New terminology and new jargon often conceal the fact that what is being described is not new. This is the case with 'harm-minimisation'. It is only in the last few years that the general term 'harm-minimisation' has been used but in fact agencies have been promoting practices which could be described in this way for some considerable time. For example, in Sexually Transmitted Diseases Clinics there has been the promotion of preventative measures against these diseases; and in the alcohol field the promotion of sensible drinking, not drinking and driving, and lower alcohol content beverages are all examples of 'harm-minimisation'. Hence, what has happened is that the quite long standing practice of harm-minimisation has been given a much clearer conceptualisation. This has been due to the advent of the HIV/AIDS problem among injecting drug users, and this clearer conceptualisation has led to harm-minimisation becoming both more public and far more controversial.

The HIV/AIDS problem has led to a focus on ways of preventing further spread of the virus
among injecting drug users. The most publicised way of reducing this spread has been via the provision of clean injecting equipment, but a wide variety of other policies which have a general influence on drug use have been incorporated into both discussion and practice. For example, even the needle/syringe-exchange schemes offer far more than simply a place to change equipment: they do of course provide clean equipment, but they also provide information on AIDS and safer injecting practices, AIDS and safer sexual practices, and they may also provide condoms. Newcombe (1987) provides another example: he has argued for a harm reduction approach to drug educational initiatives aimed at young people, based on the logic that if it is acknowledged that young people will very often try drugs (either out of curiosity or in response to peer pressure), then it becomes important to give them adequate information about drug use and about less hazardous ways of approaching such use.

Harm minimisation, then, is practised widely. There are, however, two immediate problems with the term harm-minimisation. First, many people take harm-minimisation as implying something about safety. This is not the case. Kozlowski makes the point that "less hazardous means reduced in risks or not as dangerous; it does not automatically mean safe or without risk" (1984: 310). Hence harm-minimisation is about reducing the degree of danger; it is concerned with altering probabilities.

The second problem relates to social attitudes and to the problem of being seen to condone drug use. Social attitudes towards harm-minimisation approaches such as the provision of clean needles and syringes, vary as much as they do towards drug use itself. The use of drugs other than alcohol and tobacco for purposes other than medical is not considered a viable activity within our society (Kay 1986). Therefore, any approach that does not focus on abstinence is bound to be controversial. For general harm-minimisation approaches to be accepted, it has to be shown both that they have a far-reaching purpose that will benefit society as a whole and that they do not work against the general principles held by society. In the case of clean needles and syringes, the prevention of further spread HIV among injecting drug users has the far reaching implication of preventing the further spread of the virus to other members of society, but it has been harder to show that the provision of clean injecting equipment does not go against the principle that illicit drug use is to be discouraged. In fact, many have argued that it may actually give the impression of condoning drug use. The counter-argument is that if one accepts the comments put forward by Kozlowski and Kay (i.e. that the reality is that people will use drugs, because complete prevention of drug use in society today is impossible) then trying to reduce the harm or risks involved in that drug use is of main concern. Again, the issue here is one of probability of risk or damage.

What has become the over-riding facto for the case of clean equipment is that HIV is a very real health threat. It seems clear that society is more willing to accept practical measures adopted to prevent further spread of the virus than it is of some of the more general approaches towards
harm-minimisation in the health education field (such as pamphlets showing safer ways of using solvents, etc.).

There are, then, a variety of confusions and controversies concerning harm minimisation. This paper will discuss them, in the context of illicit drug use, starting with some clarification of the definition of harm-minimisation, and moving on to a discussion of a number of policy and practice issues.

Defining the Concept

There is a variety of terms used to describe harm-minimisation in the drug-use literature. These include harm-reduction, secondary prevention, risk minimisation, risk reduction and responsible drug use. In addition, a definition of harm-minimisation can be provided both at the micro-level concerning the individual actually involved in drug use, and at the macro-level involving social (and governmental) attitudes and governmental policies relating to the area of illicit drug use.

A working definition for harm minimisation on the micro-level can be given as an approach in which an attempt is made to reduce or minimise the harm toward an individual and others through changing from high-risk behaviour (like sharing injecting equipment) to safer behaviour (either not sharing, or stopping injecting altogether).

