Harm reduction: a new direction for drug policies and programs

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2 Legalization of Drugs: Responsible Action towards Health Promotion and Effective Harm Reduction Strategies

LINE BEAUCHESNE

To feed a man without loving him is to treat him as cattle.
To love him without respecting him is to keep him as a pet.

Mencius, AD 300 (cited in Low, 1994, 320; our translation)

Canada, with its orientation towards a health-promotion policy, has distanced itself somewhat from repressive American drug policies. Health and Welfare Canada, in its 1986 publication *A Framework for Health Promotion,* adopted the definition of health promotion endorsed by the World Health Organization: 'health promotion is the process of enabling people to increase control over, and to improve, their health' (Health and Welfare Canada, 1986: 6). In other words, health cannot merely be defined as the absence of illness; health policy cannot simply be defined as investment in finding cures. Health promotion implies increasing a person's autonomy over the management of his or her own health:

> Today we are working with a concept which portrays health as a part of everyday living, an essential dimension of the quality of our lives. *'Quality of life' in this context, implies the opportunity to make choices and to gain satisfaction from living.* Health is thus envisaged as a resource which gives people the ability to manage and even to change their surroundings. *This view of health recognizes freedom of choice* and emphasizes the role of individuals and communities in defining what health means to them.
>
> Viewed from this perspective, health ceases to be measurable strictly in terms of illness and death. It becomes a state which individuals and communities alike

strive to achieve, maintain or regain, and not something that comes about merely as a result of treating and curing illnesses and injuries. *It is a basic and dynamic force in our daily lives, influenced by our circumstances, our beliefs, our culture and our social, economic and physical environments.* (ibid.: 3; emphasis added)

This Canadian approach with respect to health promotion implies several challenges; according to Health and Welfare Canada the most important of these, without doubt, is the reduction of socio-economic inequalities: 'Within the low-income bracket, certain groups have a higher chance of experiencing poor health than others. Older people, the unemployed, welfare recipients, single women supporting children and minorities such as natives and immigrants, all fall into this category. More than one million children in Canada are poor. Poverty affects over half of single-parent families, the overwhelming majority of them headed by women. These are the groups for whom "longer life but worsening health" is a stark reality' (ibid.: 4).

The consequences of drug use, for example, vary depending on a person's overall health; drug users' state of health varies considerably with social class and living conditions. Also, many remain ignorant concerning the effects of various illicit drugs as a result of current penal laws that, rather than encouraging public autonomy, handicap the implementation of a health-promotion policy to address drug use. Furthermore, as emphasized by Health and Welfare Canada, prohibition of specific drugs obscures the effects of the drugs most responsible for public health problems: alcohol, nicotine, caffeine, and prescription medications (Health and Welfare Canada 1990). To implement a Canadian health-promotion policy, therefore, drug laws must be changed.

The foregoing is significant. To establish effective harm reduction strategies, that is, policies other than managing public 'disorder' resulting from substance abuse, or imposing a moral-medical approach with a primary aim of 'contamination containment' (such as policies for AIDS, tuberculosis, and hepatitis)[1] requires, from a health-promotion viewpoint, devising ways to improve living conditions, increase autonomy, improve access to services as well as provide information on managing dependency and thereby reducing harm (AITQ 1995). The quote from Mencius that prefaces this chapter refers directly to these elements. It highlights respect for the client as central to the strategies to be developed, rather than the maintenance of order, fear of contamination, or even pity (Boilard 1994).

This article maintains that among the tools required to develop effective harm reduction strategies within a health promotion framework, legalization of all drugs must be envisaged.[2]

1 Drug Legislation and Health Promotion: Overview of the Current Situation

Several study committees, government commissions of inquiry, and research projects that measured the effectiveness of prohibiting certain drugs to prevent associated risks or danger are unanimous in their principal conclusion: prohibition is not only ineffective as a means of promoting health, it has aggravated the situations it should have prevented by resulting in the expansion of a 'black market' for drugs, and by depriving thousands of persons of specific medical treatments.

