

Whose Harm? Harm Reduction and the Shift to Coercion in UK Drug Policy

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Building on Stimson's (2000) analysis, this paper examines the shift from a focus on health towards one of crime within UK drug policy. The increased use of coerced or compulsory treatment of drug users is discussed with reference to harm reduction theory and the question of whose harm is prioritised in shaping drug services. We also identify mechanisms by which the efficacy of treatment approaches based on coercion may be lessened or reduce the efficacy of other existing services. Failure to consider these may be an important omission in any appraisal of the impact of policies that increasingly prioritise crime prevention and coercion over health and voluntarism.

Introduction

This paper considers shifts in UK drug policy from the mid 1980s to the present. It charts changes in the way that harm has been construed and the accompanying emphases on drug policy: notably the increasing reliance on coercion into treatment and the growing emphasis on crime prevention as a policy objective.

We aim to develop Stimson's (2000) argument concerning the way that priorities have changed from a focus on individual and public health (the health phase) towards the harm arising from drug-related crime within communities and at the societal level (the crime phase). This is particularly discussed with reference to a weakness within one of the main ways in which drug policy is theorised – 'harm reduction'. Prevailing definitions of harm reduction provide limited guidance when arbitrating between different types of harm that occur at the level of the individual, the community and society. This means that harm reduction theory does not necessarily prioritise the health of users as the aim of drug treatment. So the aim of drug treatment to improve the health of its clients can be undermined by other goals, which is not the case for other problematic consumption behaviours.

We will argue that the change from an approach based on voluntarism, which emphasises informing and empowering the individual, towards one that is increasingly based on coercion, may reduce the effectiveness of treatment and limit the gains that it produces. We suggest mechanisms by which this may occur that appear to have been given no more than cursory attention within evaluation and discussion of the impact of shifting UK drug policy towards a greater emphasis on coercion, compulsion and quasi-compulsory treatment (QCT), by which we mean treatment to which the

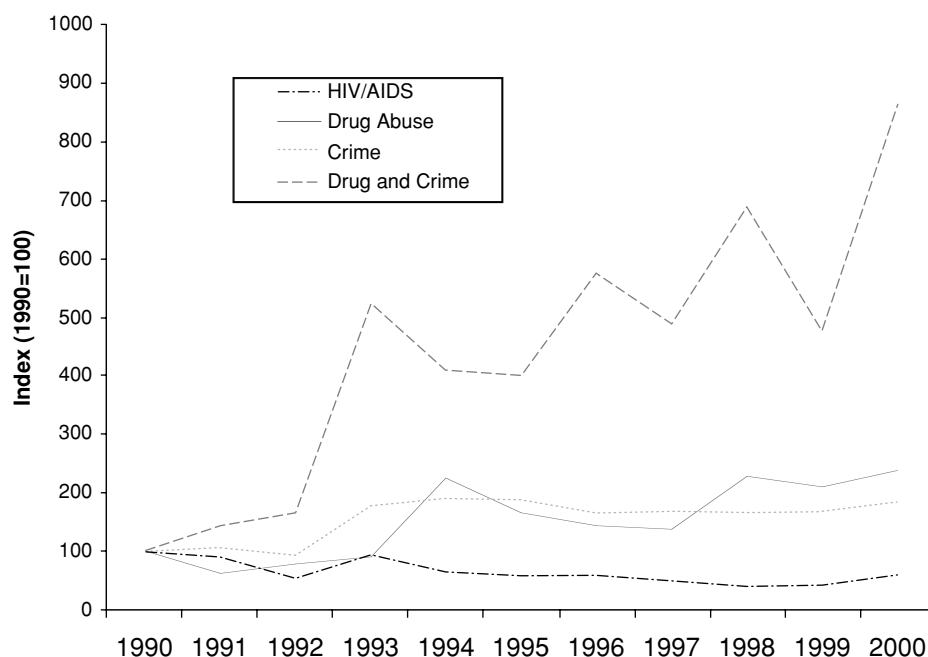


Figure 1. Articles on drugs, crime and HIV/AIDS in British newspapers, 1990–2000.

offender consents as an alternative disposal to a conventional punishment – notably imprisonment.

