiction as opposed to education or rehabilitation or research, for instance, and what factors and criteria are relevant in determining this? This, effectively, is a question about the distribution of resources and policy efforts within a harm-minimisation framework, and relates to strategy

efficiency and the social justice issue of equity.

The balance between the different areas of drug activity will inevitably be influenced by the nature of the drug-related harms that need to be confronted from time to time. Drug-related property crime, for instance, will be addressed by law enforcement [iii] while drug-related morbidity will be addressed through treatment. The relative prevalence of these different harms, too, should be taken into account in deciding how resources and efforts are to be shared between law enforcement and treatment. This makes sense because it makes sense to use resources efficiently within a harm-minimisation framework.

Harm-minimisation requires the overall level of drug-related harms to be reduced to the greatest degree they can be in the circumstances. If harms are not reduced to the greatest effect relative to the level of resources involved (ie., if they are not reduced *efficiently*) then harm has not been minimised in that case, because it could have been reduced more in the circumstances. Resources need to be used optimally to achieve the desired result within a harm-minimisation framework. This need for efficiency can help to throw light on how the components of a harm-minimisation strategy might best be balanced and inter-related.

Policies and interventions within a harm-minimisation strategy will target a range of things from the attitudes, knowledge, expectancies, behaviour and practices of individuals, through to the locations and contexts of their use. And, from time to time, interventions will also seek to target particular drugs used by certain subgroups of the population in specific ways. Precision and efficiency in all this targeting is crucial. Properly planned, informed and coordinated decision-making is just as crucial, and therefore has a central importance in the structure of a harm-minimisation framework. To be most effective, the process of decision-making will need to be planned, informed and coordinated in a certain general way, as follows.

Two basic types of decisions are central to the effective minimisation of harm:

(i) decisions about what harms, in general, need to be targeted; and

(ii) decisions about how these targeted harms can best be reduced.

The former decisions are about where, in general, resources need to be directed, and the latter are about how they are most effectively used when they get there.

The best agencies to make the first type of decision will arguably be centralised ones that have a sufficiently wide-ranging perspective on what is happening at a state-wide or regional level to be able to make informed judgements about which types of harm seem more pressing overall, and which less. On the other hand, judgements about exactly how resources should be used to address the specific harms in a particular place and time should be made by agencies that are directly acquainted with those harms, and which are more likely to have insight into what the possible solutions might be. In other words, local agencies that can maintain a degree of discretion and flexibility as to exactly how resources are best put to work to address specific local problems.

The decision-making between these two levels needs to be properly coordinated, however, if resources are to be used efficiently, in a harm-minimising way. Central agencies will only make the right decisions about the types of harms to target, and the particular localities in greatest need, if they have regular, accurate and coordinated feedback from the local level about the nature and intensity of the problems being

experienced. Central agencies need to be responsive to that feedback as well, so that centralised coordination does not simply become a disguise for centralised control.

Coordination *amongst* agencies is paramount as well. This is true of both local and central agencies. At the local level, it is important for agencies not to double-up on efforts or leave gaps. This is best achieved through the coordinated sharing of information and resources between local agencies within regions. The real-life problems experienced at ground-level are also often very complex ones. This means they will rarely be effectively addressed through only one mode of activity or intervention – purely through law enforcement, for example, or education, or health. Complex problems warrant comprehensive responses, and this in turn requires the integration of services and interventions across a range of sectors of activity (Hamilton, Kellehear & Rumbold, 1998). At the local level of program operation, this intersectoral integration will involve the establishment of such things as ongoing local community partnerships and coordination networks. Integration at the more centralised level of departmental operation would require the joint interdepartmental development and management of policies and projects that facilitate integrated and efficient service delivery at the local level.

So, it is clear from this why it is crucial within a harm-minimising framework to give a central supportive role to properly planned and coordinated decision-making, as well as integrated local and departmental activity and intersectoral cooperation.

