Harm reduction has been the single most influential idea impacting on the drugs field over the last 30 years. Recently, however, the ideas, policies and practices of harm reduction have been subjected to sustained criticism. In addition, harm reduction has fallen from political grace within the UK where drug policy has come to focus first and foremost on ensuring that drug treatment services are focused on enabling drug users to become drug free and the term harm reduction is not even mentioned within the current UK drug strategy. This article focuses on these challenges to harm reduction and considers the likely impact of a focus on abstinence within drug policy in the UK. It is suggested that harm reduction is at an important crossroads in its development where its supporters may need to either identify a way of working within a more abstinence focused drug treatment policy paradigm or risk increasing marginalization by advocating for drug law reform and drugs legalization. An alternative may be for harm reduction to focus more on influencing drug treatment services and policy development within developing countries.

INTRODUCTION

Within the drugs field, there have been few debates that have generated more controversy in recent years than that to do with the polarity between abstinence and harm reduction. Whilst legalization and drugs decriminalization remain the favoured topics of media coverage of the drugs policy debate, amongst drug misuse treatment providers, academics and drugs policy watchers, it is the relationship between abstinence and harm reduction that has generated most of the interest and debate within the world of drugs policy (McKeganey, 2010).

The notion of reducing drug-related harm has undoubtedly been the single most influential idea impacting on the drugs field for the last 30 years. Within the last few years, however, the widespread consensus around the benefits of harm reduction have become frayed at the edges under critical scrutiny of both the philosophy underpinning harm reduction and its actual achievements. Political support for harm reduction, at least within the UK, has diminished considerably such that the current national drug strategy does not even mention the term harm reduction. As I argue in this article, harm reduction now finds itself at a crossroads where its proponents will need to make a choice between finding a way of aligning their ideas, policies and practices with the new found emphasis on abstinence and recovery or risk further marginalization from the mainstream of UK drug policy by focusing first and foremost on advocating for drug policy reform. In a sense, harm reduction needs to make a choice as to whether it is principally a health-focused movement or a political movement. That choice will be far from easy to make not least because for many years harm reduction has retained a deep political agenda favouring drugs decriminalization and legalization.
goals focusing first on reducing drug users HIV-related risk behaviour and then seeking to reduce individual’s use of prescribed drugs and non-prescribed drugs:

1. reducing the shared use of injecting equipment;
2. reducing the incidence of drug injecting;
3. reducing the use of street drugs;
4. reducing the use of prescribed drugs and
5. increasing abstinence from all drug use.

Despite the fact that the ACMD originally envisaged harm reduction as combining a focus on both reducing drug users risk behaviour and reducing individuals drug use, the latter goal has been increasingly marginalized by harm reductionists in the years following the ACMD report. International Harm Reduction Association (IHRA, 2009) offered a definition of harm reduction that all but excluded the notion of reducing individual’s drug use as a core element of the approach:

Harm reduction refers to policies programmes and practices that aim primarily to reduce the adverse health social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption.

In the wake of the AIDS and Drugs Misuse Report, the priority of many of those working in the world of drug treatment shifted virtually overnight from a focus on treating individuals for their drug dependency to adopting a public health, population focused, approach aimed at reducing drug users HIV-related risk behaviour. The shift in focus which AIDS and HIV called forth saw the rapid and widespread development in the UK and elsewhere of such services as needle and syringe exchange and methadone maintenance. Along with transforming the world of drug treatment fears over the spread of HIV also had a dramatic impact on the world of drug prevention. Stimson (1990) identified the change in drug prevention activities that HIV called forth:

A key issue in shaping drug policies is the choice that has been posed between two targets, between the prevention of HIV transmission and the prevention of drug abuse. Preventing the physical disease of AIDS has now been given priority over concern with drug problems. In this paradigm prevention takes on a new meaning-the key prevention task is not the prevention of drug use, but the prevention of HIV infection and transmission. (pp. 333–334)

As concerns over the spread of HIV receded in the UK and in other developed countries, harm reductionists broadened the definition of the harms they saw themselves as focusing upon and in some instances took up a political agenda advocating for drug law reform and drug user rights. Stimson (2007), one of the most prominent academics promoting harm reduction, and who went on to become executive director of the IHRA, set out the two core elements of the harm reduction approach as it evolved beyond the initial conceptualization of the approach by the ACMD:

Harm reduction has had two main pillars. First, it has been driven by pragmatic public health approaches emphasising the need for identifying specific harms, the need for interventions to be evidenced based and targeted at the need to adopt realistic goals rather than pursue unattainable aspirational goals such as a drug free society. Many people involved in harm reduction have argued that it takes a morally neutral view on drug use, a position which is held in distinction to drug policies based in moral stands against drug use and drug users per se...The second pillar for harm reduction has been based in human rights especially the rights of drug users to life and security to health protection against harms form the community and state. (p. 68)

The focus on drug user rights has led some harm reductionists to critically assess the impact drug enforcement initiatives perceiving some of these as representing a public health menace in increasing rather than reducing the adversities faced by dependent drug users (Fitzgerald, 2005; Maher & Dixon, 1999). Drug enforcement policy itself however has come to be heavily influenced by the ideas of harm reduction. As recently as 2009, for example, the UK Home Officer identified harm reduction as being a more appropriate measure for assessing the effectiveness of drug enforcement agencies than the traditional measures of assessing the quantity of drugs seized and the number of arrests made:

Harm reduction rather than quantities of drugs seized or individuals convicted is a more useful way of prioritising activities to improve the lives of citizen in the UK. (Home Office, 2009, p. 24)

Alongside the focus on promoting drug user rights some sections of the harm reduction movement have been more strident in their calls for drug policy reform:

Over the last decade harm reduction has become much more than a public health approach. To an extent harm reduction has become an essential response to harm generating drug prohibition policies. (Moskaliewicz et al., 2007, p. 505)

I want to suggest that harm reduction is a movement within drug prohibition that shifts drug polices from the criminalized and punitive end to the more decriminalized and openly regulated end of the drug policy continuum. Harm reduction is the name of the movement within drug prohibition that in effect (though not always in intent) moves drug policies away from punishment, coercion, and repression, and toward tolerance, regulation and public health. (Levine, 2001)

As harm reduction has increasingly taken up the cause of drug law reform some harm reductionists have questioned whether the movement remains principally focused on matters of public health or whether the focus on drug user rights and drug law reform has now superseded the public health focus and become the main driving concerns of the approach. Hunt (2004), one of the leaders of the UK harm reduction movement, posed the question of whether harm reduction was principally driven by a public health or a drug user rights agenda. This is an important question not least
because it is entirely conceivable that an approach focused on public health protection could impact negatively on the rights of individual drug users – including curbing the right of the individual to use illegal drugs.

Some harm reduction supporters have criticized the attempt to clarify the central focus of the harm reduction approach and have argued instead for the functional importance of maintaining some level of ambiguity in what harm reduction is really aiming to achieve:

The harm reduction movement has succeeded where other attempts have failed partly because it blended human rights and public health, not because it chose one as superordinate. Just as ambiguity is functional for national states . . . ambiguity is functional for the harm reduction/drug law reform movement. Ambiguity helps create a large political tent under which our unwieldy coalition can fit, maximizing our appeal, increasing membership and allowing for local autonomy so that unique local conditions can be addressed . . . The public health principles that under gird harm reduction practices have afforded much needed political legitimacy to controversial policies. This legitimacy is a precious resource, some of which might be jeopardized if the movement were to give up primacy to the rights to use whatever drug one desires and to make legalization its principle policy objective (Reinarman, 2004, p. 240).

Other harm reduction supporters have been more trenchant in arguing for a much clearer political agenda for harm reduction favouring an explicit commitment to the goals of drug law reform and drugs legalization:

The question is not whether human rights or public health comes first. Rather, it is whether we collude with a policy that invariably degrades and sometimes destroys our clients and the communities in which they live or whether we speak out against it, both as individuals and organisationally . . . More important is the question of how organisations can more effectively challenge the status quo terminate prohibition and replace it with a system that is effective, just, and humane (Kushlick & Rolles, 2004, p. 245).

It is interesting to note in this regard that Danny Kushlick, one of the authors of the quote above, is both a longstanding supporter of the harm reduction movement, including being a council member of the IHRA, and the founder of Transform Drugs Policy Foundation – the main UK-based charity lobbying for drugs legalization. In this regard, it is easy to see how the twin goals of public health protection and drug law reform have always been at the heart of the harm reduction approach even if the relationship between these two has not always been a matter of open, and in some cases critical, debate.

Irrespective of whether the harm reduction is principally about public health protection or the promotion of drug user rights, it is easy to see how the latter goal has shifted harm reduction a long way from how the approach was originally set out by the ACMD. Plainly, an approach that has gone on to stress the rights of the drug user, including the right of individuals to use whatever drugs they choose, was unlikely to remain committed to the twin goals of reducing drug users risk behaviour and reducing overall levels of drug use. In the next section, though I look at the core assumptions underlying the harm reduction approach.