More precisely, these studies found no correlation between drug prohibition and a reduction in drug use. Prohibitive laws at best reduced the use of specific drugs, where their application limited drug availability (de Choiseul-Praslin 1991). There is no evidence, however, that reducing the availability of a given product will not simply increase the use of an alternative product, often more harmful to health than the one prohibited. The reasons for drug use cannot be reduced to defiance of the law, or the fact that drugs are available, or a lack of information regarding toxicity. A decision to use drugs may be based on criteria as varied as the pursuit of pleasure or euphoria, the desire to overcome shyness, curiosity, conformity to adolescent peer pressure, the desire for tranquillity or relaxation, adaptation to employment demands, the desire to forget conflicts or escape problems, and so on. Furthermore, fear of the law is not significant in influencing decisions to reduce or stop drug use. According to Erickson's study, concern for health is in fact a determining factor of such decisions:

> The use of marijuana, for example, is the most studied crime available for comparison. Conclusions from a number of studies consistently indicate that the perceived certainty and severity of punishment are insignificant factors in deterring use. Similarly, cocaine users have been found to view the legal threat as remote. What apparently has been much more important in reversing the trend of increasing illicit drug use that marked the 1970s has been the growth in perceived harmfulness of the activity, which has in turn likely augmented social disapproval of drug use behaviour. In any weighing of legal and health risks of drug use, concerns about health predominate.

Those who would claim that recent declines in illicit drug use are directly related to legal threat are overlooking the fact that dramatic increases occurred in the 1970s, when either no relaxing of laws against possession occurred or legal changes were demonstrably unrelated to use levels. Also, significant declines in cigarette smoking have occurred without arresting and jailing tobacco users, as the long-range impact of heightened awareness of the health hazards permeated through the population, and was reinforced by restrictions on smoking environments. As a primary prevention tool, criminal law is particularly ineffective against juveniles at the ages when much drug initiation occurs. Thus, declining illicit drug use has likely been independent of existing criminal law, and is unlikely to be affected by the easing of criminalization. Furthermore, it seems likely that greater flexibility in preventive programs and a consistent message of concern are more effective in the public health approach when they are not contradicted by the continued existence of punitive sanctions. (Erickson 1990: 565–6)

In the absence of a legitimate market, a black market responds to demands for illicit drugs. Drug-trafficking networks have developed where neither product quality nor places of distribution are regulated. Drug dealers are immersed in every environment: schools, discotheques, the street, the work place, and so forth. In most cases, products are adulterated to increase profits. The harmfulness of current laws prohibiting drugs is far more dramatic in this situation than were the laws prohibiting alcohol earlier in this century. Because such laws are international, the black market extends to more than sixty countries. Being so widespread, the black market has attracted a far broader range of drug traffickers, with far greater resources (Boustany 1993; Brouet 1991; Centre d'Études des Conflits 1991; de Choiseul-Praslin 1991; Fottorino 1991; Grimal 1993; de Kotchko et Datskevitch 1994; Makhlouf 1994; Observatoire Géopolitique des Drogues 1995; Sauloy and Le Bonniec 1992).

As a second health consequence of prohibiting specific drugs, their application for therapeutic use has been ignored. This applies especially in the case of marijuana or heroin. Persons who might otherwise benefit are deprived of their use to reduce pain, relieve anxiety, and so on. (Michka 1993). Another consequence is an increased difficulty in establishing harm reduction policies that would allow substance abusers sufficient autonomy to reduce the problems linked to their dependence (Brisson 1994). Without a change in existing legal prohibitions, persons with problematic illicit drug use habits cannot seek help without risking

penal repression or social discrimination. Furthermore, adequate services to help such persons are difficult to implement in the context of prohibitive laws. Needle-exchange programs, for example, are too restrictive; few of the substance-abuse programs designed for injectable drugs, in any of the countries studied, will demonstrate correct injection practices, antidotes in case of overdose, access to helpful crisis-line numbers independent of police intervention, and so on (Caballero 1992; Cesoni 1996; Lauzon 1994; Schiray 1992).

In summary, studies of the effectiveness of prohibition as a means to promote health and to establish harm reduction aims and strategies with that objective have clearly demonstrated the old cliché: not only is the remedy ineffective against the disease, its effects are worse than the disease itself. Not only do these drug-prohibition measures fail to reduce illicit drug use, or risks associated with their use, they maintain a black market where product toxicity resulting from poor quality control or high concentration multiplies incidents of overdose and the risk of health problems. Thousands of persons are denied access to treatment at the cost of their lives (Bibeau and Perreault 1995). Finally, on an international scale, prohibition underwrites the sale of illicit drugs to pay for drug use or to generate income, the role of carriers or small-scale dealers, and the consolidation of international trafficking networks with insatiable appetites for money. The result is increased demand, supported by widespread cheating, and political and police corruption (Boustany 1993; Brouet 1991; Centre d'Études des Conflits 1991; de Choiseul-Praslin 1991; Fottorino 1991; Grimal 1993; de Kochko and Datskevitch 1994; Makhlouf 1994; Observatoire Géopolitique des Drogues 1995; Sauloy and Le Bonniec 1992).

