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Occasional essay

Substance abuse and developments in harm reduction

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Abstract

A DRUG IS A SUBSTANCE THAT PRODUCES a psychoactive, chemical or medicinal effect on the user. The psychoactive effect of mood-altering drugs is modulated by the user's perception of the risks of drug use, his or her ability to control drug use and the demographic, socioeconomic and cultural context. The ability to control drug use may vary along a continuum from compulsive use at one end to controlled use at the other. The "drug problem" has been socially constructed, and the presence of a moral panic has led to public support for the prohibitionist approach. The legalization approach has severely attacked the dominant prohibitionist approach but has failed to gain much support in society because of its extreme libertarian views. The harm reduction approach, which is based on public health principles, avoids the extremes of value-loaded judgements on drug use and focuses on the reduction of drug-related harm through pragmatic and low-threshold programs. This approach is likely to be important in tackling the drug problem in the 21st century.

A drug is any substance that produces a psychoactive, chemical or medicinal effect on an individual. The term "psychoactive drug" is often used to refer to mood-altering drugs. The effect of a drug depends on a combination of 3 elements of drug use: drug (the pharmacological property), set (the characteristics of the user) and setting (the social and physical environment where drug use takes place).[1] Although a drug produces psychoactive effects on the body, the effects, or harms, vary according to user characteristics (set), such as the pattern of drug use, the user's perception of the pleasure and risks of drug use, and the demographic, socioeconomic and cultural characteristics of the user.

Drug abuse may be defined as the use of a drug that causes adverse physical, psychological, economic, legal or social consequences to the user or to others affected by the user's behaviour.[2] The interaction between drug and set makes it difficult to identify the line between abusive and nonabusive use for all users. Perceived risk of harm appears to be inversely related to level of use,[3,4] and the ability to maintain controlled use is present among many users of even highly potent drugs such as crack cocaine.[5,6]

Higher levels of drug use and drug problems have been observed among men than among women, among nonreligious people than among religious people and among young adults than among juveniles and elderly people.[7,8] In multicultural societies such as Canada's and the United States', various ethnocultural groups and immigrant groups with different lengths of residence in the host society exhibit dissimilar patterns of drug use and drug problems.[9,10] The socioeconomic condition of the user also seems to be instrumental in facilitating the ability to control use. A number of studies of cocaine and crack users have shown that the middle class have a greater stake than their lower-class counterparts in maintaining controlled use of cocaine or crack because they have successful careers and high social status.[5,11–14]

The ability of a person to use a drug in a controlled, nonabusive manner lies on a continuum. At one end is the absence of such an ability. People falling close to this end are near-helpless victims of the pharmacological properties of the drug whose use has become compulsive, uncontrollable and problematic; whereas users near the other end of the continuum are able to make informed choices and to weigh the benefits of drug use against its harmful consequences. Compulsive use fits the traditional, *mechanistic* approach to addiction, whereas controlled use implies a *voluntaristic* approach.[5,11] This continuum approach offers a way to look beyond the limited confines of the traditional, pharmacodeterministic view of drug use.

Societal reactions to drug abuse

In the broader social context, or the setting element,[1] drug use and abuse are social phenomena subject to the definition and reaction of society. How much drug use and abuse is there in society? How serious is the drug problem in society? Because there is no shortage of sources of information about drugs in society, answers are not difficult to come by. Or are they? Epidemiological surveys and community-based studies consistently identify a low prevalence of drug use and drug problems in North America[5,15,16] and hence support a more voluntaristic model of drug use.

However, the police and other law-enforcement departments are often keen to alert the public to the possible presence of a serious drug problem in the community by publicizing drug-related arrest figures, drug seizures and incarceration records. Media reports tend to copy such behaviour by supplying anecdotal stories about victims who have fallen prey to drug abuse. Politicians are eager to capitalize on drug statistics provided by the police and on media exaggerations in order to win public support by promising solutions to the drug problem in society. The result is the manufacturing of a "moral panic" among the public,[17,18] and such a panic serves the interests of all the above-mentioned parties who created it. It is easy to understand, therefore, why in Canada and the United States since the 1960s a decade has hardly gone by without a specific drug scare. There is wisdom in the claim of sociologists that social problems, including the drug problem, are socially constructed.[19–21]

