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Commentary

# Public health or human rights: what comes first?

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**Abstract**

Respect for human rights is a defining feature of harm reduction, which is commonly characterised as a public health-based movement. The importance it attaches to 'user-friendliness' and the view that drug users have a right to the same respect and dignity that other users of health and social care services receive is largely undisputed among harm reductionists. Within harm reduction there is also a developing discourse identifying drug use itself as a human right; nudging harm reduction towards being a rights based movement. This allows us to describe two philosophies of harm reduction: a 'weak rights' version, in which people are entitled to good treatment and a 'strong rights' version that additionally recognises a basic right to use drugs. Prioritising human rights or public health can lead to different concepts of harm reduction and different forms of 'right action'. Privileging health may even, in some circumstances, be consistent with prohibitionary policies if these reduce harm. By contrast, the strong rights version of harm reduction subordinates public health considerations to the right to use drugs and implies support for policies that may sometimes increase harm. In the UK, the publication of 'The Angel Declaration', which recognises a right to use drugs and proposes a skeletal regulatory framework for a post-prohibition era, adds to the impetus for harm reductionists to clarify whether they fully embrace a right to use drugs within their understanding of harm reduction. This paper elaborates these issues in the context of the constraints upon the development of an evidence-based approach to controlling drug use that arise from the UN Conventions of 1961, 1971 and 1988.


*Keywords:* Human rights; Public health; Drug use; Harm reduction

## Introduction

The debate concerning the place of 'human rights' within harm reduction has developed in recent years (Ezard, 2001; Hathaway, 2001; Miller, 2001). A fundamental human right to use drugs has been proposed as an adjunct to the Universal Declaration of Human Rights (van Ree, 1999). These developments occur alongside parallel demands that their right to use drugs should be recognised from among the growing number of people within the drug user movement who are also harm reductionists.

Within the UK, this debate has been further stimulated by the publication of *The Angel Declaration*, which results from a collaboration between a number of different drug reform activists and groups. It calls for an end to drug prohibition and recognises a right to use drugs, while promoting a system of regulated drug availability through licensed outlets alongside policies based on harm reduction. In effect, the Declaration generates a challenge to British harm reductionists to decide whether the right to use drugs is part of their definition of harm reduction: a debate that has resonance for harm reductionists elsewhere.

These debates have both theoretical and practical implications concerning what harm reduction *is*, what harm reductionists *do* in their practice, what sort of society—if any—harm reductionists are trying to generate and, concerning strategic questions of how best to get there.

Although harm reduction lacks a formal definition, different versions have been offered in the literature or are implied by more recent discussions about the right to use drugs. This paper contrasts two stylised versions of harm reduction: a 'weak rights' version prioritising health and a 'strong rights' version that fully recognises a right to use drugs. It is worth noting that these versions are exactly that—stylised. They are attempts to capture the essence of two possible, contrasting positions and are intended as an aid to analysis. In practice, many people may feel that their conception of harm reduction occupies some mid-ground between these two positions.

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The choice of the terms 'weak' and 'strong' reflect the position of these two versions along a continuum of sovereignty over the body, in line with Mill's original conception of liberty—the essence of which is captured in the following extract:

> The object of this Essay is to assert one very simple principle, as entitled to govern absolutely the dealings of society with the individual in the way of compulsion and control, whether the means used be physical force in the form of legal penalties, or the moral coercion of public opinion. That principle is, that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him, or visiting him with any evil in case he do otherwise. To justify that, the conduct from which it is desired to deter him, must be calculated to produce evil to some one else. The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.
>
> –(John Stuart Mill, On Liberty, 1869)

The strong rights version embodies these principles of sovereignty over the body and limits the means by which we may promote health to those approaches that are essentially persuasive. In accordance with Mill, compulsion is not permitted other than when, by exercising one's rights, they 'produce evil to someone else'. This strong rights version is therefore rights-based: rights over the body are prioritised.

In the weak rights version sovereignty over the body is potentially more constrained. Although some formulations of public health attach paramount importance to human rights, in the stylised version described here, optimising the health of the population is prioritised above all other considerations. Within this conception, if evidence suggested that health would be enhanced by limiting the population's dominion over their bodies, this constraint on liberty might be seen as an acceptable cost within a health-optimising project.