Harm-minimisation is often thought of as being synonymous with reducing the incidence of shared use of equipment (that is reducing a potential or real physical harm) and indeed it is this behaviour that we have used as an example in the previous sentence. Yet, in reality, it can often refer to changes in a far wider range of behaviours, each of which might serve to reduce psychological, social and legal, as well as physical harm. For example, as Dorn (1987) has shown, harm-minimisation can relate to all stages of drug use, from the about-to use novice, through to the heavily or destructively involved user- and the harmminimisation tactics will differ with each of these levels.
Another example is related to the fact that many of the problems presented to counselling agencies by problem drug users are concerned with aspects of their life that have been affected as a result of their drug use (eg. housing, employment, relationships, etc.). The problem drug user may not, in fact, be seeking the agency's help in 'getting off drugs, but instead may want advice on how to deal with the practical problems presented. In a case like this, the aim of a harm-minimisation approach would be to encourage the individual to find a solution that would reduce the potential harm that might be occurring, both to him or herself and to society, as a result of being homeless, unemployed, etc. This harm might be both psychological and social: being in these positions may result in the individual breaking the law in order to get money to purchase drugs or it may just give an adequate reason for the individual to continue with drugs. It might even increase the likelihood of the individual engaging in more high-risk behaviour. All these examples serve to underline the fact that a harm-minimisation approach relates to far more than just drugs and drug-taking behaviour. It relates to general behaviour that can be potentially harmful to an individual or to society as a whole.

The definition at the macro-level relates to the reduction or minimisation of harm to drug users (and to society due to its members using drugs) through legal measures, national policies, and the changing of social attitudes. At this level, a dichotomy in policies concerning drugs can be seen. On the one hand, the Government's response to the 'drugs problem' in the 1980's has been to develop a number of policies aimed at ensuring abstinence from drug use. First, there has been a primary focus on increasing enforcement (ie. an increasingly punitive approach). Second, a primary prevention strategy has been developed, aimed at ensuring that individuals never commence the use of illicit drugs.

On the other hand, the Government has acknowledged that more services were needed around the country (a result of the 1982 & 1986 reports of the Advisory Council on the Misuse of Drugs*), although the policies relating to services were also aimed at abstinence. However, as a result of the escalation in the prevalence of HIV, a decision has been made to develop a policy on the provision of clean needles/syringes as an attempt at reducing/preventing the further spread of the virus. The reason for this contradiction in policy is clear: whilst a primary concern of this Government is to attempt to discourage illicit drug use through the enforcement of laws and through policies on prevention measures, it has had, at the same time, to deal with the very real health threat of HIV- a potentially greater threat to society as a whole.

We began this paper by presenting two levels of definition for the term harm minimisation, thus clarifying our use of the term and providing a basis from which to examine the development of policy and practice in the drugs field in recent years. Two points need to be made about this development. The first is that, in the drugs field as elsewhere, policy and practice can often go in somewhat different directions, although they will always have a reciprocal effect on each other. Furthermore, the direction of influence is not always the same - policy will sometimes
influence practice (a top-down influence) and practice will sometimes influence policy (a bottom-up approach).

An example of the former approach in the drugs field in Britain is the 1968 policy to restrict prescribing for drug users to specialist clinics. This policy was decided at the government level and passed down to the field to implement. The bottom-up approach is illustrated by the decision to move away from long-term maintenance prescribing to short-term treatment on a reducing basis, which was decided by the clinics themselves and then incorporated into the government's overall policy.

The second point to be made about the development of policy and practice is that health issues (and the general public's perceived concerns about them) act as a major force in influencing Government's policy-making. The predominance of the medical model in the drugs field is a major factor when examining/identifying changes in direction of policy and practice in this field.

Briefly, in Britain the changes in policy over the last 60 years have had two main foci, with each one centring on primarily one approach. From the 1920's through to the 1980's, the approach in policy-making centred on the medical/treatment model, with practices ranging from long-term maintenance during the period of 1920's-1960's (MacGregor & Ettorre 1987), to short-term treatment leading to abstinence in the 1970's.

Prescribing was, of course, not the only plank of government policy as enforcement has always been incorporated into the system of controlling drug use in the UK (Stimson 1987a), but it was the primary focus. However, in the first half of the 1980's there was a shift in focus towards an approach centring on enforcement/punishment, exemplified by the five-pronged approach of:

- reducing supplies from abroad;
- tightening controls on drugs produced and prescribed here;
• making policing even more effective;

• strengthening deterrence;

• improving prevention treatment and rehabilitation (Home Office 1985 & 1986).

