Opinion

Bioethics Research Notes 11(4) December 1999

Performance Indicators of Harm Minimisation:Drug Policy Outcomes in Sweden, Australia, and the United States

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"Harm minimisation" policy in Australia, in deference to the formal illegality of [the] psychopathic drugs, has an ostensible meaning, but also a not-so-hidden agenda. Harm minimisation, if it is accepted that drugs are harmful, must mean following policies which will achieve the lowest possible level of drug use; and also, in that it is close to impossible, at least in the short term, to eradicate drug use entirely, it means establishing policies which will ensure the lowest possible harm, as a result of drugs, to those who continue to use them, and also to non-drug-users who may be adversely affected by the behaviour of those who do.

Such a policy, if intelligently implemented, requires acknowledgment that policies which are most effective in minimising usage may have a poor rating as regards minimising the harm caused by drugs in the persisting minority of drug users; and that policies which are most effective in minimising self-inflicted and social harm of persisting drug use may, contrariwise, raise population levels of drug usage. The weight to be given to the two aspects of the policy needs to be made explicit. On the whole, it would be sensible not to follow policies for the reduction of harm to and by drug users, if in the process the number of drug users will be raised, although if the harm avoided is substantial and the associated rise in drug usage insignificant, a case could be made for an overall beneficent outcome.

The inference of a hidden agenda in Australia's "harm minimisation" policy derives from the fact that the problem of this interaction has not been explicitly addressed, and that its key policies represent the second component only (reducing harms of usage) of a balanced harm minimisation policy. The rationale behind the harm minimisation policy we actually have is that the psychopathic drugs *need not* cause harm (can be purely recreational), and therefore should not be illegal, and hence harm minimisation policy should concern itself only with drug users who have slipped over the line into abuse. On this premise, only the second component of a balanced harm minimisation policy should, logically, be activated. The possibility that the chosen policies may result in greater prevalence of usage is, therefore, inconsequential. That they may, hence, result in higher overall levels of harm is ignored or denied.

Proponents of "harm minimisation" are opposed to a continuing presence of the primary component of a balanced policy, which is nevertheless maintained via illegality, policing and the justice system, and argue that these strictures are antagonistic to harm minimisation itself. Meanwhile, their favoured policies persistently undermine the

effectiveness of these primary strategies. This mutual antagonism need not occur. In Sweden the two components of a genuine harm minimisation policy work hand in hand.

Sweden and Australia

A comparison of drug policies in Sweden and Australia, and of drug usage and associated problems in the two countries, is highly suggestive of the comparative efficacy of the two approaches.

Sweden*:* Sweden has, since the resurgence of psychopathic drug usage in the 1960s, adopted drug policies at various points in the spectrum of harm minimisation, and changed them in response to unpredicted outcomes (just as Australia so singularly has not). The first initiative, in the sixties, was a trial of the liberal prescription of drugs to those who claimed to be addicted, complemented by access to health care. The project was abandoned after three years because of the escalating numbers of participants, who were also found to be supplying the drugs they received to friends and traffickers. Despite ready access to drugs, the crime rate increased among those on the programme.

From 1968, Swedish policy concentrated on law enforcement, treatment and education, with the goal a drug-free society, and there were increasingly severe penalties for infringement. However, in the 1970s it was again forcibly argued that it is counter-productive to target personal use. But by the mid-seventies, heroin had gained a footing for the first time, and the duty of society to intervene on behalf of the individual at risk again gained ethical precedence.

Coercive care of adult drug abusers was introduced in 1982, but treatment is more generally an optional alternative to imprisonment. The coercion provided by the law and the care provided by treatment are used cooperatively. Methadone-assisted rehabilitation of heroin addicts has been implemented, with a strict limit on numbers.

Drug use was criminalized in 1988, and a maximum penalty of six month's imprisonment for illicit drug use was introduced in 1993. Possession of small quantities of cannabis or amphetamines may result in only a fine, but possession of heroin or cocaine receives a strict term of imprisonment. Drug trafficking may be punished by 20 years imprisonment. Police target street trading so that known centres for obtaining drugs cannot develop.

Schools and municipal social services provide extensive education against drug use. Harm minimization, in the Australian sense, has been rejected, on the grounds that such policies as needle distribution would convey an ambiguous message about society's attitude to drug abuse. The response to the HIV threat was to increase programmes of rehabilitation.

Australia*: "*Harm minimisation", in its limited second component sense, has been the driving force in Australia's National Drug Strategy since the mid-eighties. Despite the

fact that these policies have produced nothing but escalation, not only of use, but of harm, there has been no move to reverse them.