Shifts in the construction of drug-related harm

As Stimson has noted, since 1997 the drug policy discourse of the New Labour government has been one that largely focuses on drugs as an engine of crime. This shift in emphasis within UK drug policy reflects a change in the way that drug-related harm is constructed and prioritised.

Whereas in the late 1980s and the first half of the 1990s the primary focus of concern about drug use was a fear that it would lead to the rapid spread of a life-threatening viral infection – HIV/AIDS – the focus is now increasingly on drugs as an engine of criminal behaviour. One indicator of this is the corresponding growth in the number of newspaper articles that link drugs *and* crime, compared to those that focus independently on HIV/AIDS, drugs or crime. This is evident in a search for the terms ‘HIV or AIDS’, ‘drug abuse’, ‘crime’ and ‘crime and drugs’ in the Clover Newspaper Index, which records all articles in the broadsheet press in England and Wales for the period 1990–2000 (<http://clover.niss.ac.uk:8080/>). Whereas the number of articles referring to ‘crime and drug’ has increased by a factor of more than eight, interest from the broadsheet newspapers in HIV/AIDS has roughly halved, reinforcing the observations made by Stimson (see Figure 1).

Public attention and resources may have been focused on HIV/AIDS because of concerns of its spread from drug users to the wider population (Moss, 1987). However,

the harm reduction policies that arose from this concern assumed that coercion was unlikely to change health behaviour. Instead of attempting to force drug injectors to stop sharing their equipment, for example, they were given the information and facilities necessary to do so, and enabled to take up these services voluntarily. With HIV/AIDS, injecting drug users were considered to be at risk of harm, with the indirect consequence of harm to non-drug users. As the concern shifts to crime, drug users are no longer seen as being harmed (there is very little attention given to the criminal victimisation of drug users), but as harming non-drug users.

From voluntarism to coercion

It has been argued that there is no simple dichotomy between voluntary and coerced treatment (Bean, 2002: 64), and this has been supported by North American studies of perceived coercion among clients entering drug treatment (Wild *et al.*, 1998; Marlowe *et al.*, 2001; Young and Belenko, 2002). Drug users may feel pressure to enter treatment from friends, family and employers, as well as from the state. However, legal coercion has the fundamental difference that the state is the only one of these potential sources of pressure, which has the power to track drug users down and lock them up if they do not comply. Also, the rest of us have no role in exercising such pressure, except if it is applied by the state. It is none of our business if a person's partner or parent tells them to enter treatment. But if the state does so, it is doing so in our name and this makes it our business to debate whether it is right to do so.

The British state rarely compelled users to enter treatment until quite recently.¹ Throughout the 1980s and into the 1990s, drug services focused on the delivery of a range of interventions and treatment that drug users chose to take part in. These services were based on voluntarism and operated across a harm reduction hierarchy mapped out by the Advisory Council on the Misuse of Drugs (1988), which encourages change that ranges from modest steps, such as a reduction in the sharing of needles and syringes, through to the attainment of abstinence.

Harm reduction has been internationally acknowledged as an effective public health approach (Tsui, 2000). A number of studies have now confirmed the effectiveness of harm reduction measures such as needle exchange and methadone maintenance in reducing transmission of infectious diseases and the deaths that these diseases cause (Wodak, 1995; Merson *et al.*, 2000; Gibson *et al.*, 2001; Mattick *et al.*, 2003a, 2003b). In the UK, harm reduction services have succeeded in reducing the transmission of HIV among injecting drug users (Stimson, 1996; Strang, 1998) and it seems that they may even be reversing the high prevalence of Hepatitis C (Hope *et al.*, 2001). Other forms of voluntary drug treatment, including residential rehabilitation services based on abstinence, also produce positive health gains for their clients in the UK and the USA (McNulty and Kouimtsidis, 2001; Gossop *et al.*, 2002). And meta-analysis of the effects of voluntary drug treatment, including abstinence-based and substitute prescribing has shown that both types of treatment reduce the criminality of the people who go through them (Prendergast *et al.*, 2002).

These successful services have been developed with an ethos that prioritises the health and well-being of their clients by assisting them to make changes voluntarily. But as drug-related harm has increasingly come to be understood as the harm *by* people who

use drugs, instead of harm done to them, so there has been a shift to the increasing use of coercion into treatment through the criminal justice system.

