HCLU Policy Paper

on Harm Reduction Drug Policy

It is a scientifically confirmed fact that people have been using certain drugs with the purpose of changing their state of consciousness for several thousands of years. This is attested by the record of the twenty centuries of our modern era as well as by the records of times B.C., and the days we live in are no exception: some people are using drugs, occasionally or regularly, to change their state of consciousness. If to varying degrees, the problem of drugs is present in all countries around the world, different as they may be in terms of their size, system of political or religious organisation and living standards. Some of the drugs consumed are accepted, others are made illegal. The line drawn by governments between legal and illegal drugs may vary according to cultural context, and it may, and occasionally does, shift as time goes by.

The term “drug problem” is typically used with reference to illegal drugs. Responses to the drug problem may be of various kinds. The *prohibitionist approach* defines all forms of drug-related conduct – including consumption – as falling under criminal sanctions, while – at the other end of a scale of a variety of policies - more liberal-minded policies penalize only the distribution of certain drugs, and tend to refrain from prosecuting consumption. A relatively recent trend in liberal drug policies is called the *harm-reduction approach*. Certain elements of it have made their way into the drug policies of several countries, while other countries are reluctant to accept even its underlying idea.

What is Harm Reduction?

The main point of harm-reduction drug policy is that society should provide a response to the negative effects of drugs in terms of realistic considerations of public health, social welfare and human rights rather than prejudices, self-centred moral preaching or repeated declarations on the original sin involved in using drugs. The harm reduction approach can be expounded in a series of statements. The first and most important step is the recognition that our goals must be realistic and attainable. This implies the acceptance of the fact, unpalatable as it may be to many, that a great number of our fellow-humans have always been, and will always be, using consciousness-altering drugs. Thus, a “drug-free society”, i.e. a human community in which no one ever uses an illegal drug of any kind, cannot be pursued with any realistic hope of success. If we subscribe to this view, it will be obvious that a reasonable drug policy should not aim at a complete elimination of drugs, but rather at the following more modest aims:

- as few people as possible should use them.

Accepting the overwhelming likelihood of there being always persons who just use these drugs, it would be useful and welcome, as a second step, for these people to choose their manner or extent of degree of drug consumption so that

- it should not be more harmful than is inevitable

and that they should favour drugs which are less harmful to their health than others. Finally, as a third step, we need to do something about those of our fellow humans who decide, despite all preventive action and information provided to consume the more harmful drugs. We have to make arrangements which give them the possibility of

- choosing less dangerous modes of consumption

which impose the least possible inconvenience on themselves and their environment.

Supporters of harm reduction drug policies agree also that the greater part of the individual or social harm, tragedy and human suffering attributed to drugs today is due to inadequate responses to consumption and inappropriate drug policies rather than directly to the consumption of the particular substances. We could also put this by saying that most of the harm caused by the consumption of drugs is due not to the particular drugs consumed but to the fact that they are illegal.

Examples from the Practice of Harm Reduction

That the greater part of the dangers and harm attributed to drugs is engendered by mistaken drug policies can be most conclusively shown with respect to the drugs which are regarded as the most dangerous ones. According to the UN World Drug Report (2000), most of the troubles caused by drugs in the world today are due to the consumption of opiates, especially heroine and cocaine. These drugs are widely taken intravenously, which is the most risky method of drug consumption. Appropriate harm-reduction techniques can relieve much of the harm to individuals and society. Harm-reduction drug policies specifically addressing the situation of intravenous users include e.g.

Needle Exchange Programs,

which were first introduced in Western Europe and later in a growing number of countries in the 1980s and 1990s. The efficacy of these programs remains unrecognised or not sufficiently recognised in many countries till the present day. One of the greatest hazards involved in intravenous drug use is the sharing of needles between drug users, which may result in the transmission of severe diseases such as Hepatitis B, C or HIV. Needle exchange programs are attempts to prevent infection by providing intravenous drug users with sterile needles. These programs are “low-threshold” services, i.e. drug users are not required to

abstain from drug use or to show themselves ready to abstain, in order to be eligible for the program. The successor states of the former Soviet Union deliver sad examples of the fast spread of various infections and viruses in communities of intravenous drug users unchecked by needle exchange programs. In some countries, e.g. Ukraine or Russia 75-80% of the new cases of HIV infection may be due to intravenous drug use, or rather to a drug policy which has not been prudent and candid enough to learn from the example of other countries governments.