It is, of course, immediately important to acknowledge that definitions of public health are diverse and that some conceptions of public health are more rights-based, rejecting the more paternalistic approach considered here. For example, in a discussion of the 'new public health' Ashton and Seymour (1993, p. 108) refer to the links between empowerment, 'citizen control' and risk-taking behaviour in a way that is in sympathy with the strong rights model. Nevertheless, there is ambiguity within the public health literature about the degree of control that people may ultimately exercise over their bodies and this means that a public health approach seems potentially to accommodate both weak and strong rights versions.

## The public health perspective

Although, for practical purposes, there is a good deal of consensus about what harm reduction is amongst its adherents, it has no formal, agreed definition. The International Harm Reduction Association—the official organisation of the harm reduction movement—does not currently offer one. A number of definitions of harm reduction have nevertheless been proposed (e.g., Hamilton et al., 1998; Lenton & Single, 1998; Newcombe, 1992). Within the definitions offered, harm reduction is commonly described as being rooted in public health (e.g., Erickson, 1995, p. 283; Newcombe, 1992, p. 1; Stimson, 1992). The Faculty of Public Health Medicine of the Royal Colleges of Physicians of the United Kingdom (2002) offers a widely adopted definition of public health that emphasises disease, longevity and health:

> 'the science and art of preventing disease, prolonging life and promoting health through organised efforts of society'.

Whilst harm reduction's philosophical origins can be traced back at least as far as the Rolleston report (1926) its development into a coherent set of practices and ideas is more accurately associated with the identification of one particular disease—AIDS—in the 1980s and the response to the threat that this posed to injecting drug users and—through people who inject—to the general population. In this sense, harm reduction developed as a set of policies to prevent the disease AIDS; only subsequently, turning its attention to other infectious diseases, such as hepatitis B and C. Beyond infectious diseases, other health-related harms have also emerged as targets for harm reductionists, notably the annual toll of overdose deaths. Other forms of drug use with identifiable risks of harm, such as harms associated with ecstasy use or road traffic accidents that arise from drinking alcohol, have also been discussed as being within the ambit of harm reduction (e.g., see Fromberg, 1992; Newcombe, 1992).

However, the logic of the public health perspective within harm reduction can be applied beyond the limits of interventions, such as needle exchange, methadone treatment and public information campaigns to control infectious diseases. 'Drug dependence' is incorporated within the International Classification of Disease (World Health Organization, 1992). Therefore, policies that prevent drug dependence—as a form of harm—are logically within the scope of harm reduction, as this can be seen as another form of 'disease' that should be prevented within a health-optimising public health approach.

In recent years, one of the most prominent accounts of a public health-based policy to limit alcohol-related disease has been articulated by Edwards, Anderson, and Babor (1994). This is considered here as a reference point for a public health approach to illicit drugs. Alcohol problems are understood as being incident in a subset of all alcohol drinkers within the population. The considerable evidence showing that measures which reduce population levels of alcohol consumption result in a reduced burden of disease across the population underpin policy objectives of reducing population consumption. Edwards et al. provide a robust argument for using strategies, such as fiscal measures (taxation) to limit alcohol consumption, and thereby net harm arising from diseases, such as liver cirrhosis, alcohol-related cancers and alcohol dependence across the population, by increasing the price of alcohol. This approach, occurring within a regulated market for alcohol, appears consistent with Mill's requirement that, while remonstration might be used, compulsion may not; with fiscal measures as a form of 'remonstration though the pocket'. However, it is noteworthy that Edwards et al. discuss prohibition as a feasible policy option for small societies and Islamic states without any reference to people's right to use alcohol in these areas (pp. 130–131). Because it is unlikely to be endorsed by policy makers, the authors otherwise dismiss prohibition as a policy option. However, their account of prohibition's health benefits suggests that, were it a practical proposition to extend it, this policy might be supported. There appears to be no absolute rejection of prohibition as something that is inconsistent with a public health approach, nor any apparent acknowledgment of an ultimate right for adults to consume alcohol.