The need to use resources and effort effectively also explains the central role of each of the different *means* or pillars of harm minimisation cited in Figure 1. Clearly, an adequate regime of treatment and rehabilitation is necessary to address the existing harms of problematic drug use, many of which are urgent and immediate, and need priority attention. But also, potential harms as well as existing ones need to be addressed. Significant effort and attention needs to be directed at prevention through early intervention, education, and the targeting of youth use. Reducing the risk factors for problematic use among adolescents reduces the need to spend a greater level of future resources on the harms that would arise if problematic youth use were allowed to develop. As Eric Single and Timothy Rohl state in their evaluation of the National Drug Strategy, “Targeting youth is an investment in the future” (Single & Rohl, 1997).

There is also an important role for supply reduction. Carefully targeted, harm-sensitive efforts at detecting drug trafficking, for example, can be instrumental in reducing the potential harms that would arise if such efforts were not made. So, demand reduction, supply reduction and treatment and rehabilitation are all central to a balanced harm-minimisation framework.

And finally, harm-minimisation is unlikely to be achieved at all by any of the above means without the foundational support of appropriate training and the regular input of timely, targeted data-collection, research and evaluative feedback.

5.3 : Supply reduction versus demand reduction

Should demand reduction and supply reduction be given equal emphasis in a harm-minimisation framework when it comes to determining where effort and resources should go? The degree to which the goal of supply reduction should be pursued compared to other goals will depend on how effectively the supply reduction goal can be achieved compared to those others. Past experience shows that despite vigorous efforts on the part of customs and law enforcement agencies to stem the supply of illicit drugs, and despite significant expenditures, supply and trafficking still continue and at an increasing rate. Given this, and given that there are other immediate and urgent risks and harms that *can* be effectively addressed, it makes sense within a harm-minimisation regime to direct a significant amount of attention to reducing demand.

There is reason to think also that a concerted effort at demand reduction will achieve two goals at the one time by having an indirect impact on supply. Where there is a continuing decline in demand for drugs, there is likely to be a decreasing incentive to supply them, and this suggests that, on balance, resources may be more effectively used in the pursuit of demand reduction.

This is not to say that efforts at supply reduction should be abandoned, only that those efforts should be pursued in a way that can be reasonably expected to significantly reduce harm. This might mean, for instance, that instead of setting out to eliminate drug markets completely through policing (which can in fact be harm-creating), policing should rather target its activities so as to reshape those markets in ways that make them operate less harmfully (Sutton & James, 1996).

5.4 : Social justice within a harm-minimisation framework

Efficient resource use is by no means the only, nor the most important, issue relating to the implementation of a harm-minimisation framework. It is imperative within such a framework that resources also be distributed justly and equitably between all those individuals and identifiable groups who either experience, or are at risk of harm. The interests of all should be given fair consideration in decisions about where effort and resources will be directed.

This means that a harm-minimisation framework should be especially sensitive to groups in society who have special needs, either in the type of resources they require or in the amount. The groups that have special needs will change over time, as will the needs they have. But many such groups are readily identifiable. NESB communities, Aboriginal and Torres Strait Islander communities, women users, adolescent as well as older users, and disabled and homeless users, to name only some, are all known to have special needs or to experience special circumstances associated with their drug use, or in accessing help.

Ministering to these groups in a just and equitable way will mean catering for the particular differences that exist in them and which impact on the degree to which drug-related harms can be reduced in these groups. For instance, there is evidence that residential treatment options for women that allow children to live in, tend to improve treatment outcomes for women. Similarly, drug-related harms in NESB and indigenous communities will be best addressed only through the provision of resources that allow the development

and implementation of culturally sensitive treatments and interventions. Ministering to these groups in a just and equitable way will also mean devoting special attention to the antecedent sociocultural, psychological and economic conditions that make the problems greater for them than others. Because of the pre-existing disadvantages, differences, and special needs among some groups, a fair and socially just response to drug-related harms may require a special effort to be made and a greater than normal amount of resources to be devoted to addressing the needs particular to those groups. A socially just approach to harm-minimisation will also be particularly attuned to the nature of the changing needs, disadvantages and special circumstances that arise in different groups from time to time. Some of these will be clearer or more apparent than others. The disadvantages associated with a non-English speaking background, for example, will generally be more apparent than the disadvantages of distance associated with rural living, and the need to have an appropriate regional distribution of services.