### THE CORE ASSUMPTIONS UNDERLYING HARM REDUCTION

Underlying the harm reduction approach are three core assumptions each of which can be subjected to critical consideration. Those assumptions are:

1. AIDS and HIV do indeed pose a greater threat to individual and public health than drugs misuse;
2. it is possible to reduce drug users risk behaviour without needing to reduce the overall prevalence of problem drug use;
3. there is very little prospect of recovery from dependent drug use;
4. and as a result, the best that services can do, in the face of the inevitability of individuals continued drug use, is to enable them to use those drugs with lower levels of associated harm.

Over the last 20 years, when the policies and practices of harm reduction have been enormously influential in the UK and elsewhere, each of these assumptions has been shown to be misguided and in some cases plainly wrong. First, has HIV proven to be a greater threat to public health than drugs misuse? In Table I, the data on new cases of HIV infection amongst injectors within the UK are summarized.

In contrast to the annual recording of new cases of HIV infection within the UK, there has been only intermittent assessments of the prevalence of problematic drug misuse within the UK. Table II summarizes the results of the drug user prevalence research undertaken within the UK since 2000.

On the basis of Tables I and II, there is simply no comparison between the growth of HIV infection amongst injecting drug users within the UK and the

---

**Table 1. New cases of HIV infection amongst injecting drug users in the UK.**

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland</td>
<td>17</td>
<td>18</td>
<td>13</td>
<td>13</td>
<td>12</td>
<td>22</td>
<td>18</td>
<td>7</td>
<td>15</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Rest of UK</td>
<td>48</td>
<td>69</td>
<td>45</td>
<td>85</td>
<td>72</td>
<td>98</td>
<td>84</td>
<td>92</td>
<td>108</td>
<td>87</td>
<td>80</td>
</tr>
</tbody>
</table>
growth in problematic drug use. Whilst there was little expectation at the growth of the drugs problem 1988, when the ACMD asserted that HIV represented a greater threat to individual and public health than drugs misuse, in fact from 2000 onwards the scale of the drugs problem in the UK has massively outstripped the problem of drug use related AIDS and HIV.

Table III summarizes the information on the number of drug and HIV-related deaths in the UK and is illustrative of the different impact on mortality that drug use and HIV have had.

In Table III, the figures relating to the number of UK HIV-related deaths include all deaths irrespective of the risk category involved. Injecting drug abuse, however, constitutes a risk factor in only around 2.5% of those who are identified as being HIV positive within the UK. On that basis, there can be little doubt that problematic drugs misuse within the UK is associated with substantially more deaths than those related HIV.

The second assumption underpinning the harm reduction approach is that it is possible to reduce drug users risk behaviour without reducing the overall prevalence of problem drug use. However, the data from successive surveys of drug users within the UK have shown the persistence of high levels of HIV-related risk behaviour despite the enormous investment in harm reduction policies and practices that has taken place over the last 20 years.

Table IV shows powerfully that even in the face of substantial investment in harm reduction services, including services focused on reducing the sharing of non-sterile injecting equipment amongst injecting drug users, nevertheless the proportion of drug injectors reporting recent sharing has changed only modestly over the 10-year period 2000–2010. In the case of injectors aged 24 and under 30% of those questioned reported having passed on injecting equipment in the last month in 2010 compared to 31% in 2000. Similarly, 40% of injectors questioned reported having shared needles in the last month compared to 60% in 2000. Whilst a 20% reduction in the level of sharing over a 10-year period might be thought to be impressive; in fact, the key question here is whether that level of reduction is sufficient to reduce the overall spread of blood borne infections amongst injecting drug users. The data in relation to the level of hepatitis infection amongst injecting drug users show that the recorded reductions in drug injectors risk behaviour is simply not sufficient to reduce the overall spread of blood borne infections.

On the basis of Table V, from the UK Health Protection Agency (2011), the proportion of injecting drug users within England Wales and Northern Ireland who are Hepatitis C positive has increased from an estimated 38% in 2000 to 47% in 2010, whilst the proportion of those who are Hepatitis C positive and who have started injecting within the last 3 years has almost doubled from 12% in 2000 to 23% in 2010. These data powerfully show that the spread of blood

Table II. Prevalence of problem drug use in Scotland and England.