Secondary to the shift to the enforcement model, there has also been a shift in how services for problem drug users are provided. The clinics are no longer the primary service available, as the development and proliferation of a broader range of services including street counselling agencies, rehabilitation houses, etc., have enabled more clients to be drawn in. As Stimson pointed out: “drug policies are in a state of transformation in which medicine is being displaced from its former central role and being replaced by a more extensive and diffuse response involving a broader range of agencies and ideas about drug problems” (1987b: 38).

While there are many benefits to having agencies in the voluntary sector (a nonauthoritarian venue that will attract clients), cynics can argue that this situation allows for the reduction of funding, once the initial pump-priming grants end and once the public relation function of such an initiative is less important.

Present changes in policy - consumer-demand or response to perceived political need?

In some ways the most recent policy changes, relating as they do to the issue of AIDS, have caused the government to perform something of a volte-face. Recently in response to the increasing spread of HIV among injecting drug users as a result of sharing injecting equipment,
the ACMD in its report ‘AIDS and Drug Misuse Part 1’ (1988) called for a general harm-minimisation approach to be adopted:

"The first goal of work with drug misusers must therefore be to prevent them from acquiring or transmitting the virus. In some cases this will be achieved through abstinence. In others, abstinence will not be achievable for the time being and efforts will have to focus on risk-reduction" (p.1)

The Government, faced with the rising health issue of the spread of HIV in the UK, has provided official support and some funding for the establishment of pilot needle/syringe-exchange schemes. Indeed, the summary of the Government's strategy, whilst re-affirming their five-pronged approach, adds a new AIDS-related general health focus to the treatment and rehabilitation front. Their rationale (and that of the ACMD) is that "HIV is a greater threat to public and individual health than drug misuse" (Home Office 1988:1). And yet this shift has caused the government to simultaneously adopt two sets of policies which are, at best, uneasy bed-fellows. On the one hand they are clearly anti-drugs, with their emphasis on detection, enforcement and abstinence; yet on the other, through necessity, they have endorsed a harm-minimisation, controlled use approach which provides free supplies of needles, and which requires no willingness to change drug-using behaviour before treatment is offered.

Possibly as an attempt to remain faithful to the harder, more confrontative orientation which existed prior to the HIV concerns, the Government has also chosen not to adopt or change policies that would lead to an even greater extension of harm-minimisation approaches in practice. For example, the ACMD report also proposed an increased role for GPs in the area of prescribing, as a measure by which to encourage risk-reducing practices; a recommendation which, as yet, has not been acted upon by the Government.

Recent policy statements, then, indicate a shift towards incorporating a harm minimisation philosophy into the existing framework of services. However, this is not a shift away from the focus on enforcement nor is it a shift away from encouraging abstinence (ie. reducing supply and demand). The shift towards harm minimisation can be viewed as a movement towards a multi-levelled approach, with services centring on a consumer-demand model. Alternatively, it can be viewed as a response to the need to be seen to be doing something about AIDS with this sector of the population.
Putting policy into practice:

the provision of needle exchange schemes

The primary aim of needle exchange schemes is to encourage injecting drug users to stop sharing injecting equipment (and thereby reduce further spread of HIV) by making clean equipment accessible. While the threat of AIDS has been the rationale for the existence of the schemes and the policies supporting them, there are two other aims within the organisations which offer such schemes:

1. To make contact with members of the drug-using community that may not have come to the agency before and, as a result;

2. To reduce various health risks through providing information on issues like injecting practices, safer sex, diet, and general health care.

Many drug counselling agencies have become the primary outlets for clean equipment and this utilisation of counselling agencies as harm-minimisation outlets has presented a number of problems in the actual work of putting a harm-minimisation philosophy into practice. Examples of some of these problems are concerns about training and support, working methods, service priorities, and responsibility, each of which are discussed below. Yet possibly the most immediate problem faced by agency workers is ambivalence about the task of only providing clean equipment and information without asking many questions at the outset, instead of entering into a counselling relationship.

Ambivalence: For many workers, trained to counsel, the provision of clean equipment 'with no (or few) questions asked' has meant a re-evaluation of their roles and, possibly, their
fundamental attitudes and feelings towards drug use, drug users, and the task of 'helping' users. While many workers see harmminimisation as a general philosophy that covers most of their work, a lot of it has been an underlying concept within the context of counselling. That is, counselling often involves helping an individual to change a behaviour that will reduce or solve the problem being experienced, and this process is, of course, harm-minimisation. Yet the practice of just providing equipment without counselling has meant that workers have had to consciously adopt this philosophy, which has meant that sometimes they will have to simultaneously hold two different approaches to their work. On the one hand, the workers are there to offer an empathetic environment in which individuals can present their problems for counselling; on the other hand, with other users of the service, they have to provide an almost business-like service of exchanging equipment.