Full sensitivity to all this requires ongoing research and feedback from the coal-face of harm reduction activity. Most of all, it is imperative to have representatives of those in-need groups involved in the whole process of decision-making and problem-solving.

5.5 : Threats to a harm-minimisation framework. Managing the message

A comprehensive and complex drug strategy will succeed in minimising harm only if it also has the capacity to manage those things that threaten its continued viability. Different threats will arise in different ways at different times, and strong social and political vigilance and commitment to harm-minimisation will be needed to overcome them as they arise. But two major forms of threat are worth explicitly noting here: (i) objections to a harm-minimisation approach that result from misinformation or misunderstanding of its meaning and purposes; and (ii) the public misperception that the “use-tolerant” dimension of harm-minimisation constitutes an official acceptance of drug use, with the effect that this acts to normalise that use. To address both threats, a harm-minimisation framework should come bundled with appropriately targeted public education that outlines the motives, rationales and processes of harm-minimisation, and also seeks to redress any inadvertent normalisation of drug use that “use-tolerant” harm-reduction might engender.

6: The Core Elements of a Harm-minimisation Framework

The previous discussion sought to give an indication of what harm-minimisation means, what makes it justified as a fundamental goal of drug policy, and also what the basic structure of a framework for pursuing harm-

minimisation involves. The hope in doing this was to isolate some of the general characteristics that emerge as the hallmarks of a good harm-minimisation framework, with an eye to reserving these as key criteria for understanding and evaluating harm-minimising policy and practice. These criteria are listed below. It is true that they are demanding, but it should be kept in mind that they are intended as the hallmarks or criteria connected with an *ideal* framework for harm-minimisation.

A. Being ***evidence-based*** is pivotal: The previous discussion revealed two key reasons for this: Firstly, it follows from the definition presented here that harm-minimising policies and practices must be based on a fully reasonable expectation that they will reduce harm to the greatest degree allowed by the particular context of their application. What makes such an expectation fully reasonable, is its reliance on the best evidence that is currently available concerning those contexts of application. Secondly, accurate evidence, information, and research is essential to the appropriate targeting of efforts and coordination of decision-making, both of which are required for the efficient use of resources.

B. ***Sensitivity to context*** is important: As we have defined it, harm-minimisation is context dependent in the sense that a policy or practice may succeed in reducing or minimising harm in one set of circumstances, but fail to do so in another (or else to a completely different degree). Contextual factors such as differences in the nature of users, usage behaviours, drug-types, social and environmental influences, and so on, will underlie this possibility. A harm-minimising drug framework needs to be sensitive to the many contextual factors and differences that can affect the degree to which harm is actually reduced. Sensitivity to context is particularly important with interventions in domains of activity that are traditionally aligned with use-reduction (policing and law enforcement, corrections, justice administration), to ensure that they will in fact be harm-sensitive.

C. A harm-minimisation strategy ideally needs to be ***comprehensive in scope***: The range of harms confronting any system of drug policy and practice will be broad, varied and changing. The effective minimisation of such harms, therefore, requires an approach that is as comprehensive as possible and incorporates interventions that span all domains of social activity, from health-care and education to law enforcement and legislation.

D. ***Diversity, flexibility and innovation*** are important: The nature of the drug-related harms that confront a drug strategy are varied, and the circumstances of their occurrence are changeable as well. A drug strategy will arguably have little prospect of minimising harm under these conditions if it does not employ a diverse range of interventions which are delivered in a way that is sufficiently flexible to respond to new information and changing conditions. As Patricia Erickson observes, 'Flexibility of response is the keynote.' (Erickson, 1993). Similarly, a harm-minimising strategy, if it is to

efficiently and effectively pursue its goal, needs to have the capacity to experiment and develop innovative responses to drug-related harms, especially those entrenched hard cases which seem to resist responding to traditional approaches.