The criticism most often voiced against needle exchange programs is that by providing such programs the government would promote drug use rather than making efforts to make people desist from it. The criticism is misplaced because in reality these programs target drug addicts who are unable or even unwilling to give up using drugs anyway. Someone who uses drugs intravenously will not give up his habit simply because he or she has no access to sterile needle. Needle exchange programs therefore do not assist drug use; what they do is to minimise the harm to drug users and society at large caused by the drug users themselves.

That needle exchange is useful for society can be proved simply: one need only compare the annual expenses of providing an intravenous dug user with needles with the expenses of providing health care for an HIV patient. Another advantage of needle exchange programs can be seen in the opportunities they provide for helpers to make contact with a group of drug consumers who are otherwise difficult to approach. This makes it possible for them to provide these drug users with information which might help them to give up their habit later on, or provide them with other forms of aid.

Needle exchange programs can be implemented in several ways. Provision of needles may take the form of services offered at a fixed place or it can be targeted at street drug users in a mobile way. Another established method of provision is the active involvement of particular drug users who provide sterile needles for communities of drug users of varying size. In such cases it is a good idea to provide drug users with some sort of official certificate of their status.

What is Methadone Good for?

Methadone is a synthetic opiate which was developed around the middle of the 20th century. It can be used for drug-detoxification, i.e. for the aim of eliminating poisonous substances from the organism, but there are a number of more modern chemicals available for that purpose today. During detoxification the drug addict is given a dose of methadone which will relieve him of experiencing withdrawal symptoms resulting from his or her abstinence from the illegal opiate previously taken. This is followed by a period during which gradually decreasing doses of methadone are administered until, in a few weeks,

it is completely phased out. This makes it possible for the patient to give up using drugs without the inconvenience of experiencing withdrawal symptoms.

What has made methadone known around the world in the past few decades is its use in long-term methadone maintenance treatment. A significant number of drug addicts are unable to live without an opiate: they are unable or unwilling to cope with the difficulty involved in trying to give up. Methadone maintenance treatment offers a solution for these persons. With the appropriate dose fixed, the patient may be given the prescribed amount of methadone for a long time: months, years, or even during his/her whole life.

Opponents of methadone maintenance claim that such programs offer patients no assistance in their effort to stop using drugs. All the government does in adopting such programs – they argue – is to exchange dependence on one drug for a dependence on another, and thereby to sustain the disease – drug addiction – itself. There is no denying that methadone makes the consumer dependent, and it is also a fact beyond dispute that the government, by supporting methadone maintenance programs, becomes a partner in the maintenance of dependence and addiction.

Yet, if our standard of comparison is based on a weighing of the advantages and disadvantages to be expected from these programs, we can see that these are beneficial both to the addicts themselves and to society. Methadone has a negligible euphorising effect, much smaller than that of heroine. A patient on methadone is capable of reintegrating into society and of becoming a useful member of it in all respects. He is capable of holding a job and taking care of himself as well as his family. He can drive a car and use transport facilities safely. He does not expose his organism to infections and diseases. He does not have to devote an entire day to getting his dose of heroine, which alone is an inestimable benefit to society. A person receiving methadone maintenance treatment is comparable to the diabetes patient who depends on a daily dose of insulin rather than to the paradigm drug addict. Let us forget about the different ways in which they came to have their disease and the basic point becomes that both need medical treatment in order to be able to sustain a normal pattern of living.

Methadone, which needs to be taken only once a day for the desired effect, is available at drug outpatient departments or pharmacies. Under a different arrangement GPs are involved in the distribution of the medicament. In Holland methadone-distribution buses are run to extend the opportunity to street drug users , the group of drug addicts who are the most difficult to reach. In these cases appropriate maintenance treatment is not really possible, but methadone can still substitute for illegal heroine on a one-off basis.

Can Prescribed Heroine Be a Solution?