Public belief in an ever-growing drug problem has fuelled the prohibitionist reaction to drug use and the user. This view assumes that illicit drug use is a morally corrupt behaviour, one that violates the "collective conscience" of the community.[22] The control of such immoral behaviour is necessary, requiring a strong law-enforcement apparatus and a drug policy that declares war on drugs and heavily punishes drug users. Major criticisms of this approach include its moral arbitrariness in dividing drugs into licit and illicit ones, marginalization of drug users, straining of the

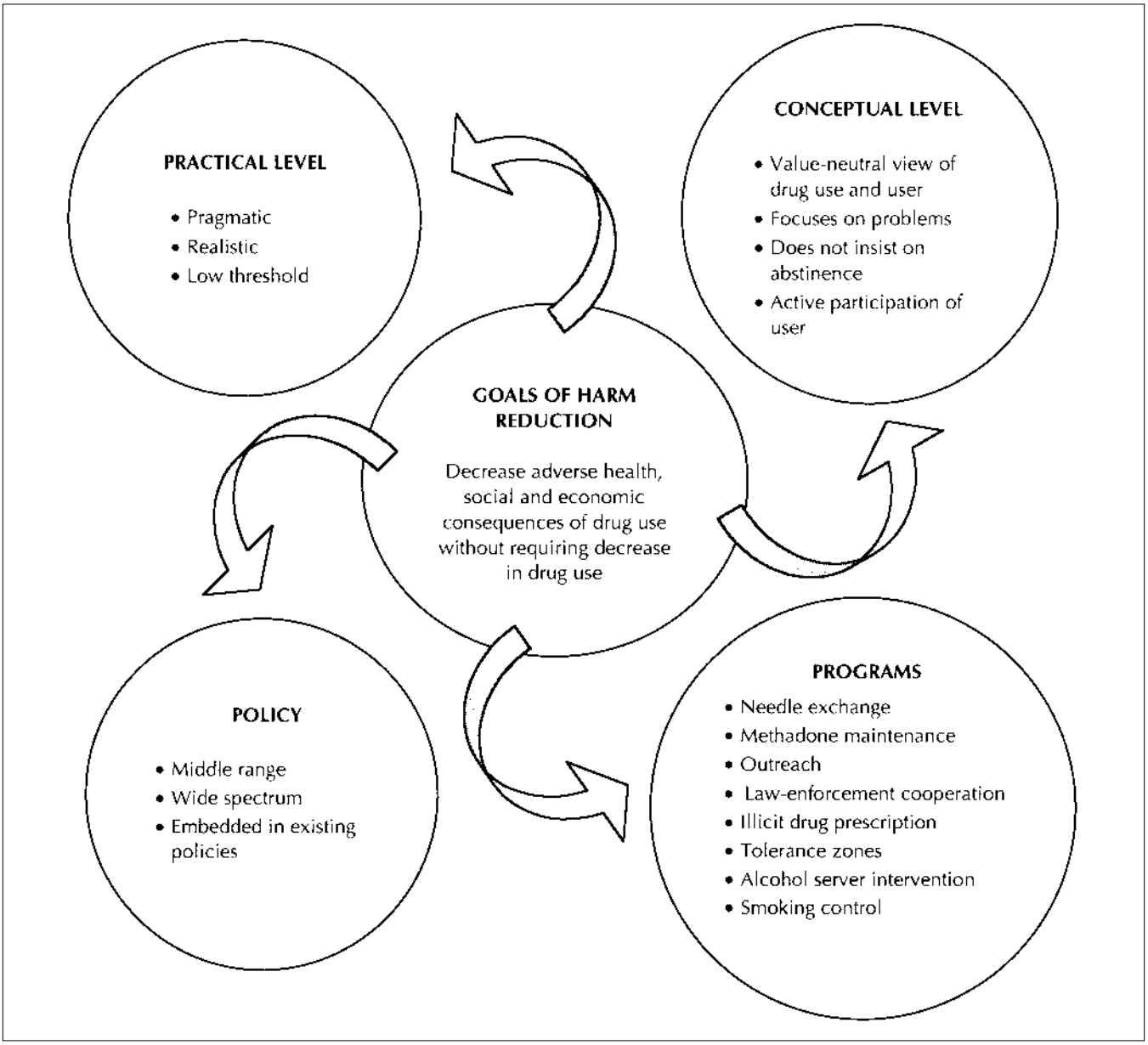

Fig. 1: Harm reduction model.