E. ***Coordinated policy and targeted program activity*** is central to harm-minimisation**:** By definition, a harm-minimising strategy needs to direct its efforts and resources in the most efficient and effective way it can to reduce harms. It was seen that this efficiency will not be possible without the appropriate targeting and systematic coordination of decision-making and program operation. This coordination, it was argued, requires a balanced sharing of decision-making between the local and centralised levels.

F. An ideal harm-minimisation strategy will be ***integrated and cohesive***: Having different specific activities with their own lower-level objectives within a strategy was seen to be an effective way to respond to diverse problems and circumstances. This diversity of objectives and activities, however, will be quite pointless and counter-productive if there are tensions and antagonisms among them - if one policy or activity frustrates or interferes with the other. Whatever their particular and immediate purposes, they will need to be cohesive with each other to ensure that their overall collective effect is to achieve the primary goal of minimising harm. This means that harm-minimising policies, programs and interventions spanning different domains of social activity cannot be developed and enacted in isolation from each other. They need to be perceived in an integrated way, and viewed in terms of the part they and other activities play in the overall goal of minimising harm.

G. The full range of drug-related harms will only be identified and minimised through the ***inclusion and "humanisation" of users*** in decision-making processes about potential solutions. It is clear that problematic drug users are socially marginalised in various ways, and this in itself is a substantial harm. Care should be taken, therefore, not to further compound this marginalisation through the sorts of solutions that the state or professionals propose for the drug problem. Including users, or representatives of users' interests, at all levels of the harm-minimisation process will go a considerable way to ensuring that this marginalisation is curbed, and that users are empowered to assume some control of their lives. Having users play a part in the dialogue concerning drug policy also ensures that accurate information about users' needs and perspectives on use is reflected in policy decisions and intervention approaches (Des Jarlais & Friedman, 1993).

H. *Ongoing dialogue and communication between key stakeholders* is essential. There are two sorts of reasons for this – those arising from the varied nature of the drug problem, and those connected with the variety of stakeholders and interest groups that are involved in its solution. Despite the clear need to assign priorities to different sorts of drug-related harm, it was seen that there is no obvious systematic criteria-based way to do this. In the absence of this, one viable second-best option is to maintain open social dialogue about the nature of drug-related harms and their relative urgency. Ongoing communication is also instrumental to the development of flexible, coordinated and enduring responses to those harms.

Just like any major social problem, there will be a variety of stakeholders and groups having vested interests in how the drug problem is approached. There will be service providers, clients, policy-makers, members of the general public of different persuasions, and other special interest groups. The interests of all these will not necessarily converge, but some sort of working consensus is certainly necessary in order to sustain major programs and initiatives, or to vary them if need be. The only way to negotiate this sort of social consensus and to take account of these interests is for all those concerned to engage in open dialogue where differing views are heard and moderated in the light of others.

I. *Harm-minimisation gives special emphasis to prevention and demand reduction:* Experience has shown that efforts at reducing harms through supply reduction have met with limited success to date, despite considerable expenditure. In comparison, harms can be effectively reduced through prevention and demand reduction initiatives. The absence of systematic criteria for prioritising harms also provides supplementary reasons for an emphasis on prevention. When it is unclear how existing harms should be prioritised, it was suggested that a good pragmatic second-best option is to focus as much effort as possible on making sure harms do not arise in the first place, by preventing problematic use.

J. *Harm-minimisation can be "use-targeted", and therefore compatible with use-reduction*, as long as the use-reduction is harm-sensitive, and succeeds in reducing the harms associated with use without causing other "collateral" harms.