Harm-reduction drug policy is characterised by openness to new solutions. The last few years have seen a gradual acceptance of methods which may, at first, strike outsiders as unsuitable ways of trying to deal with the drug problem. The prescription of heroine for heroine drug addicts is a case in point. The first pilot program at harm reduction of this kind was launched in the United Kingdom in the early 1990s. This is by no means surprising, the U.K. being the country with a history of precedents for doctors prescribing heroine and cocaine for patients addicted to drugs. Heroine programs are to be launched in Germany and Spain within a foreseeable time, Canada and France also seriously considering their introduction. The country whose name first springs to mind in connection with heroine-maintenance programs is Switzerland. The greatest difference between methadone and heroine maintenance programs is the fact that heroine programs do not aim at phasing out the patient's using the drug. The aim of heroine maintenance programs is not to get patients off the drugs but to put an end to illegal drug consumption by providing those on the program with heroine.

Why are such programs operated and why is it good for anybody that the government should provide drug addicts with the drugs they require? Again, the answer to these questions is best provided in terms of cost/benefit calculations. A street heroinist, unless he is rich, has to spend practically his or her entire day to getting the money for his daily dose, which he can mostly do only at the cost of committing illegal acts. Drugs pass through several hands before they get to the consumer and since everyone involved wants to have good share, the purity of the drug decreases gradually at every stage of transmission. This results in the street drug user's getting a lot more additional, diluting chemicals of unknown origin and quality than heroine, and these chemicals are often more harmful than the drug itself. Worse still, the reduced content of efficient substance induces many drug users to opt for the most dangerous way of administering the drug, i.e. injection, as opposed to sniffing or smoking which is enough to achieve the desired effect when the drug contains a sufficient dose of effective substances.

Sources of supply keep changing as the police are trying constantly to track down drug dealers, but change of source often involves a change in the quality of the substance itself, which may lead to drug users sending themselves to death with a lethal overdose . Illegal heroinists are often in a poor state of health, they often fall victim to diseases and their organism is increasingly exposed to infections. We must not forget the fact that every act of illegal purchase of a drug dose adds to the income of black marketers, and particularly that of organized criminal groups, and contributes to drive up inflation.

It is worth our while to compare what happens to an illegal heroinist if she does not have to face life on the periphery of society, persecution or detoxification programs and what happens to her if we make her drug available to her. The drug addict does not need to commit illegal acts every day to get her substance. She does not have to spend all her day running around to get her substance, she has time to attend to matters other than getting her substance.

Medical heroine is pure so it does not burden her organism with additional polluting substances. The heroine always contains the same amount of effective chemicals so the addict is not exposed to changes in quality. The probability of an overdose is much smaller. In addition, experience shows that the knowledge that they will get their necessary dose makes drug addicts partaking in such programs choose to stabilise or decrease their dose, and indeed a greater number of them come to feel motivated to give up drug consumption than do illegal heroinists.

Thus, the program is undoubtedly to the benefit of drug addicts. Is it any good for the society? Opponents of medical heroine programs bring up the same arguments against heroine maintenance programs as they set against the application of methadone: they do not find it acceptable that the Government should not only tolerate but positively assist drug addicts in drug consumption instead of making efforts to get them off the substance, and are outraged by the fact that drug addicts are provided with their drugs free of charge. The programs which have started in some countries of Western Europe or are going to be launched soon, stipulate very strict conditions for a drug consumer to be entitled to provision with heroine. In the Swiss experiment e.g. only hard addicts can take part who are above 21 years of age, have been using heroine for several years, and have had at least two unsuccessful attempts at giving up using drugs. The program is thus aiming at people who are unlikely, even with assistance, to be able to give up drug use on the means available.

Nothing could be farther from the truth than describing the government as a "supreme dealer" making drugs available to naive youths. The government is only providing drugs safely for those addicts who would get them anyway and at any cost. Maintenance of such programs may cost tax payers' money, but criminal activity aimed at getting illegal heroine imposes much more severe costs on society: we must pay the police, the judge, the ambulance called in cases of overdose, we must cover the expenses of hospital treatment, bear the losses of a stolen purse, and make our car repaired after it was broken up by an addict in search for money to buy his daily dose. Thus, the program helps not only drug addicts to normalise their lives but can also be rather useful for society as a whole.