2 Harm Reduction Strategies: The Foundations of Socio-Medical Control?

Until the early 1970s, an array of bureaucracies exercised a virtual monopoly over the production of publicly available drug information, a monopoly threatened by the Brecher Commission (Brecher et al. 1974) in the United States and the LeDain Commission (LeDain 1973) in Canada twenty years ago. This monopoly is largely responsible for the continued current dominance of the prohibitionist discourse, a moral debate in which entire populations are embroiled (Michka 1993). This debate increases the hold of penal and medical prohibitionist control, and pre-

cludes establishing effective harm reduction strategies that respect the individuals targeted for service.

To promote solidarity among members of a society, a state, or a geopolitical collective such as 'the West,' nothing is in fact more effective than a common enemy towards which public fear can be chanelled (Szasz 1994). History abounds with scapegoats whose principal function was to maintain social unity and cohesiveness in the group supporting the interests of leaders: 'We have throughout history observed holy or religious wars against persons professing a different faith; more recently we have witnessed racial and ethnic wars against persons with nonconforming physical attributes; currently we observe a medical or therapeutic war against those who use illicit drugs. Let us not forget that the modern State is a political apparatus which enjoys a monopoly on the power to declare war. It chooses its enemies, declares war on them, and profits from this enterprise' (Szasz 1989: 70).

It is simpler to create public solidarity *against* something than towards change, or towards challenging existing power and social norms. Opposition to a defined evil immediately places the person in opposition on the 'good' side, requires no effort towards making change, and does not challenge the popularly perceived need to 'control the enemy' – by violence if necessary (Barel 1982). If the drug addict continues to be used as the political enemy in national and international strategies, how can a context of services to drug addicts be created that is integrated with other services, and that gives the same respect to drug addicts as to any other persons (Bibeau and Perreault 1995)?

Mainstream information supports such political strategies. Even research is bent to the norms of laws that reinforce the legitimacy of prohibition (Alexander 1990). Only a small proportion of the population will examine research material directly to verify the validity of its methodology or the coherence of its results as proof of its findings. It is simple, therefore, to publicize weak and sensationalistic bits of research, generally through the media or through bureaucracies implicated in the management or enforcement of current drug laws, and to sow panic concerning the dangers of illicit drugs (Arnao 1989). The 'great illusion' (Comte-Sponville 1989) maintained by such information is that drugs themselves provide the motivation for drug abuse; solving any and all drug problems thereby becomes a matter of making them disappear. This reasoning evades critical reflection on quality-of-life issues, or on societal norms to which certain groups of persons adapt by using drugs that may eventually become problematic (Bibeau and Perreault 1995).

This comedy of errors is not funny. It stains the earth with blood and corrupts the fragile institutions of democracy. Worst of all, it diverts our attention from the real causes of the misery and violence that surrounds us. Cocaine is not a significant cause of crime, violence, addiction, heart disease, brain damage, unhealthy babies, student apathy, low productivity, or terrorism in the Third World. It is the destructive illusion that we can relieve these deeply rooted problems by attacking cocaine that is the real danger related to cocaine in our times. (Alexander 1990: 215)

Instead of establishing educational and preventive programs that teach better management of restricted drugs, instead of encouraging the implementation of better research, and instead of improving training or access to resources for addictions workers with a clientele in need, the prohibitionist discourse results in repressive police operations and drug-use detection, prevention, or treatment programs that constitute social-control activities, rather than health promotion and harm reduction strategies developed within a health-promotion perspective.

In other words, not only is police activity underwritten by a logic of social control, but other types of intervention are equally required to conform to legal norms and may easily evolve into control strategies (AITQ 1996). For example, institutional clinicians are generally required to frame drug problems according to legal norms; their employing institutions are unwilling or even unable, in this instance, to define problems outside of the context of law. To conform to institutional norms, clinicians must automatically consider the use of illicit drugs as a form of deviance that requires correction (Bertrand 1986). The treated person has even less power to change this clinical perspective, where few resources exist for support or assistance.[3]

In fact, the legal situation and social discrimination against drug addicts imposes on a clinician a role of authority that not only risks becoming an abuse of power, but is also antitherapeutic. How can clinicians establish a relationship of trust with the treated person when it is suspected that clinicians must report on their progress to referring institutions (Brochu 1995)?

In summary, within a context of prohibition, intervenors who wish to avoid becoming agents of social control, who hope to deliver a coherent, effective, and health-promoting message, and who work to establish effective harm reduction policies often find themselves in an uncomfortable position with respect to their employing institutions. They must avoid their own exclusion by the social control structures.