<table>
<thead>
<tr>
<th>Time period</th>
<th>2000</th>
<th>2003</th>
<th>2006</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland</td>
<td>55,800</td>
<td>51,582</td>
<td>55,328</td>
<td>59,600</td>
</tr>
<tr>
<td>England</td>
<td>327,466</td>
<td>332,090</td>
<td>328,767</td>
<td>321,229</td>
</tr>
</tbody>
</table>

Table III. Drug- and HIV-related deaths in Scotland and England.

<table>
<thead>
<tr>
<th>Place</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug deaths in Scotland</td>
<td>356</td>
<td>36</td>
<td>421</td>
<td>455</td>
<td>574</td>
<td>545</td>
<td>485</td>
</tr>
<tr>
<td>Drug-related deaths in England</td>
<td>1497</td>
<td>1608</td>
<td>1560</td>
<td>1727</td>
<td>1939</td>
<td>1876</td>
<td>1784</td>
</tr>
<tr>
<td>UK deaths related to HIV/AIDS</td>
<td>497</td>
<td>603</td>
<td>576</td>
<td>631</td>
<td>617</td>
<td>599</td>
<td>682</td>
</tr>
</tbody>
</table>

Notes: \(^a\)Figures from General Register Office for Scotland (2011), \(^b\)Figures from Office for National Statistics and \(^c\)Figures from Health Protection Agency (2011).

Table IV. Needle and syringe sharing amongst current injectors in England Wales and Northern Ireland.

<table>
<thead>
<tr>
<th>Risk behaviour</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of passing on injecting equipment last month</td>
<td>31</td>
<td>33</td>
<td>34</td>
<td>29</td>
<td>28</td>
<td>23</td>
<td>19</td>
<td>19</td>
<td>19</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Percentage of injectors aged 24 or below</td>
<td>31</td>
<td>36</td>
<td>44</td>
<td>37</td>
<td>36</td>
<td>29</td>
<td>26</td>
<td>22</td>
<td>27</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Percentage of sharing injecting equipment last month</td>
<td>60</td>
<td>59</td>
<td>60</td>
<td>55</td>
<td>55</td>
<td>53</td>
<td>48</td>
<td>47</td>
<td>41</td>
<td>37</td>
<td>40</td>
</tr>
</tbody>
</table>

borne infections (and the behaviours associated with that spread) remain very high even in the face of the widespread development of harm reduction initiatives aimed at reducing drug injectors needle and syringe sharing behaviour.

The third core assumption underlying the harm reduction approach has to do with the belief that the prospects of recovery from dependent drug use are very low and that as a result it is more important to focus attention on reducing the harms associated with individuals continued drug use rather than seek to enable individuals to cease or reduce their drug use. An illustration of how harm reduction influenced clinicians regard the issue of recovery from dependent drug use can be seen in the comment below from one of the leading harm reduction influenced clinicians within the USA commenting on the responsibility of drug treatment professionals in working with drug users who are aspiring to become drug free:

Addicts who embrace an ultimate goal of enduring abstinence should be assisted in every way possible, but they must be advised with brutal frankness of the low prospect of success and the grim, potentially fatal, consequences of failure. (Newman, 2005, p. 266)

If it is accepted that dependent drug users are unlikely ever to recover, and further that their failed attempts at recovery place them at very high risk of dying, it is very easy to see why harm reduction influenced clinicians would be that enthusiastic in encouraging individuals to reduce or cease their drug use. But should we be so pessimistic about the prospects of abstinence and recovery from dependent drug use in the first place? Recent research from the US reporting on the recovery experience of physicians with a serious drug or alcohol problem has shown that the prospects of successful recovery might be a good deal higher than has previously been thought:

In total, 647 physicians (80.7% of the original sample) completed their treatment. On the basis of urine testing 126 (19%) of these physicians were identifies as having relapsed in their drug or alcohol use over the five year period of the study. By contrast 531 (81% of those completing their treatment) remained drug or alcohol free over the study period. (McLellan, Skipper, Campbell, & Du-Pont, 2008)

Within this study, the majority of the physicians were involved in abstinence-oriented drug or alcohol treatment programmes. The fact that such a high proportion of the drug and alcohol addicted clinicians could remain drug free might be regarded as of little relevance given that the majority of clients of public funded drug and alcohol treatment services do not have the same level of financial, emotional, practical resources as the clinicians within the McLellan study.