As an educational policy, “harm minimization” is defined as teaching safe use of drugs - abstinence is not seriously addressed. Much of what has passed for education has since proved to be poorly substantiated. A generation of ex-students now believes that alcohol and cigarettes are more dangerous than cannabis, while in fact the worst health effects of all three develop after a few years of heavy use of cannabis, compared with a 20-40 years delay for alcohol and tobacco, respectively, and the immediate and long-term effects of cannabis on motivation and mental stability are far worse. The only side-effect of heroin was initially said to be constipation. The question of “safe” dosage has not been specifically addressed. Drug use is presented as normal. For example, material prepared for NSW schools encourages children to make their own choices from various levels of use of drugs - and this in a society in which such drugs are illegal. The choice not to use drugs is reluctantly admitted as a possibility, in a manner that suggests it is an eccentric choice.

Other features of Australia’s harm minimization policy are free methadone maintenance for heroin addicts and an extensive free needle exchange programme. Treatment and rehabilitation, important features of the second component of harm minimisation in Sweden, have had no place in Australian “harm minimisation” policy. Methadone clinics make no serious attempt at treatment. The number receiving methadone trebled between 1987 and 1998, rising from 5,000 to 15,000. Contrary to hypothesis, free methadone has not reduced opioid deaths. As was the case in Sweden, clients are often polydrug users and engage in trafficking.

Similarly, free needle distribution is not used as a window for rehabilitation. Under NSW policy (1994), although condoms are supplied in needle packs, and clients are encouraged to introduce friends to the service, staff must *not* provide information on drug treatment services unless requested.

The introduction of free needle distribution was justified on the grounds of preventing transmission of HIV among intravenous drug (ID) users. Incidence of HIV remains low, but the evidence that it is due to availability of free needles is unconvincing, as Hepatitis C (HCV), which is also blood-borne, has spread alarmingly among ID users and has a prevalence among them of 50-60%. Thus abundance of free needles has not prevented needle-sharing. As with free methadone, needle distribution has escalated since its inception, and deaths from injected drugs have escalated over the same period.

In Australia generally, the maximum penalty for possession of small amounts of cannabis is two years imprisonment. In South Australia and the Australian Capital Territory, however, possession of small amounts of cannabis has been decriminalized. Trafficking in illegal drugs may be punished with life imprisonment Through the late eighties and most of the nineties, there was a movement, in the allocation of funding, from law enforcement to “education”.

Where Sweden retreated from liberalising policies in response to their evident lack of success, “harm minimisation” proponents in Australia seek their extension and the addition of further policies which similarly dilute the position on illegality - namely, free heroin and injecting rooms.

***Outcomes**:* The following Table provides comparative statistics for Sweden and Australia which can be taken as indicators of the relative success of the two policy approaches, given the considerable similarity of the two countries in culture, general civility, and standard of living.

	Sweden	*Australia*
Lifetime prevalence of drug use in 16-29 year olds (Sweden) & 14-25 year olds (Australia)	9%	52%
Use in the previous year, as above	2%	33%
Estimated dependent heroin users per million population	500	5000-16000
Percentage of dependent users aged <20	1.5%	8.2%
Methadone patients per million population	50	940
Drug-related deaths per million population	23	46
Percentage of all deaths at age <25	1.5%	3.7%
Drug offences per million population (Sweden - arrests; Australia - convictions)	3100	1000
Average months in prison per drug offence	20	5
Property crimes per million population	51000	57000
Cumulative AIDS cases per million population	150	330

The above figures are drawn from the *United Nations World Drug Report 1997* (adjusted where necessary to a rate basis), and indicate that Australia’s policy of “harm minimisation” has induced widespread drug usage - 52% lifetime usage (i.e. used at least once) in Australia compared with 9% in Sweden among young people. The highest prevalence of lifetime usage in Sweden occurs in the 30-49 years age group. In Australia, rates of usage are minimal above age 40, while the greatest increase in use has occurred in the 14-24 years age group. This demonstrates the effectiveness of Australia’s drug education policies in encouraging drug use, particularly in the age group most exposed - school children.

Further data indicates that the change from the liberal to the prohibitive in Swedish policy has been effective in reducing the initiation of young users, whereas usage by young people in Australia has been rising over the same period. Only 1.5% of Swedish young people (aged < 20) are drug dependent, compared with 8.2% of Australians in the same age group.

The information conveyed in “harm minimization” education is clearly unable to counteract the effect of higher rates of usage - drug-related death rates are twice as

high in Australia as in Sweden - 46 *versus* 23 per million population. Moreover, the share of under 25 year olds in drug-related deaths in Sweden is very low - only 3.6%. The Australian figure in this category was not available, but the higher percentage of all deaths at age <25 (3.7% compared with 1.5% in Sweden) indicates a higher presence of trauma for Australian young people, of which drug-taking undoubtedly forms a part.