Having to incorporate two different policies (and more importantly, two different practices) into the work environment can also lead to an increase in stress felt by all concerned in the agency. The added stress for the workers involves dealing with an increased demand on their time, working in two ways, determining which way is appropriate in a situation as it arises and the related confidence (or lack of it) they feel in doing this, and finally, in dealing with the feelings of ambivalence discussed above which many workers experience.

These problems have implications for the agency's management relating to such areas as training and support, providing the service, and setting priorities.

**Training and Support:** Workers have been given training seminars/courses on AIDS, safer sex, injecting techniques, dealing with aggression/violence, and any other matters that might arise in providing this service. While some of these might (some would argue should) have been dealt with anyway, the development of needle exchange schemes has brought the need for them to the forefront, and as specific exchange-related issues as opposed to general ones. Along with the increased training (particularly on matters not solely related to drug use), support for the workers providing this service has been emphasised as an issue. Support has always been emphasised in the drugs services field, but the advent of needle-provision schemes has increased this. The degree of difficulty experienced in taking on two approaches to work varies considerably an therefore the amount of support needed by workers differs.
Providing the Service: One issue on providing the needle exchange service is staffing. In some cases, counsellors may no feel able to use both working approaches and will prefer not to be involved in the provision of clean equipment. Management, in acknowledging and accepting this, have had to make suitable adjustments in staffing to ensure that both areas of work will be offered effectively and efficiently. Another issue is the actual method of providing the equipment - on a strict exchange basis or on a provision basis (i.e. not requiring used equipment to be returned before issuing clean works). Even strict exchange schemes have found that 1:1 exchanges do not always work in practice and the agencies have had to made discretionary decisions on providing clean equipment without equal returns (Monitoring Research Group 1988a, 1988b, Velleman & Rigby 1989).

A third issue is concerned with the users of the service and whether or not the are injecting or not. Some agencies ask to see injecting sites while others ask about injecting practices without requiring visible proof of injecting (unless there is some doubt, particularly when dealing with young users). It has become clear that there has to be flexibility in making decisions about providing services of this nature, as the successful implementation of policies will be influenced by this range of issues.

Setting Priorities: This leads onto the issue of setting priorities. Some agencies have had to decide on which services are to receive priority with relation to staff time, promotion, training, support and funding. Finding a balance between these two different services has been difficult for some agencies and due to the increase in work-load without an increase in support (financial or staff-wise), some agencies have had to decide against providing a needle exchange scheme, either in the first instance or after an initial trial period (Monitoring Research Group 1988a).

Responsibility: There are three areas of responsibility to consider: client, agency and co-ordination of services. In terms of client responsibility, workers in the drugs field adopt the idea that drug users are/can be responsible individuals and that the ultimate responsibility for reducing potential harm rests with them. Therefore, the client is responsible for making any decisions on changing behaviour. However, drug users may need guidance on how to change
their behaviour to reduce the potential harm and this leads to the responsibility of the agency. Agencies have found that they need to be aware of the different types of changes that may be needed (like changing injecting sites, injecting more safely, obtaining a 'script' so injecting can stop, etc.) and to have access to information that will lead to helping the drug user with the immediate problem. If the agency cannot deal with an issue directly, then it requires a network by which it can obtain the necessary information.

Therefore, co-ordination/co-operation between drug agencies and other professionals/organisations is important.

One of the difficulties faced by some agencies has been on identifying the boundaries of their responsibility in dealing with all of the various issues that might be presented to them. Tackling Drug Misuse: a Summary of the Government Strategy’ (Home Office 1986) called for the establishment of District Drug Advisory Committees that would have the primary responsibility for determining the need for services and to ensure the development and co-ordination of these services. Not all health districts have DDACs and not all of the existing ones run efficiently and effectively and therefore there is less successful co-ordination of services.

Future planning: developing harm-minimisation practices

In the few years that needle-exchange schemes have been operating in the UK, a number of issues have repeatedly made themselves apparent. One such issue is the approach the agency should take in making its scheme 'user-friendly', thereby attracting new customers and retaining old ones. Questions about what to supply (size of needles, swabs, needle clippers, disposal units, sterile water, etc.), opening hours of the agency, what information to provide, how best to promote the service, and how to monitor its use without driving people away have all been addressed, although there are no clear cut answers as yet. Many agencies have committed themselves to continually re-addressing these issues, many are trying out different approaches and learning from the experiences of other agencies. At present the planning of future services in the field appears to be incorporating a consumer-demand orientation which can certainly
allow for general harm-minimisation practices to take root.