criminal justice system, infringement of the civil rights of citizens, indirect sustenance of a black market, and its inability to curb the availability and consumption of illicit drugs.[23–25]

The drawbacks of the prohibitionist model provide a springboard for proponents of legalization to advocate their belief that the legalization of all of the so-called illicit drugs could wipe out the black market, enable regulation of the supply of psychoactive substances and make available more resources for treatment and prevention work.[26] This extreme libertarian perspective is too drastic and untested to gain the confidence and acceptance of both the public and policy-makers.[23] Is there an approach that favours neither prohibition nor legalization?

Approaches to addiction
- Mechanistic: Emphasizes, or overemphasizes, pharmacological effects of drug
- Voluntaristic: Recognizes active role of rational user in drug use

Harm reduction

The late 1980s witnessed the emergence of the harm reduction approach (Fig. 1), which represents a shift from the legal sanction debate to public health principles. The nature of this approach has been widely explored, and by now some international consensus on its basic characteristics has been reached.[23,27–32] At the conceptual level harm reduction maintains a value-neutral and humanistic view of drug use and the user, focuses on problems rather than on use per se, neither insists on nor objects to abstinence and acknowledges the active role of the user in harm reduction programs. At the practical level the aim of harm reduction is to reduce the more immediate harmful consequences of drug use through pragmatic, realistic and low-threshold programs. At the policy level harm reduction generates a patchwork quilt of middle-range policy measures that match a wide spectrum of patterns of drug use and problems and can sometimes be accommodated by the existing larger drug policy framework. Examples of the more widely known harm reduction strategies are needle exchange programs, methadone maintenance programs, outreach programs for high-risk populations, law-enforcement cooperation, prescription of heroin and other drugs, tolerance zones where users can inject drugs in a hygienic environment, alcohol programs such as server intervention and tobacco programs ranging from control of smoking in public places to the use of nicotine gum and patches.[33] The importance of the involvement of medical practitioners in many of these harm reduction programs is explicit and cannot be overestimated.[34]

Erickson[30] observed 3 phases of the development of harm reduction. The first phase stemmed from a growing concern in the 1960s about the health risks associated with tobacco and alcohol use in the population. The second phase began in 1990 with a sharp focus on AIDS prevention among injection drug users. We have now reached the third phase, in which an integrated public health perspective is being developed for all licit and illicit drugs. In this new phase more and more new topics pertaining to the harm reduction model are being explored. These topics include scrutinizing the concepts related to harm reduction (e.g., prevalence reduction, quantity reduction, micro harm reduction and macro [total] harm reduction),[35] targeting adolescents through proper drug education and understanding of their perception of the risks of drug use,[4,36] establishing a complementary relation between harm reduction programs and abstinence-oriented treatment,[37] generating social capital at the community level as an important component of the macro harm reduction programs,[38] applying harm reduction strategies to ethnic communities[39,40] and considering the political economy of the harm reduction movement itself.[41] There is also an urgent need for rigorous evaluations of the cost-effectiveness of harm reduction programs to be conducted.[42]

The harm reduction model has evolved from a vague theoretical and practical framework a decade ago into a more mature and coherent paradigm today. During its evolution it has been understood by some misinformed members of the public to be a Trojan horse for legalization, criticized for sending the wrong message to drug abusers and the public and disparaged as promoting a defeatist position. However, as more and more people have recognized the nature and benefits of harm reduction, this more positive perspective has picked up momentum in the last 2 decades. The emergence of the harm reduction model by no means signifies the demise of the prohibitionist and legalizationist approaches. The debate over prohibition, legalization and harm reduction will, and ought to, persist, so that existing drug strategies will continue to be frequently reviewed and improved. Harm reduction should be welcomed as an important player in the drug field in the 21st century.

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