It is one of the aims of harm-reduction drug policies that those drug consumers who use drugs considered dangerous to them should do it in ways that minimalize the harm to themselves and their environment. Two arrangements have been devised to meet this objective: needle exchange programs and

Safer Injection Rooms,

which are being set up in an increasing number of countries. Switzerland, Germany, Holland and Australia are the countries in which experts have had

experiences with legal “shooting rooms” which are worthy of serious consideration. In these rooms drug users are provided with sterile needles and are allowed to administer their drug themselves. During opening hours there is always a doctor or a qualified nurse on duty who can help treat cases of overdose. The “forerunner” of shooting rooms, the Needle Park of Zurich, was launched in 1987 to reduce the number of those using drugs in public areas. The availability of shooting rooms can be shown to have reduced the proportions of addicts using drugs in public places. Beyond reducing the number of needles thrown away in streets, these programs have a number of other favourable effects. To take an example, between 1991 and 1997 the number of cases of lethal overdose could be reduced to one fifth of what it had previously been in Frankfurt, the German city which has the longest history of running such rooms, while in other German cities, where no such rooms were available, the number of lethal overdose cases stayed level or increased. In addition, when overdose occurs in shooting rooms, thanks to the presence of health care staff on the scene, as many as ten times fewer cases led to an overdose requiring hospitalisation than street cases, which amounts to a great difference in terms of health care spending.

Harm Reduction with the Help of True Information

A charge often brought up against adherents of the harm reduction drug policy is that harm-reduction amounts to popularising and supporting drug consumption. These accusations are ill-placed. All drug experts who support harm-reduction policies acknowledge all drugs as potentially dangerous and thus are convinced that it is desirable that there should be as few drug users as possible. At the same time, efforts to provide information and prevention should not avoid those who have tried out illegal drugs or are using them regularly. Information and prevention must always be correct and unpretentious. There are several examples of the deleterious effects of information exaggerating the dangerousness hazards of particular drugs. Most drug problem experts ascribe the sudden explosion of heroine consumption in the U.S. in the 1970s to the incredible and deterrence-oriented preventive efforts on the part of drug education. Some of the media and official anti-drug propaganda claimed then that consumption of marijuana made the consumer aggressive and awakened murderous tendencies. Those who tried marijuana found that these claims had been unfounded. Having lost their trust in the information providers, many withheld belief from the news that was being spread about the really serious consequences of heroine consumption.

Examples of “harmful information” are delivered also by cases in which informers exaggerated some facts about drug consumption thereby unleashing some effect which they never intended. In the early 1990s young people in

several countries died because they had taken ecstasy and too much liquid while dancing to avoid dehydration and overheating, which happened to cause them to die. Why did they do it – one might ask. The answer lies in the message emphasized by drug education programs at the time as the most important thing to bear in mind about ecstasy that when this drug is taken, sustained dancing may cause the organism to overheat, but no mention was made of the danger involved in excessive liquid intake.

Harm Reduction and Marijuana

The most widely taken illegal drug around the world is marijuana. It also ranks fourth as a psychoactive substance after coffee, tobacco and alcohol. According to UN statistics, over 150 million people take it, yet the harm associated with its use is much smaller than that caused by heroine or cocaine, both of which are consumed by an incomparably smaller number of our fellow humans. The policy of liberalisation of the use of marijuana or hashish, proposed by harm reductionists, is based on the finding that there will always be people who will use illegal substances, and our basic interest is that as many of them as possible should choose the less hazardous ones.

There are several countries in the world which have already changed their previous strict policy toward cannabis derivatives or are planning to make such changes in the near future, Holland being the most well-known example, a country in which hashish and marijuana have been practically available without restrictions for 25 years now. The Dutch experiment in quasi-legalisation has proved successful. The number of Dutch soft drug users does not exceed the European average, and there are even a few countries pursuing strict drug policies in which a greater proportion of the population consume such substances than in Holland. The effect of the liberalisation of marijuana – which is accompanied by appropriate arrangements for prevention – on the most endangered generation of teenagers is remarkable. Statistics reveal that 10 years after the liberalisation of cannabis 12% of Dutch secondary school students have tried marijuana at least once and 5,4% of them were using it on a regular basis, while the same indices among secondary school students in the U.S. were much higher: 59% and 29% respectively.

Statistics show that the legalisation of soft drugs affects the number of users of more hazardous hard drugs favourably. In countries where marijuana is sold in coffee shops the average age of hard drug users has been continuously increasing. One of the main arguments deployed previously against marijuana as the gateway drug, according to which it is users of this drug who later switch to more dangerous substances, has been undermined, thanks to the Dutch example. Only a small fraction of those using or trying cannabis ever get as far as heroine.