Within the Australian Treatment Outcome Study, which looked at the outcomes of treatment for a sample of 429 heroin users, 40% had been abstinent for the preceding 12 months at the 3-year follow-up point. Similarly, a recent analysis of the outcomes of drug treatment services within England found that 37% of heroin dependent clients and 52% of crack cocaine dependent clients were abstinent from either drug in the 28 days before their review (Marsden et al., 2009). These studies underline the finding that abstinence from dependent drug use can be an achievable goal for a very substantial proportion of the clients of drug and alcohol services.

In the light of the levels of abstinence in these studies, it would be entirely misplaced to assume that recovery from dependent drug use is such a rare phenomenon that it is more appropriate for drug treatment services to focus on reducing the harm associated with individuals’ continued drug use than to focus on assisting individual’s attempts at becoming drug free. However, there is a further area of concern around harm reduction oriented drug treatment which consists in the worry that aspects of the approach may lengthen the period over which individuals remain drug dependent and may also be associated with a growing number of deaths amongst those receiving harm reduction oriented drug treatment.

The most widespread harm reduction treatment for dependent drug use within the UK, and in many other countries, is the prescription of methadone on what is described as a maintenance basis. The attraction of methadone for harm reduction influenced clinicians is easy to see. Research in Edinburgh for example, has shown that drug users prescribed methadone are less likely than their counterparts to experience a fatal drug overdose:

For each additional year of opiate substitution treatment the hazard of death before long-term cessation fell 13%...after adjustment for HIV, sex, calendar period, age at first injection, and history of prison and overdose. (Kimber et al., 2010)

However the positive findings on the benefits of methadone identified in this study contrast to an extent with government statistics that are showing an

<table>
<thead>
<tr>
<th>Table V. Prevalence of Hepatitis C amongst current injectors England Wales and Northern Ireland.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
</tr>
<tr>
<td>---------------------------------</td>
</tr>
<tr>
<td>Prevalence of Hepatitis C amongst current injectors</td>
</tr>
<tr>
<td>Prevalence of Hepatitis C amongst injectors with less than 3 years injecting experience</td>
</tr>
</tbody>
</table>
increasing proportion of addict deaths in the UK being associated in some way with methadone (Table VI).

This table based upon information from the Registrar General shows the increasing percentage of drug-related deaths associated with methadone in Scotland over the period 2004–2010. These data do not show that methadone caused the addict’s death – rather the data show the proportion of deaths where on autopsy methadone was found to be implicated (most often in conjunction with other drugs) in the individual’s death.

As well as being associated with an increasing proportion of addict deaths, methadone has also been shown to lengthen rather than shorten the period over which individuals remain drug dependent:

Opiate substitution treatment was associated with an increased duration of injecting…for each year of treatment, before adjustment, duration was increased by 11%…For patients who did not start opiate substitution treatment, the median duration of injecting was five years (with nearly 30% ceasing within a year) compared with 20 years for those with more than five years of exposure to treatment. (Kimber et al., 2010)

The research from Kimber et al., whilst identifying a number of the positive outcomes associated with methadone treatment, found that those drug users who had been prescribed methadone remained drug dependent for substantially longer than their counterparts who were not prescribed the drug. Here then, one of the central planks of harm reduction oriented drug treatment is shown to have the capacity to lengthen rather than shorten the period over which individuals remain drug dependent.

**HARM REDUCTION: THE FALL FROM POLITICAL FAVOUR AND THE RISE OF DRUG USER ABSTINENCE**

Whilst harm reduction has been the single most influential idea influencing drug dependency treatment within the UK over at least the last 30 years, the approach has undergone a recent and dramatic fall from political favour in the last few years. The Scottish Government (2008) announced a new drug strategy which identified abstinence and recovery rather than harm reduction as the key goals of treatment:

In the government’s view recovery should be made the explicit aim of services for problem drug users in Scotland. What do we mean by recovery? We mean a process through which an individual is enabled to move on from their problem drug use, towards a drug free life as an active and contributing member of society. (p. 23)

The focus on abstinence highlighted by the Scottish Government in its ‘Road to Recovery’ drug strategy has been further underlined by the UK government in its latest drug strategy titled ‘Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life’. Within this strategy, it is asserted by government ministers that:

A fundamental difference between this strategy and those that have gone before is that instead of focusing primarily on reducing the harms caused by drug misuse, our approach will be to go much further and offer every support for people to choose recovery as an achievable way out of dependency. (Home Office, 2010, p. 2)

The term harm reduction that was so central to politician’s thinking and so central a part of previous drug strategies in the UK is not even mentioned in the current national drug strategy. Within England and Scotland, the new focus driving policy and provision is all about abstinence and recovery rather than the reduction of drug-related harm.