This approach seems consistent with that seminal publication within UK Drug Policy—the Advisory Council on the Misuse of Drugs (ACMD) Report on AIDS and Drug Misuse (1988)—which largely enabled the development of harm reduction services within the UK and published a hierarchy of objectives that embraces an objective of abstinence from all drugs: (1) Reduce the incidence of sharing injecting equipment; (2) reduce the incidence of injecting; (3) reduce the use of street drugs; (4) reduce the use of prescribed drugs; and (5) increase abstinence from all drug use.

In this way, the public health perspective, and in particular, the version espoused by the ACMD within the UK, implies that preventing drug use can be construed as a legitimate goal of harm reduction. Whilst some harm reductionists might not regard promoting abstinence as being within their role, the logic of the public health approach potentially incorporates this and means that, if they can be deployed effectively, strategies which prevent drug use—which in turn results in drug dependence for a fraction of drug users—should be employed.

However, because of their prohibited nature, illicit drugs are not amenable to the fiscal measures Edwards and his colleagues promote for alcohol. Despite the fact that the use of illicit drugs, such as cocaine and heroin, have measurable and negative price elasticity, i.e., when real price increases, use decreases (Saffer & Chaloupka, 1999), the price of illegal substances cannot be manipulated through taxation because the market for illicit drugs is, effectively, unregulated. The overall framework shaping efforts to reduce drug use is therefore through drug interdiction: the success of which may broadly be judged by the oft-quoted statistic from the UNDCP itself (1997, p. 124); that the global illicit drugs economy approaches 8% of all international trade.

On this basis, the logic of the pure, health-optimising public health model can be read to mean that, prohibitionary policies to reduce use—if they can be made to work—are justifiable as, if drug use can itself be prohibited then all other things being equal, less harm will result. Many harm reductionists would immediately argue that prohibition cannot be made to work and that it often intensifies the harms associated with drug use: an assessment that may well be correct. Nevertheless, the logic seems undeniable and, should effective policies for achieving drug prohibition be developed, then it would seem incumbent on harm reductionists operating strictly from priorities of health rather than rights to advocate and pursue them.

The idea of 'effective drug prohibition' may appear as something of a straw horse here so, at this point, it seems worth noting that technological changes arising from new understandings within genetics and transgenic procedures, by which genes from one organism are inserted into another, may yet yield powerful tools in the drug prohibitionist's tool box. Should effective interventions become available, for example, vaccines that nullify the psychoactive effects of drugs such as cocaine (Office of National Drug Control Policy, 2002), which might ultimately be used to vaccinate the general population, or developments involving strains of fungi that affect coca (*Fusarium oxysporum*) and opium (*Pleospora papaveraceae*) then, by inference, the health-optimising, weak rights harm reductionist may be impelled to support their use.

Of course, it is equally possible that advocating anti-prohibitionary policies in line with a right to use drugs could also be endorsed by the public health-prioritising harm reductionist. This would be the case if there were evidence that, on balance, prohibitionary policies generate more harm than they remove. However, in practice, evidence in this area cannot be produced as policies involving regulated forms of drug distribution are prohibited under the UN Conventions of 1961, 1971 and 1988 and therefore cannot be evaluated. In effect, the Conventions prohibit the production of knowledge and evidence regarding the impact of different policies involving different, regulated supply systems.

The preceding discussion reflects the pre-eminent reliance on an evidence-based approach for informing which policies harm reductionists endorse within the weak rights model. Decisions are determined by the overall affect on harm in a—supposedly—morally neutral context. Strang (1993, p. 3) captures this position admirably when he says:

> "The true champion of harm reduction is not necessarily anti-drugs; nor necessarily pro-drugs. He or she expresses support, opposition or indifference to a proposed legal or social response solely on the basis of the extent to which it increases or decreases the amount of harm consequent upon the drug use in question. A pre-determined position on drug use as intrinsically 'bad' or 'good' has no meaning in this context, where the response is determined solely by the extent of observed or anticipated harm which results from the drug use. Thus, the champion of harm reduction is neither for nor against civil rights for drug users. . . ".
>
> –(emphasis added)

More latterly, this claimed 'amoral' status with regard to the civil rights of drug users has been criticised. Despite its avowed neutrality, harm reduction has been accused of effectively endorsing the status quo of drug prohibition because this is the prevailing global policy (Hathaway, 2001). If evidence of an adequate standard to arbitrate on questions, such as the efficacy of different systems of drug control, is never likely to be generated, then claims to be evidence-based on these matters seem spurious. Holding an evidence-dependent position, if the evidence is unlikely ever to be produced, may give a misleading impression of openness to change.