Two corresponding innovations have been introduced in Britain – Drug Treatment and Testing Orders (DTTOs), which are now under rapid expansion (Home Office, 2002) and Drug Abstinence Orders (DAOs). DTTOs enable the courts to order an offender who consents to undergo treatment: If the order is breached, for example by failing to attend treatment, then the offender can be re-sentenced. More recently, under the Criminal Justice and Court Services Act (2000), specified ‘trigger offences’ can now lead to the imposition of a Drug Abstinence Order, which requires offenders to submit to drug testing and to additional punishments if they continue to test positive; regardless of whether they consent.

The shift towards crime prevention and coercion seems all the more important given that the revised UK drug strategy launched in December 2002 announced an intention to double the number of Drug Treatment and Testing Orders by March 2005 and extend this approach into services for young people by introducing ‘drug testing and referral of young people for treatment following arrest’ and giving ‘courts the power to include drugs treatment as part of community sentences’ (Home Office, 2002).

Furthermore, the opposition Conservative Party is currently proposing a policy that may go further and hinges around an increase in the number of ‘intensive residential drug treatment places’ of more than an order of magnitude, from 2000 places to over 20,000.² A subsequent speech by the Shadow Home Secretary – Oliver Letwin – suggests that coercion rather than voluntarism is likely to dictate who gets this intensive treatment when he explained that ‘each young addict will be given the choice between undergoing treatment and facing criminal proceedings’.³

These developments in the use of compulsion or quasi-compulsion are not restricted to the UK. Drug Courts were developed in the USA and partially informed the development of DTTOs. Ireland has also introduced new systems based on the American drug court model and Scotland also has them. In the Netherlands, a new system of compelling persistent offenders who are considered to be drug dependent to enter treatment is being evaluated (the SOV system). Different forms of quasi-compulsory treatment also exist in Austria, Germany, Italy and Switzerland (Werdenich and Waidner Forthcoming). Russia is also considering the introduction of compulsory treatment (*Moscow Times*, 25 September 2002).

Despite the marked, international extension of quasi-compulsory treatments their efficacy is far less certain than is suggested by their growing popularity. Claims such as ‘[d]rug courts have produced the largest number of clean addicts to be found anywhere’ (Bean, 2002: 83) are not supported by the evidence. Both Nolan (1998) and Hoffmann (2000) have scrutinised and questioned the claims that have been made for the efficacy of drug courts in the USA. One extensive review of the research found that drug courts receive support from the agencies involved and that the drug use and crime of people who do not drop out reduces while they are in treatment. But many people do drop out and the overall effects on drug use, crime and health are unclear (Belenko, 2001). More recently a review of the literature published in English, Dutch, German, French and Italian (Stevens *et al.*, 2003) found conflicting evidence on the effects of quasi-compulsory treatment. It found evidence suggestive of a positive impact on retention, and equivalent outcomes to voluntary treatment (USA and Switzerland); that coerced treatment is ineffective in reducing crime (The Netherlands); and that coercive approaches

are largely ineffective, and with potential adverse effects on voluntary treatment services (Germany).

The available evidence strongly suggests that voluntary treatment is successful in reducing drug-related harm. The evidence on coercive drug treatment is much less clear.

Harm reduction theory and the primacy of the drug user

The recent review of UK drug policy by the Home Affairs Select Committee (2002: paragraph 270) concluded that 'harm reduction rather than retribution should be the primary focus of policy towards users of illegal drugs'.

We argue that this focus may be diluted and even undermined by the shift to coercion, and that harm reduction fails adequately to resolve an inherent tension that enables both coercive measures to reduce crime and others that seek primarily to improve individual health.

Although there is some consensus about what harm reduction is and what it has achieved, it has no formal, agreed definition. It is an approach that prioritises the reduction of *harm* over the prevention of drug use and is generally considered with reference to different types of harm (health, social and economic) that occur at different levels (individual, community and societal): a schema that was first offered by Newcombe (1992). Using this definition, harm may include an overdose suffered by an individual heroin user, a reduced sense of safety among residents on a housing estate with high levels of drug use or the economic costs to society of police and medical staff who deal with the consequences of drug use. Looked at this way, the harms to be reduced can be suffered both by drug users and non-drug users, by individuals and groups, either directly or indirectly. Initiatives can be called harm reduction, even if they have no intention to reduce harms to drug users themselves.