K. *Harm-minimisation can be "use-tolerant", and does not <u>necessarily</u> require reduction or cessation of use:* In some contexts, efforts at reducing use can simply act to create harms or magnify existing ones. A good harm-minimisation strategy will not seek to reduce use in these contexts.

L. Efficiency is not the only guiding constraint on the goal of harm-minimisation. The minimisation of harm should ideally be achieved in a way that is ***just and equitable***. This means targeting resources and efforts to those groups whose characteristics or particular differences or social circumstances disadvantage them in various ways and leave them susceptible to harms or risks of harm, or else less accessible to help.

M. ***Evaluation*** is paramount: Because circumstances change and are rarely constant, and because not all of the contextual factors that influence successful reduction of harm are immediately apparent, it is important to evaluate program activity to gain regular, accurate feedback. It is important to evaluate on the basis of meaningful comparisons, too. Appropriate research, monitoring and evaluation is pressed upon us by the context dependent nature of harm-minimisation, and the need to maximise the long-term reduction of harm.

N. ***Managing the message of harm-minimisation*** is crucial to ensure that (i) the public is fully informed about the meaning and point of harm-minimisation, and (ii) that "use-tolerant" forms of harm-reduction do not inadvertently act to normalise drug use through being seen by the public as an official acceptance of drug use.

7. Locating harm-minimisation in the context of some other major illicit drug themes.

The previous discussion has hopefully given some indication of what harm-minimisation amounts to and what a framework of policies and practices guided by that primary goal looks like. What has not been discussed so far, though, is what implications harm-minimisation has with respect to some other key themes that often arise in relation to illicit drugs. Having now a fuller understanding of harm-minimisation, some of those implications can be teased out.

Abstinence-based interventions: It would be reasonable to think that because harm-minimisation, as that concept has been refined, does not require the cessation of drug use, it is incompatible with abstinence, and that a drug strategy guided by harm-minimisation could not consistently include interventions with abstinence as an objective. This perception, though, is not correct.

There are a number of reasons to suggest that abstinence-based interventions might have a place within a harm-minimisation framework. It was

noted that such a framework can quite consistently contain programs, policies and interventions that have a variety of immediate "local" objectives, as long as those objectives contribute effectively to the minimisation of harm. It is a virtue to have a broad range of approaches to match the equally broad range of clientele, circumstances and harms that need to be addressed. It may well be that some users respond much more effectively to programs geared toward abstinence than others. Importantly also, it was seen that harm-minimisation is compatible with interventions that seek to reduce (or stop) use, as long as those interventions do so in a harm-sensitive way (ie, in a way that can reasonably be expected to reduce harm). There may be contexts in which abstinence-based programs are harm-sensitive in this way.

Added to these considerations is the fact that the eventual cessation of use can always be a secondary objective of harm-minimising interventions. For instance, although the central purpose of the recent Swiss heroin trials was to stabilise and improve users' lives in various ways, another aim was to consistently expose users to treatment and rehabilitation options with the hope of them eventually ceasing their use. In this case, the central goal of harm-reduction was supplemented with a secondary objective of eventual abstinence. So there is a place for abstinence-based programs within a harm-minimisation framework, but only those programs that are harm-reducing in the right way, and great care needs to be taken to include only that sort.

Zero-tolerance: If this is taken to mean an absolute prohibition of drug use *under any circumstances*, where education and health-care interventions and the law are all geared to enforce or reinforce this *at all times*, then it is clearly incompatible with a harm-minimisation framework. If zero-tolerance never tolerates or allows the use of drugs, then it will be opposed to harm-reduction or minimisation which, as we have refined it, will sometimes tolerate the continued use of drugs when this is necessary to ensure the reduction of harm, or to avoid creation of harm.

Prohibition, decriminalisation and legalisation: Unlike abstinence, which relates to particular types of intervention or program, prohibitionism is a general policy to do with controlling the availability and use of drugs. Broadly defined, prohibitionism denotes any legal and policy regime which does not allow either the possession, use or supply of scheduled drugs, and which actively discourages these through (i) policing, detection and enforcement, and (ii) the application of penalties and sanctions.