It should be noted that aspects of this analysis are not new. Mugford (1993) was making similar points almost 10 years ago and highlighting other limitations of harm reduction theory such as our inability to value pleasure—that pivotal benefit of drug use—within an approach grounded in a utilitarian, cost-benefit analysis.

## A 'strong rights' version of harm reduction

In contrast to the health-optimising imperative, an alternative, under-pinning principle for harm reduction can be suggested, which is to regard people's decision to ingest drugs of whatever sort by whatever means as an inalienable human right. van Ree (1999) has proposed exactly such a thing within the pages of this journal, in which he advocates the inclusion of a new 'Article 31' within the Universal Declaration of Human Rights "Everyone has the right to use psychotropic substances of one's own choice"—implicit in which is also, the right to choose not to use psychotropic substances. It is also possible that Article 12 of the Universal Declaration of Human Rights could be interpreted to include this, with its wording:

> "No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks".

Politically and practically, the renegotiation and addition of a new right to the Universal Declaration of Human Rights is highly unlikely. Reference to van Ree's paper serves mainly to illustrate that the right to use drugs is a right for which people have explicitly argued. Practically, it seems more likely that any change will arise through legal interpretations of existing rights to privacy, which could clarify that a "right to use psychotropic substances of one's own choice" exists within the private realm. It is noteworthy that at the time of writing, the right to privacy has been the most popular defence under the Human Rights Act (1998) within the British courts.

Within the strong rights formulation of harm reduction the role of the public health-driven harm reductionist would then be to assist people to reduce the harms that arise within the *legitimate* exercising of this right, relying on devices, such as persuasion. In other words, the right to use drugs—so long as it is exercised without offending the rights of others—overrides health considerations. If recognising this right were to result in a net increase in both drug use and drug-related harm this would be regarded as an undesirable but necessary price to pay by harm reductionists who cherish individual sovereignty over the body.

Such stylised depictions as the ones used here necessarily blur over a great deal of nuance. One point that seems especially important concerns people's capacity to make informed choices about their drug use when they live in poverty or are marginalised or discriminated against within society. Under such circumstances it can reasonably be argued that people are less able to make informed choices about their consumption and that extending any rights to use drugs is not justifiable unless underlying structural problems are first rectified. This may be seen as a pragmatic and practical position. However, it is worth noting that logically its corollary would seem to be that the poor and marginalised should be also prohibited from making other apparently poor consumption decisions, such as their choices to smoke tobacco, consume high levels of alcohol and eat foods rich in saturated fats: decisions they make from a similarly disadvantaged position.

Regardless, the recognition of a right is entirely different from encouraging people to exercise it. It would remain an intellectually coherent position to say 'I recognise your right to use drugs but discourage you from exercising it because of its potential effect on your health'. This is no different to the way that suicide is widely treated, by which it is no longer criminalised in most countries, yet there is considerable investment through psychiatric services to prevent people from exercising this right. Or, for a more direct analogy, the way that we permit adults to smoke tobacco but increasingly offer treatment to those who wish to abstain, run health promotion campaigns to persuade people not to smoke and enact policies that protect non-smokers from passive smoking, which potentially violates their right to life.

However, endorsement of policies that used force to try to stop drug use through prohibitionary measures could not be permissible within the strong rights version of harm reduction. Persuasion and social marketing would be among the tools available to harm reductionists who, still working

to public health objectives, sought to prevent drug use. Though within a regulated drug market, fiscal controls and other levers of regulation may be more likely to emerge as the most powerful mechanisms for promoting health.

From this perspective, some of the considerable and possibly insurmountable problems of measuring, valuing and arbitrating between harms at the individual, community and society level, for which a utilitarian harm reduction theory currently has no practical solution, would be avoided. In general, policies that allow an individual's right to use drugs to be constrained for the 'greater good' would not be acceptable. Individual choices about what individuals put in their bodies would be given primacy within the individual/community/society nexus described by Newcombe (1992). Nevertheless, consistent with a human rights perspective, drug users who violated the rights of others would remain open to the full range of sanctions reserved by the state for these circumstances and, if such violations were attributable to their drug use, they might ultimately forfeit any freedom to use drugs.