Newcombe's schema provides little guidance regarding the way in which policy makers should arbitrate between programmes that influence harm at different levels and to different people. Disregarding the considerable practical problems of measuring and valuing different types of harm, it is of little help in choosing between programmes that primarily benefit either individual health, increase community safety or reduce overall costs to society. Within a finite public purse, it does not resolve the question of which should be prioritised. Consequently, there is a risk that policy decisions affecting the provision of treatment and care are susceptible to changes in value judgements concerning different harms at different times – an important consideration given the marginal, stigmatised and largely voiceless position of drug users within British society. This may allow the health needs of drug users to be subordinated to community or social harms within treatment services. Such a shift undermines the principle that appears to apply almost universally in treatment and care systems for other populations: that the priority within any particular treatment and care programme should be the *individual well-being of the patient or client*.

The illegality of drugs obscures the primacy of individual health in the treatment of problematic use, especially when that treatment is connected to punishment. For example, while Bean accepts that the aim of treatment should be 'to prevent and reduce harm resulting from the use of drugs' (Bean, 2002: 58), he later asserts that 'the sole aim of drug treatment agencies working within a criminal justice setting . . . must be compliance with the law' (Ibid: 72), including abstinence from illicit drugs. Very many

drug treatment agencies do not demand complete abstinence from illicit drugs, as they consider such a demand would not assist the client to succeed in treatment. The coercive shift in drug policy threatens to subordinate the focus of drug treatment agencies on the health problems of their clients to the aims of other organisations who are charged with protecting against other harms to the wider population.

It would appear that the provision of health and social care for people who use drugs is almost unique in the way that the needs of the patient or client can be subordinated in this way. Drug use is one of a number of 'consumption behaviours' that have an impact beyond the individual level – within the community and social realms. However, it is unusual in the way that its treatment is now substantially shaped by community and social level considerations in a way that would generally be regarded as unacceptable for other forms of consumption-related morbidity.

For example, tobacco smoking has a variety of well-rehearsed effects on individual and public health through passive smoking. However, smokers are not coerced into smoking-cessation treatment. Likewise, consumption of a diet rich in saturated fats causes both individual harms associated with obesity, and significant social costs through the burden on healthcare systems. Mandatory dieting has, however, not yet been proposed. Alcohol generates both an individual disease burden, along with community-level harms – such as public disorder, alcohol-related sexual assault and drink-driving deaths – with corresponding social costs for the criminal justice system and within the health service (Cabinet Office, 2003). Nevertheless, the over-riding criterion determining whether someone receives treatment for alcohol-related problems is still based on the drinker's choice and consent. Alcohol Abstinence Orders do not yet exist within British law.

It seems that the discourse of harm reduction, having come into being as a way of focussing on health instead of repression in dealing with drug users now risks being used to justify policies that are not primarily concerned with health. This would be easier to justify if there were reliable evidence that coercive measures can reduce health and criminal harms to a similar extent as those based on non-coerced entry to treatment. But on the contrary, a Dutch study has shown no effect on crime at the community level from coerced treatment (Korf *et al.*, 2000). Stimson has also argued that the numbers that are involved in drug treatment are so small compared with the number of criminals that even a large expansion of treatment can have very little effect on the overall crime rate (Stimson, 2001). This leaves the health benefits of treatment as its best justification, and the best way of arbitrating between different priorities in drug treatment services.

Unexamined mechanisms by which an expansion of coercive approaches may undermine voluntary treatment

There are some, contested, but consistently expressed suggestions from the research, that coercive treatment does produce health benefits. But very little attention has been paid to possible mechanisms that may produce negative effects.

Coercive approaches are likely to affect the service provided to those who are already in treatment. If drug users who are not ready to face up to the challenges of treatment are sent into services alongside other users who are more motivated, then resources, attention and the rules and norms of therapeutic groups may have to be shifted to accommodate them. German researchers have found that drug workers believe that coerced clients have a negative effect on the treatment process, as they tend to continue behaviours and

attitudes learnt in prison that are not conducive to treatment (Egg and Kurze, 1993) and that this has the effect of increasing the drop out of other treatment clients (Alzinger *et al.*, 1998).