Another issue that has received renewed focus is that of outreach work. In order to reach some of the users exhibiting the high-risk behaviour of sharing, it has been suggested that the service needs to be offered (or at least publicised) in the communities within which the users live. Outreach work of this sort does fit into the concept of harm-minimisation and the consumer-demand model of service provision, although it also raises all the concerns of training, support, time, etc. that any new approach to working in this area does. Some agencies are already providing some outreach work and others are incorporating it into their future plans.

Summary and Conclusion

We began this paper by saying that the concept of harm-minimisation is not new. Harm-minimisation practices have occurred in the services field for some time, but the focus on it in the drugs field is a new one and has emerged as a result of the problem of HIV among injecting drug users. This has led to a greater concentration on clarifying the needs/demands of drug users and the responses of the various agencies working with them.

The definition of harm-minimisation was presented on two levels: the individual level, and the social/government level. Generally, agreement can be found that harm minimisation (however it is defined) is primarily concerned with reducing the potential harm to an individual or group exhibiting high-risk behaviour. The main harm reduction approach attempted is to provide measures (verbal measures information/education, practical advice; or equipment measures - needles, syringes, condoms, etc.) that enable the individual or group to reduce or cease their high risk behaviour.

An examination of the development of national drug policies in the UK over the last 60 years reveals their changing nature. On the one hand, there has been the move from a medically-centred focus on the 'addict' to an enforcement-centred focus on the supply of drugs. On the other hand, in terms of dealing with drug users, the policies reflect a shift from the single-level approach of medically-based treatments (all clients were offered only one approach either the earlier maintenance prescribing or the 1960's/1970's clinic system) to the
multi-levelled approach (drug users are offered a broader range of services including clinics, counselling agencies, shop-front facilities, etc.) that began to emerge in the 1970's/1980's. While the present policy statements on the provision of clean injecting equipment as a measure to reduce the further spread of HIV once again focus on the medical-centred approach, they do not indicate a shift away from the enforcement-based emphasis in overall policies. What is indicated is an acknowledgement of the need to provide services for drug users that will reduce the risk of harm to the individual and, ultimately, society. This acknowledgement opens the door to the consideration of incorporating other harm-minimisation practices into the drug-services field.

While the initial focus of this present approach has been on needle-exchange schemes, agencies have found themselves addressing the feasibility of incorporating further harm-minimisation practices. It is clear that, in practice, services for drug users are constantly changing in response to the demands made upon them and that there must be flexibility in service provision. However, what is not so clear is how many agencies can adapt their work to these new demands, given existing resources. If services are to continue developing in response to client demands, policies will need to reflect this movement towards a general harm-minimisation approach.

Policy decisions, particularly at the government level, are very much influenced by social attitudes and perceptions and this may be a current barrier to the adoption of a harm-minimisation approach. The public concern about the spread of HIV has allowed for a certain (albeit not complete) acceptance of needle/syringe exchange schemes, but the acceptance of other harm-minimisation practices would mean adopting a philosophy that abstinence is not the only idea that can/must be advocated to drug users.

Since achieving complete social-attitude change is difficult, particularly in the shortterm, the best that can be hoped for at present is a partial acceptance of general harm-minimisation practices, based on two points: the acknowledgement of continuing drug use by today's society and the argument that society itself will be 'helped' through the reduction of highrisk behaviours like theft, violence, etc.

By adopting/promoting this viewpoint, other harm-minimisation practices can be accepted as needle-exchange schemes have - as necessary measures to reduce potential harm to individuals and, in turn, society. This is perhaps the best argument that advocates of
harm-minimisation can use for their case, and it is an argument which they should use vigorously if they wish to see an increase in the provision of a range of harm minimisation practices. This is because much of the future development of policy and practice is dependent on the acceptance of these views by politicians and by the general public.

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Harm-Minimisation: Old Wine in New Bottles?

Written by Richard Velleman
Saturday, 22 December 1990 00:00

London HMSO


Velleman, R., and Rigby, J., 1989 An evaluation of the provision of sterile injecting equipment to injecting drug users in the Bath and Swindon health districts Bath, University of Bath.

- The Advisory Council on the Misuse of Drugs (ACMD) is an independent group set up to review and give the government advice on matters concerning treatment, rehabilitation and prevention in the drugs field.