While the proportion of methadone patients to heroin addicts is similar in the two countries, one may conjecture that the use of methadone for *rehabilitation* in Sweden, rather than for maintenance as in Australia, contributes to the dramatically lower rate of heroin addiction there (less by a factor of at least 10).

Property crime rates are not higher in Sweden than in Australia, despite the more stringent enforcement of drug illegality.

Free needle distribution in Australia does not appear to have resulted in better control of the AIDS epidemic here, with our cumulative AIDS rate more than twice that of Sweden.

Thus it seems clear that Sweden's attention to b*oth* components of genuine harm minimisation, reducing usage to a minimum and following policies, in relation of the minority of continuing users, which do not reduce the effectiveness of the primary goal, has produced far better outcomes in minimising harm than has Australia's concentration on the second component to the detriment of the first.

The United States

It is often claimed by Australian lobbyists that the United States' concentration on the first component of harm minimisation, and rejection of the second, has shown itself entirely ineffectual. America's drug policy has been less unified and internally consistent than Sweden's, due to the capacity of the various States to introduce some of Australia's favoured "harm minimisation" policies on an independent basis, but equally this independence has allowed a greater presence of rehabilitation approaches in the US than we have had in Australia.

Policy distinguishes "casual" and "hard core" users, the latter being targeted for treatment services and law enforcement. At the Federal level, use of drugs is not an offence *per se*, but *possession* is punishable by law. A first offence for personal use attracts a maximum of one year's imprisonment, and repeated offences a three year maximum. Penalties for manufacture and trafficking can be life imprisonment or death (depending on State laws).

Drug use rose to greater heights in the US than in Australia in the course of the seventies, but fell considerably in the eighties, over a period when usage in Australia was rising. As reported in the *United Nations World Drug Report 1997*, compared with Australia's lifetime prevalence of drug use in 14-24 year olds of 52%, the US has a 57.5% usage in 19-28 year olds. Use in the previous year in 14-25 year olds in Australia was 33%, compared with 28% in 14-24 year olds in the US. The average age of current

illicit drug users rose steadily between 1979 and 1994, although maximum usage is still at less than age 21.

The estimate of dependent heroin users in the US, which has never had free methadone or needles on the scale we have in Australia, was 1,900 per million population, compared with Australia's 5,000-16,000. Cocaine has a level of usage in the US which it has never achieved in Australia. The estimate of heroin plus cocaine users was 10,500 per million population, and 49% of drug deaths in 1994 were caused by cocaine overdose. Both countries had drug death rates of 46 per million population.

These figures are far from convincing evidence that Australia's concentration on the second component of harm minimisation is more successful than America's perceived concentration on the first in law enforcement - in fact, rather the reverse, particularly given America's less favourable background levels in health and general social well-being, and higher starting point.

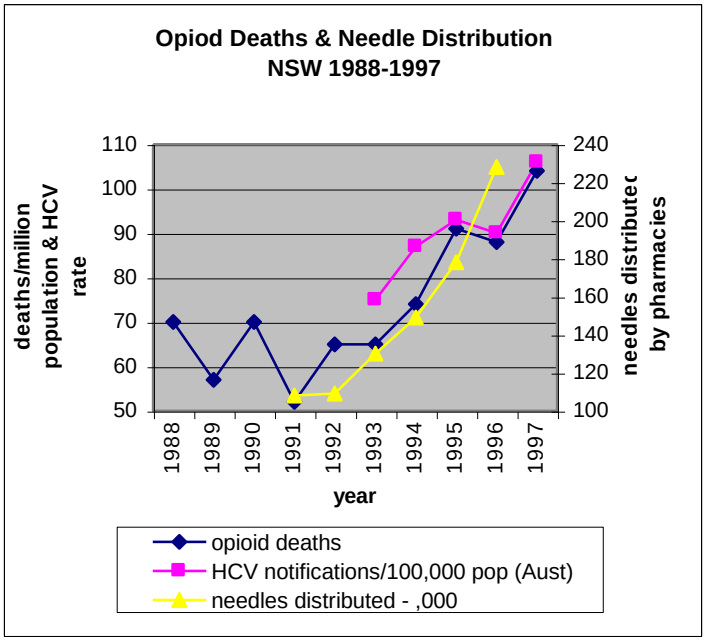
Cannabis*:* Lifetime prevalence of cannabis use among Year 12 students fell in the US from 60% in 1980 to 33% in 1992, but between 1992 and 1994 it rose slightly from 33% to 38%. In Australia, according to Household Surveys, it rose from 27% in 1988 to 39% in 1998.