There is also an effect on the drug treatment workforce, where there is a shortage of skilled workers, which is currently the case in England (National Treatment Agency, 2002). As a new tier of coercive approaches is introduced into drug services, there is likely to be a shift of scarce human resources towards work with more poorly understood efficacy. This process may be exacerbated if managers are also given incentives to deploy staff away from voluntary services to fulfil DTTO contracts because there is a higher risk of direct, contractual penalties or the threat of non-renewal of the contract is higher.

Beyond this, there are other possible mechanisms by which coercive approaches may reduce the positive outcomes that could otherwise be expected from treatment, by changing the image of drug treatment services from perceived independence to one in which they are mistrusted and seen as working hand-in-hand with the police – reducing people's propensity to approach services voluntarily. It is even possible that faster access to better treatment within DTTOs may unintentionally create incentives to offend in order to jump long waiting lists for community treatment.

In his discussion about drug courts, Bean (2002: 90) makes passing reference to the stresses and strains on existing systems that these changes produce, and seems to imply that this is a temporary price that has to be paid for radical changes that will ultimately be worthwhile. However, it is far from clear whether these effects are short-lived, transient consequences of such system changes, or even worthwhile in the long-term.

What is certain is that the decision to invest in treatment targeted at drug users who offend has an opportunity cost of in terms of the provision of treatment with better understood efficacy. Money spent on quasi-compulsory treatment is unavailable for the treatment of other drug users or for health objectives other than abstinence, such as the treatment of hepatitis C infection, improved prevention measures through optimising needle exchange coverage or the development of improved programmes to reduce rates of overdose and other causes of drug-related deaths. This point is pivotal to the question of how treatment choices are prioritised and whether treatment decisions are determined by the drug user's well-being or the concerns of others. Debates about the adoption and expansion of quasi-compulsory approaches that prioritise crime prevention should not be narrowly defined solely in terms of the effectiveness of those approaches but also need explicitly to consider the opportunity costs that these policy choices imply.

Conclusion

We have presented evidence supporting Stimson's (2000) thesis that UK drug policy has shifted towards approaches based on crime prevention and the coercion of drug users. We argue that this endangers the proven gains that have been produced by the earlier, voluntaristic approaches by diverting resources to more uncertain, coercive interventions. This has an evident opportunity cost that is being ignored and risks discouraging other drug users from entering and staying in treatment, it may divert staff from treatment modalities with better-known efficacy and may create perverse incentives to offend.

A central problem that we have highlighted concerns the way that priorities within the provision of health and social care services for drug users are determined. The focus on harms other than the direct health effects of drug use is shaping programmes for drug

users to a degree that would be unacceptable in other fields in which individual health behaviour also has an impact at the community and social level.

Harm reduction theory has evident utility for understanding and analysing different levels of harm – individual, community and societal. However, it presently stops short of providing any affirmation of the priority of the health needs of the drug user, which have to compete with a range of other potentially conflicting objectives. Unlike other ‘consumption behaviours’ that also cause harm at the community and societal level, there appears to be no clearly articulated principle that prioritises the well-being of drug users within programmes designed to impact upon them. This suggests that it might be timely to reappraise whether such a principle should be included more clearly within definitions of harm reduction. Failure to clarify the underlying principles and values that shape the delivery of health and social care for people with drug problems may reduce their effectiveness and leave them vulnerable to the vicissitudes of populist politics.

Finally, we do not yet know whether, or to what extent, the growing reliance on coercive treatment approaches in the UK will deliver benefits to individual and public health, nor to community safety. We have cited some of the conflicting evidence on this, and suggested mechanisms associated with the introduction of coercive approaches that may impede and undermine voluntary treatment systems that have relatively well-established efficacy. These mechanisms and their effects of wider treatment and care systems have largely been ignored by policy analysts within evaluations of compulsory and quasi-compulsory treatment and deserve attention in any full appraisal of the impact of introducing these programmes.

Notes

1 Although it had the power to do so through, for example, the 1A6 probation order. These orders were not often used (Bean, 2002).

2 Iain Duncan-Smith, 3 July 2003 http://www.conservatives.com/news/article.cfm?obj_id=65836&speeches=1 accessed 11/9/2003

3 Oliver Letwin – 19 August 2003 http://www.conservatives.com/news/article.cfm?obj_id=69916 accessed 11/9/2003

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