3 From Drug Prohibition to Regulating the Drug Market Place

From Decriminalization to Legalization

Approbation for the decriminalization of cannabis and its derivatives alone as the ultimate goal of improved judicial drug policies aimed at supporting harm reduction strategies has decreased among antiprohibitionists even while this remains an integral step towards more global strategies. This form of decriminalization would reduce certain abusive police controls and permits the social integration of a particular type of drug user, but remains a very limited solution in terms of health promotion, especially for users of intravenous drugs. It does not guarantee the quality control or improved distribution networks essential to reduce the dangers of intoxication; and it does not legitimate recreational drug use. Even with drug users who are adequately informed concerning their products, even with products of low concentration and quality control in a regulated market, users are not considered capable of managing their own usage. Finally, this policy does not leave room to challenge existing social-control measures.

A legislative strategy that represents responsible action toward health promotion aimed at implementing harm reduction strategies thus implies the legalization of all drugs. *Legalization is not, in itself, a solution to the problems of drug abuse.* Improved regulation to reduce the risk of harm, through improved conditions under which drugs are marketed, must be accompanied by the three inseparable tools of drug policies based on health promotion: adequate prevention programs, reasonable access to services and treatment, and socio-economic interventions that, by improving the quality of life of a certain sector of the population, facilitate their acquisition of healthier living habits (AITQ 1995).

From Legalization to Market Place Regulation

The three tools that must accompany drug regulation become even more important in a licit drug market, which tends to ensure its own expansion through stimulation of product demand. The weight of advertising currently aimed at promoting all types of medications, as well as alcohol, coffee, or tobacco (despite certain restrictions), testifies to this fact, as do drug-usage models validated by television programming.

The advertising of licit drugs encourages a close look at studies con-

cerning the effectiveness of regulations that restrict drug advertising. All drug advertising, despite its apparent diversity, contains the same message: the user of medications, alcohol, tobacco, coffee, chocolate, or colas feels better, avoids pain, is more serene, or improves the quality of his or her life. Can the drug-promotion message be reduced by legal means, when it is constantly repeated to the public? Preliminary conclusions of studies on this question indicate that, even with advertising restrictions, new drug policies should not be created with the illusion that the drug-promotion message will disappear. Drug advertisers will always have sufficient imagination and resources to find new loopholes.[4] Specific restrictive measures may be required to support efforts towards prevention.

In summary, an examination of current drug laws clearly demonstrates that to determine new drug-marketing policies, based on a health-promotion viewpoint, requires challenging the current prohibition of illicit drugs and also the current marketing regulations concerning licit drugs.

4 Legalization of Drugs and Harm Reduction Strategies

The need to implement drug laws that promote health by ensuring cohesive and equitable regulations that include all drug marketing underlies the scenarios suggested by antiprohibitionists. Such regulations must not only consider economico-political obstacles to the modification of current laws; they must also take into account that any change challenges society's prevailing attitudes and drug-use habits (Evans 1990).

With new marketing methods for regulated drugs aimed at ensuring product quality and reduced concentration, it is reasonable to predict that an array of currently used adulterated products will disappear. These would either not be competitive in a new market place, or inadequate in terms of quality. Other drugs would be refined and sold in reduced and more manageable dosages. When alcohol use was legalized, bootleg liquor was not. Quality alcohol products were legalized, and products of regulated alcoholic content made available so that persons learning to use these products would not be poisoned. Legalization considerably lowered the price of alcohol, and placed its distribution under the control of liquor boards or specific liquor outlets. Similarly, it may be assumed that the expertise of persons who already have illicit drug-use habits would be accessed in defining appropriate dosages and

consumption methods, and in determining the therapeutic value of such drugs.[5]

In any case, these are minor details in the scenario of a new drug market place. What is lacking, in light of current market trends, is the anticipation that pharmaceutical corporations would produce new synthetic drugs (Olievenstein 1989). New drugs – because of pharmaceutical companies' greater power to market their products, to produce them at lower cost, to offer a wider range of mood alterants, and in theory to ensure safer consumption (this will in any case be the approach promoted by pharmaceutical companies) – are likely to overtake the market.

Anticipation of the creation of such drugs includes concern that access to new mood-altering products will create new habits, not so much for recreational use as for increased employment productivity or for developing other potential skills. The popularity of Prozac is an eloquent example (Breggin 1994). Does this potential signify the use of new drugs to enforce even greater adaptation to the demands of employment, or to regulate our moods and those of our children? The question is not entirely frivolous (Cohen 1995). Drugs are already commonly used to regulate our bodies to meet employment demands. Many persons depend on Valium, Prozac, caffeine, or alcohol to reduce stress, to facilitate sleep, and so on. New drugs in a changed market place would not of themselves create drug-consumption models that differ greatly from current usage habits. It is not a fear of the development of new recreational drugs that animates the debate concerning a changed drug market place; it is concern that the development of new drugs will (or already does) prolong the drug-use habits that exist, and thus prolong habits that generate harm. Who will be the users and abusers of new drugs? New users or the same old faces?