There can be strong forms of prohibition and weaker ones (South Australia, 1978), depending on the degree of seriousness or strictness with which penalties and/or enforcement are applied. The strongest form – total prohibition – for instance, will apply severe criminal penalties in conjunction with vigorous policing, intervention and enforcement. Weaker forms, including decriminalisation, will still disallow drug possession, use or supply, but will apply weaker civil penalties with levels of policing and enforcement that reflect this. Prohibitionism, therefore, denotes a family of approaches which involve varying degrees of severity. Prohibitionism is opposed to legalisation, which does allow the possession, use or supply of drugs, but can also involve similar variations in the conditions under which they are allowed.

It is sometimes argued that harm-minimisation is neutral regarding policy and legislative regimes (Erickson, 1995; Single, 1997). This is true to the extent that the goal of harm-minimisation does not by definition presuppose any particular policy or legislative regime (Strang, 1993). But harm-minimisation

will not be neutral in the *implications* it has for different policy approaches. It will simply favour those approaches that contribute most effectively to the reduction of harm, and of course, the nature of prevailing circumstances will always be relevant in determining this.

Clearly, a full exploration of the relationship between prohibitionism and harm-minimisation would by far exceed the scope of the present discussion. What can be pointed out, however, are some of the factors and considerations that are relevant to clarifying that relationship.

It is crucial to keep clear sight of the difference between the aims of prohibition and its realities. One of the key aims of prohibition is ideally to stop or reduce people's use of illicit drugs. And it may even be, as it is often claimed, that the fundamental and underlying point of this is to reduce or minimise the harms of use. If harm-minimisation were to be defined simply in terms of aims, then prohibition in this case would count as harm-minimisation by definition. But, as harm-minimisation was eventually defined, it was the outcomes that could be reasonably expected that became central, and not aims. This means that to determine how prohibitionism stands with respect to harm-minimisation, we need to be mindful of the reality of its known or likely effects. The following two observations are relevant to this:

- The use of illicit drugs has not decreased as a result of prohibitionism in Australia, although it is difficult to say how much drug use (and resulting harms) there would have been without prohibitionism.
- Many harms have been attributed to prohibitionism, mainly in connection with the black-market trade in drugs and the clandestine circumstances of usage. These include crime, violence and corruption, and harms resulting from unsafe use.

The upshot of these observations is that if some form of prohibitionism (or decriminalisation, or even legalisation, for that matter) is to be blended into a harm-minimisation framework, it will need to be a form that is very harm-sensitive. Prohibitionism will need to operate in a way that is acutely aware of the potential it can have for creating harms. There is probably truth in the view that no regime of legal control or regulation is completely harm free in its impact, and that the choice is really a matter of finding a regime that reduces the most harm and creates the least in doing so.

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[i] A virtue of this, too, is that it allows a policy or intervention to still count as an example of harm reduction/minimisation, even though it might, in the very end, fail to reduce/minimise harm. But it will only still count as harm reduction or minimisation if the failure was due to something *unforeseeable*. A foreseeable failure would mean that the expectation that harm would be reduced or minimised was not based on all the relevant available evidence, and so was not fully reasonable (ie. not a case of harm-reduction/minimisation, on our definition).

[ii] The recent National Drug Strategic Framework document sees a harm-minimisation framework as incorporating supply reduction, demand reduction and harm-reduction as its dimensions. While it is clear what is intended in this, it is argued here that harm-reduction filters throughout *all* areas of a harm-minimisation framework, and is consequently not a distinct and separable dimension in itself. In the structure preferred here, demand reduction, supply

reduction and treatment & rehabilitation together encompass all of the possible intervention activities within a harm-minimisation strategy, and all seek to be harm-reducing in clearly and sufficiently distinct ways.

[iii] Or, perhaps in a more deferred way, through legal and policy reform to address the influence of the drug black-market on drug prices.

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