**THE FUTURE FOR HARM REDUCTION**

In view of the fall from political grace that harm reduction has experienced it is interesting to consider what the future might hold for the approach that at one time held centre stage in UK drug policy and practice. Unquestionably, the focus on abstinence and recovery within the current drug strategies in the UK pose a real challenge to harm reduction. In relation to methadone maintenance, a central plank of harm reduction influenced drug treatment, for example the signs are that it will no longer be judged as acceptable to allow individuals to remain on methadone for many years. The UK National Treatment Agency (2010) has given a clear indication of the way in which the focus on recovery is likely to have an impact on the acceptability of allowing individuals to remain on methadone for many years:

No-one should be parked indefinitely on methadone or similar opiate substitutes without the opportunity to get off drugs. New clinical guidance has introduced strict time-limits to end the practice of open-ended substitute prescribing in prisons. this principle will be extended into community settings. New clinical protocols will focus practitioners and clients on abstinence as the desired outcome of treatment, and
time-limits on prescribing will prevent unplanned drift into long-term maintenance. sound evidence-based clinical judgment endorsed by clinical governance will be able to identify cases where the approach would not be appropriate, but the intent is to see a fundamental shift in the balance of treatment for opiate addiction, away from long-term maintenance towards abstinence and long-term recovery.

The focus that is now being given to recovery within drug treatment policy within the UK is likely to have an increasing impact on drug treatment services as staff are encouraged to nudge their clients down the road to recovery. That commitment is likely to give rise to another question namely, what to do about those drug users who are in contact with drug services, and who may have reduced the level of their drug use and risk behaviour as a result of that contact, but who do not want to become drug free? Clearly, it would be inappropriate to simply discharge individuals from treatment on the basis that they do not share the current preoccupation with recovery. Equally, however, it is unlikely to be possible to realize the political goals of fostering a change in drug treatment services unless there is a shift in the core work of those services.

In drug treatment policy terms, the question here has to do whether harm reduction services can find a way of working with more recovery, abstinence oriented and drug treatment services. In the case of those drug users who have reduced their drug use and risk behaviour, there is a need to ensure that services, including harm reduction services, are able to work with those individuals in embedding the positive improvements they have made in their drug use and avoiding the situation in which individuals slip back into a previous pattern of chaotic drug use as a result of services switching their attention from harm reduction to drug user abstinence. However to the extent that harm reductionist criticize the development of a recovery agenda within the world of drug treatment, favouring instead the goals of drug law reform and drug user rights advocacy, the possibility remains of harm reduction becoming even more marginalized from the mainstream of UK drug treatment policy.

There is though an alternative option for harm reduction which is to focus increasingly on influencing drug treatment systems within developing countries where the costs of developing a fully fledged recovery-oriented treatment system may be judged to be too great and where an approach aimed at reducing the risks associated with individuals continued drug use may be seen as more pressing and less costly. There is certainly a logic in that argument on the basis that a number of the developing countries are experiencing an epidemic of HIV that is every bit as alarming as the epidemic that was once feared would overtake drug users within the UK and which led to the initial development of the harm reduction approach itself (HM Government, 2009). However, there may be a danger too of a twin track drug treatment system within which the richer developed countries pursue a recovery model in their drug treatment systems and the developing world instead witnesses the proliferation of an approach that whilst reducing the harms associated with individual’s continued drug use does not assist them in reducing the overall scale of the drugs problem within their society. In due course, even the developing nations where harm reduction ideas and practices are currently being supported, including by the IHRA, may come to realize that their long-term health is more probably ensured by an approach that favours reducing the overall scale of the drug problem within their midst than accepting the inevitability of drug use and seeking solely to reduce the harms associated with that continued use.

ACKNOWLEDGEMENTS

This article was prepared following a debate that took place in Glasgow and Edinburgh between myself and Professor Stanton Peele on the challenge of abstinence and harm reduction. I am grateful to Christopher Russell for organizing the debate and to Professor Betsy Thom for agreeing to focus a volume of the journal on the topic of these debates. I would also like to thank Stanton Peele for his contribution to the debates and to Dr Roy Robertson and Mike Ashton for chairing the discussions.

Declaration of interest: The author reports no conflicts of interest. The author alone is responsible for the content and writing of the article.

REFERENCES