The *UN Report* remarks that a change in usage generally follows a change in perceived harmfulness with a one year time lapse. The rise in cannabis use in 1994 in the US, reversing more than a decade's downward trend, followed a decline in the perceived risk of cannabis (as reported in surveys) in 1993. This provides highly suggestive evidence that the continuing rise in cannabis use across the late eighties and nineties in Australia has been due, at least in part, to educational efforts to establish its relative harmlessness, and equally the escalation in heroin deaths (see below) may result from the message, reinforced by needle distribution, that ID use is not in itself dangerous.

Needle distribution, heroin deaths, and HCV infection

Needle distribution to ID users in New South Wales was piloted in 1987 and began formal operation in 1988. By 1989, there were 40 public outlets in NSW and by 1994, 250, supplemented by 500 distributing pharmacies. Thus the programme was firmly established by the early nineties, and its growth has shown no sign of stabilizing. Two million needles were distributed in 1989, 3.5 million in 1994, and 5.5 million in 1996. Detailed documentation of needle distribution is not readily available, but the Pharmacy Guild of New South Wales reports an increase in distribution via pharmacies from 106,000 in 1991, to 226,000 in 1996, an increase which parallels that of total distribution.

The accompanying Graph plots needle distribution by pharmacies in NSW from 1991 to 1996 against NSW opioid overdose deaths from 1988 to 1997. It also shows Hepatitis C (HCV) notifications (incident and unspecified), primarily occurring in the ID-using population, for Australia from 1993 to 1997. (Tests for HCV became available in 1990 and infection rates are reported to have increased steadily between 1991 and 1993.



New South Wales and South Australian data are included for the first time in 1997).

It can be seen that, for both outcomes, increases in pathology have accompanied increases in needle distribution, and in particular have occurred about a year after substantial rises in needle distribution, matching the pattern described for the US of a decrease in perceived risk resulting in increased exposure. Thus it appears that rather than the promised safety of clean needles reducing the harm of ID use, the resultant increased usage increases its harm as well.

False predictions

In each instance of the instigation of a new phase of “harm minimisation” policy, its proponents have confidently predicted that harm to users and to the community will be reduced, and a certain face validity in their arguments has enabled them to carry their case. Yet each time they have been wrong.

It seems likely that the source of error lies in their misunderstanding and interpretation of the motivational elements in the interaction of their policies and the actual behaviour of both potential and current drug users. The antipathy to prohibition and the belief that to legalise drugs will improve matters appears to arise from a belief in a non-cooperative or anarchic streak in human nature which means that to forbid something is to make it more attractive; and that to permit it is to make it unappealing. This element in human nature no doubt exists, but other factors are at work too.

Firstly, there is that in drugs which makes them appealing, once experienced, whether they are forbidden or not, even when they offer only demoralisation and death. And

secondly, to forbid something has a semiotic impact, signalling danger, while to permit it signals safety. To rational man (not yet on drugs), the prohibition, if perceived to be founded in fact, will function more strongly than the tendency to non-cooperation. Only if, as "harm minimisation" and drug education have sought to portray, what is believed to be harmless is forbidden, will the former predominate. We do not fail to notify the public of a dangerous rip in the surf, or of live electric wires, nor decline to take steps to prevent the foolish nevertheless putting themselves at risk. Equally, it is important not to "cry wolf". The "harm minimisation" lobby have believed that prohibitionists are crying wolf as regards drugs, but it is now transparently clear that their belief is dangerously wrong.

Our current Prime Minister is resisting the Australian version of harm minimisation and attempting to implement the more balanced Swedish model. Unfortunately, Australia is in the position that the majority of positions of public influence in the drug policy field are held by proponents of "harm minimisation", who thereby have a substantial ability to block research or argument which is likely to undermine their position. The practice of directing Commonwealth research grants to specific areas, which began in the seventies, allowed those with a particular interest in a field with socio-political as well as scientific ramification (such as AIDS and drug use) to set up the first specialist research units, and thereafter, as the established experts, to prevent the development of contradictory expertise and alternative approaches.

Thus, although established with the best of intentions for a more balanced policy, the Commonwealth's *Australian National Council on Drugs* has only two non-"harm minimisation" committee members, who are powerless against a large majority committed to "harm minimisation". And the outcome of the NSW Government's recent *Drug Summit* was a foregone conclusion should any voting on policy occur, simply because of the much greater attendance of "experts" promoting "harm minimisation".

Perhaps, as a young colleague says, the most his generation can hope for is damage containment, while they wait for the ageing radical Baby Boomers, with their dysfunctional social theory and obsessions, to eventually get out of the way.

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