These questions remind us that when looking for the best way to regulate a new drug market place, we must not lose sight of the political question of health promotion and harm reduction strategies that regulations should support. To maintain health promotion and harm reduction as a priority, analysing the impact of a new drug market place cannot be limited to analysing how illicit drugs may be used for recreational purposes. Such limitations too often omit consideration of the common attitudes and habits with respect to licit drugs.

Antiprohibitionists concur that while the economico-political controls maintaining current prohibitions must be countered, this is only a preliminary consideration. To come to terms with the entire range of drugs requires deeper reflection if regulations are to pursue health promotion

for effective harm reduction strategies. Such terms imply a secondary level of consideration, which takes the role of drug use in post-industrial society into account.

Conclusion

Primary, secondary, and tertiary prevention practices currently being developed with the aim of harm reduction are confronted with a difficult situation. If they focus on drug-related harm and fear of AIDS rather than adopting a broader health-promotion focus, they risk accepting as normal the hopelessness and reduced opportunities for a certain segment of the population. But broader health-promotion policies contradict current drug laws (and projected changes such as the Controlled Drugs and Substances Act), as indicated by British Columbia Chief Coroner Cain in his 1994 drug-policy report:

> I suggest that society must now reject negative criminal sanctions as the source of social control in drug abuse and turn rather to some other methods of control.
>
> Time and time again I heard the following expressions: personal values, family values, role models, education, treatment, jobs, and housing. And yes, spiritual values ... Both body and mind must be involved, neither one to the exclusion of the other.
>
> Agencies involved in the drug abuse problem will not conquer or reduce the personal and social harms until they know, understand, and challenge the root causes of these problems. (Cain 1994: 86)

Prohibitive laws may thus be considered a primary cause of harm:

> This leads us to the need to establish a basic distinction between reducing drug related harms (health, family and violence problems, impaired driving, etc.) and harms related to drug controls, that is the prohibitionist context (marginalization, criminality, toxicity problems, reduced living standards and conditions, etc.) And if the maxim describing the cure as worse than the illness, referring to drug laws, is based on fact, we may globally consider the harms resulting from drug prohibition as greater and more in need of change than those resulting from legalized use (in spite of the undeniable seriousness and extent of harms linked to impaired driving). (Brisson 1994: 4)

While a great deal of research is currently being undertaken, much remains to be done. Reflection on this matter is important, and contributes towards understanding the strategies that must be developed on an

international, national, regional, and local scale to meet these considerations. At stake are not only health promotion and harm reduction strategies, but also the democratic foundations of society.

NOTES

1 In this vein, many services offered to drug addicts are clearly based on fear of the spread of AIDS, and their basis thus becomes extremely fragile outside of this medical goal. The approach considerably reduces the potential of interacting honestly with drug addicts, of increasing their autonomy and their ability to manage, and eventually overcome, their dependence. Bibeau and Perreault 1995.
2 A more detailed presentation of these considerations is presented in Beauchesne 1992.
3 It is nevertheless true that drug users and addicts are increasingly trying to form organizations to lobby institutions: for example, ASSUD (Association des usagers de drogues) in France, or Citoyens comme les autres in Belgium, as well as the traditional Dutch organizations whose role in recent years has become less central.
4 These are the conclusions that have encouraged the Canadian Centre on Substance Abuse (CCSA) to propose the following recommendations in its memo to the CRTC: 'While it is impossible to prove that advertising increases consumption, the Centre underlines that it is equally impossible to prove that it is without effect. It is to be feared, however, that if advertising is prohibited, the alcohol producing industry will channel its enormous resources toward other forms of promotion. The result may be a decrease in price, an action which, it has been proved, will increase consumption.

   'The industry also threatens to spend more money underwriting sports events or rock concerts, both of which attract a youthful public. "The short term economic effect of restricting advertising may increase consumption," stated Mr. Single.' Centre Canadien de Lutte 1991, *Action-Nouvelles; Bulletin* (p. 12).
5 For example, *kava* from the Fiji Islands has effects similar to those of alcohol but is much easier to manage, and has fewer side-effects than alcohol. Similarly, several drugs may be much safer than currently licit drugs such as tobacco. See Siegel 1990.

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