In some respects embracing the strong rights position within harm reduction practice would leave many things the same. Harm reductionists would continue to work in a socio-political context in which drug prohibition was enforced through the various UN Conventions of 1961, 1971 and 1988. Interventions, such as needle exchange and substitution treatment, and the host of allied harm reduction activities, should continue to be promoted and offered just as before. There would, however, be a clear imperative towards explicit support for drug law reform by the strong rights harm reductionist: because drug prohibition would violate a basic human right to which they would be committed.

## The Angel Declaration

During 2001, a group of UK drug law reform groups and individual activists gathered together to attempt a process of harmonising their view of what system should replace drug prohibition, in order to campaign collectively on this platform rather than speaking from contradictory stances. The process largely look place within an Internet discussion list—the Blue Skies Group—and was moderated by a barrister and board member of the British civil rights organisation *Liberty*. Membership was established through a loose, pre-existing communication network and extended through recommendations for additional members within the group. It eventually incorporated members of civil rights groups, former members of the police, drug policy reform groups, substance-specific groups of drug users, such as those who use cannabis or 'dance drugs' and harm reductionists. Following extensive discussion and debate regarding the content on the Internet, a meeting was held on 18th September 2001 in a restaurant at Angel, Islington, North London, and gave rise to a document that was, accordingly, named *The Angel Declaration* (The Angel Declaration, 2004; see: http://www.angeldeclaration.com).

Key principles and proposals of the Declaration are that: (1) Drug prohibition is inconsistent with the UK's human rights commitments and that the Misuse of Drugs Act (1971) should be repealed. If it were necessary, international treaty obligations should be re-negotiated to achieve this; (2) drug availability would be controlled through a system of licensing with varying levels of regulation for different 'primary classes' of drug, determined by a new authority—a National Drugs Agency; and (3) beyond the underlying recognition of a right to use drugs, the Declaration articulates a strong, secondary commitment to reducing drug-related harm at the level of the individual, the community and wider society.

In effect, The Angel Declaration is an embodiment of a strong rights version of harm reduction. Although many of the underlying challenges this poses are not new, it generates a greater necessity for harm reductionists to declare their allegiance—to public health first, or to human rights? Neither allegiance implies complete disregard for the other. The weak rights harm reductionist would undoubtedly continue to have concern for the rights of drug users to be treated with dignity and respect. The strong rights harm reductionist retains a very explicit commitment to public health. Nevertheless, each formulation potentially leads to different priorities and forms of right action.

## Discussion

The language of human rights provides a comfortable, verbal touchstone for harm reductionists. Yet, it can refer both to relatively uncontroversial rights—such as the right to treatment with respect and dignity by services, as well as more basic rights over the body—the right to use drugs of one's choice. This suggests that individual harm reductionists should be clear about which rights they regard as inviolable, which are more qualified rights, and which are not necessarily rights at all.

This paper has argued that harm reduction's public health basis enables versions that can be distinguished according to whether health is prioritised or whether adults are viewed as having an absolute right to decide what they ingest, even if this may cause them harm. Given its lack of any formal definition, the values that harm reduction embodies can be contested and potentially include both the weak rights and strong rights versions.

The tensions between harm reduction as a rights-based movement or a health-optimising movement are becoming greater, as is evident in the critiques of Ezard (2001), Hathaway (2001) and Miller (2001). Increasing drug user involvement within the harm reduction movement is, arguably, a good thing and flows from underlying conceptions of empowerment that are pivotal to harm reduction. Yet, it also means that the harm reduction movement has a growing membership of people to whom it may be saying 'we're

glad to have you along, but we do not support your right to do what you do!'