If, on the other hand, marijuana is illegal, the dug dealer selling grass is more likely to offer other drugs, too, to anyone seeking his services.

Several sociological surveys have also pointed out the fact that users of marijuana differ significantly from the users of other illegal substances: “smokers of grass” include a much greater number of persons with a settled existence and most of the users of this drug can generally be said not to break any legal rules other than those prohibiting the use of marijuana. One can claim, therefore, that by prohibiting cannabis certain countries turn citizens who harm only themselves but not others into criminals. In light of this it will not seem surprising that in may countries of Western Europe the legalisation of marijuana is being discussed and considered as a serious option. In many European countries as well as in Australia the use of cannabis is not a crime, or is to be judged less severely than the use of other drugs. Belgium and Switzerland are expected to introduce legal rules similar to those already in force in Holland.

Harm Reduction and Drug Policy in Hungary

In Hungary the expression “harm reduction” is surrounded by misunderstandings and prejudices. The response to the dug problem is defined by the Penal Code, threatening consumers with severe sanctions. In 1998, a modification to previous legislation made rules on drug consumption stricter even than they had been before. The law presently in force punishes occasional drug consumers more severely than drug addicts, depriving the occasional juvenile marijuana user of the choice of drug outpatient treatment and counselling as alternatives to prosecution. The National Drug Strategy, a scheme designed to address the problem in a comprehensive manner, has been promulgated with considerable delay, one and a half years after the adoption of the new, more restrictive Drug Law. According to the HCLU, the Strategy is at odds with the legal background offered by present legislation. The principles and aims set out in it are more or less sound, but its whole concept is doomed to remain ineffective so long as the criminal law remains the main instrument of reducing demand, which is the case in Hungary as of today, where an occasional young user of marijuana may be punished by a two-year prison sentence.

With the presently existing strict legal background most harm-reduction programs are ineffective for lack of government subsidies or reach out to a very thin stratum of drug users. The methadone program was started in the absence of any legal regulation which led to anomalies, including the objectionable practice followed by doctors sympathetic to and supportive of the program of prescribing semi-illegal medicaments. At last, in 2001, the much needed rules have been issued, and so at present, methadone can be in principle prescribed for drug addicts, yet the proportion of those receiving maintenance treatment is very low, a mere 1,5% of heroine addicts, against a 25% in Slovakia, 15% in the Czech

Republic and over 12% even in Poland. The national health insurance scheme does not support methadone maintenance and the number of clinics in which methadone is prescribed is very low.

A limited number of needle exchange programs are in operation but they are unable to reach potential recipients on a massive enough scale. The situation in the capital city, Budapest, a city of a population of two million, is typical, there being one needle exchange place with limited opening hours to cater to the needs of several thousands of intravenous drug users, not to speak of the complete lack of mobile or street needle exchange facilities for a long time now. On the other hand, if we think of other methods of harm-reduction drug policies practised and established in other countries, the introduction of which in Hungary in the near future is inconceivable, the mere existence of methadone and needle exchange programs cannot be underestimated. The role assigned by the present government to harm-reduction drug policies is illustrated by the 2001 Report of the Ministry in charge of the drug problem. Devoted to an analysis of the experiences of a year under the stricter legal rules on drugs, the chapter entitled "Harm Reduction in Hungary" ran to a little less than two pages in the 180-page Report. Earlier Reports are no different in this respect.

What are the main aims of HCLU in the area of harm-reduction drug policies in Hungary?

- The methods and advantages of harm-reduction drug policy should receive greater publicity in order to reduce misconceptions and prejudices about them;
- the government should direct a substantially greater part of funds available for dealing with drug problem to the treatment and rehabilitation of drug patients than at present;
- a great many more patients addicted to heroine should be involved in maintenance treatment;
- the government should address harm-reduction methods such as needle exchange programs as worthy of support rather than of mere toleration;
- genuine social and professional dialogue about the softening of drug legislation and the decriminalisation of drug consumption should be started;
- scientifically tested and internationally accepted results should be taken into consideration, and well tested programs with good results should be adopted in Hungary;
- Hungary should recognise the achievement of countries which have integrated harm reduction into their drug policy and have shown that drug policy has serious chances of success in the long run if it sets realistic targets, focuses on the genuine interests of public health, relies on well established scientific results, and pays respect to the principles of human rights.