The strong rights version of harm reduction embodied in The Angel Declaration, envisages a society in which adults are not prohibited from making informed choices about what they ingest, and can legally obtain drugs of their choice within regulated markets offering products of assured quality. This would eradicate or reduce some forms of harm, such as poisoning with adulterated drugs and the considerable costs of criminalising drug users, but would risk exacerbating others by expanding the population of people who consume drugs. The overall impact cannot properly be predicted. In medicine, this would be recognised as a position of equipoise, in which the clinician has a duty to seek evidence as to which approach is superior and then intervene accordingly. However, although some forms of decriminalised availability can be investigated, the UN Conventions of 1961, 1971 and 1988 do not permit evaluation of regulated supply systems for drugs that are used for leisure. It therefore seems disingenuous to be waiting for an adequate evidence base to inform policy regarding the impact of implementing the strong rights model, as this can never be completely forthcoming to the standards generally demanded by evidence-based medicine within a context of international drug prohibition. The prevailing system does not provide 'room for manoeuvre' for those who would seek evidence concerning the impact of legal, regulated forms of drug supply. This can arrive no sooner than a definitive pronouncement on the number of angels that can stand on a pinhead, as research on prohibited systems is itself effectively prohibited. This particular problem seems to underpin Hathaway's (2001) criticism of harm reduction that *qui tacit consentit—silence denotes consent*—to the global prohibition of adults' rights to determine what they ingest. Only with changes to the existing international law could experiments take place that would illuminate the impact of such policies and enable a genuine evidence-based approach to this issue, which might best proceed from cautious, carefully evaluated national experiments with those substances that are least likely to cause harm.

However, ultimately, whether one prioritises health or sovereignty over the body revolves around a value judgement concerning the relative importance of these, upon which research cannot arbitrate. As such, there can be no 'correct' view in any absolute sense. This is implicitly recognised in a discussion paper of the International Harm Reduction Association, which concludes that:

> Any decision about the extent to which harm reduction and drug law reform should be considered as separate entities or as indivisible aspects of the same philosophical framework can only be made at a local level. This decision will depend on local conditions. In some areas, the urgency of responding promptly and effectively to a threatened or actual HIV epidemic among and from injecting drug users or implacable support for harsh forms of drug law enforcement may encourage local public health practitioners to regard these entities as quite separate. In other communities, public health practitioners may well take the view that meaningful harm reduction inevitably requires reform of the drug laws considered responsible for most of the drug-related harm.
>
> –(IHRA, 2003)

An undoubted success of harm reduction has been its ability to bring together disparate interests in a way that has enabled a progressive and practical programme of activity to be implemented in many countries around the world. A threat from any proposal to define harm reduction more clearly and align it with either the weak or strong rights position would see some disintegration of this coalition of interests. In the short term at least, this may hinder important public health developments in countries that could be persuaded of the merits of the public health argument but would be discouraged if they saw this linked too closely to a right to use drugs, and harm reduction as a Trojan Horse for a radical programme of drug policy reform. The position described in IHRA's discussion paper seems calculated to maintain this broad grouping of people who have different values and priorities spanning the weak rights and strong rights positions. It is resonant of the pragmatism that characterises many harm reduction interventions.

Nevertheless, although it seems right to refer to local conditions, the existing international legal system of drug control effectively prevents any understanding through evidence of the possible impact of certain regulated supply systems on harm. This suggests that, regardless of whether one endorses a right to use drugs as a matter of principle, or whether one favours an approach that is driven by evidence, it is desirable for existing international legislation to be changed. The principle of subsidiarity should underpin national decisions about local drug control conditions to enable the possibility of developing evidence concerning the impact of regulated supply systems on drug related harm.

When I read some things that I wrote not so long ago, I am interested, and a little chagrined, to see how much my own thinking about harm reduction has changed (see Hunt, 2001). I was privileged to be invited to participate in the discussions regarding the wording of The Angel Declaration as a spokesperson for harm reduction. As a nurse and social researcher I had never formally studied the underlying international and national legal framework relating to human rights and the debates and ideas that flow from these. As a result of participation in that process, I found myself increasingly challenged to address my own views about the human rights within harm reduction and remedy some of the sloppiness and contradictions I discovered within my own thinking. As I did so, I found myself drawn towards the strong rights position. As a consequence, an inescapable part of the 'right action' for me is to make this confession, seek to discuss it with my peers and, in the light of a developing discussion about human rights and harm reduction, encourage others to

be clear about their own position on the right to use drugs and the international legislative framework that constrains it, and then act accordingly.

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