For the final few minutes I would like to give some thought to whether there are possible easy gains. Some of the responses we may wish to consider stand as opportunities for reducing harm at no cost. In this consideration, cost is not being considered as a financial cost but a cost in terms of other harms accrued. Let us look at some examples of uncontroversial harm reduction measures which perhaps we overlook because they are not revolutionary enough.

For my vote, the most revolutionary revolutions are those which bring about fundamental alterations in key aspects of our lives, without necessarily evoking impassioned opposition from sections of the population. For a local example, what about the designated driver programme promoted by our hosts, the Alcohol and Drug Foundation, for example. With a mixture of carrot and stick, they invite bars and hotels to participate in a voluntary scheme in which the bouncer approaches a group of lads in a drinking party, for example, and suggests that they should decide, with that motivational interviewing style, for which bouncers are renowned, that they should decide at this early stage in the evening, which of them would be driving for the rest of the evening and then the management of the establishment provide free non-alcoholic drinks to this designated driver.
Or what about the addition of vitamin supplements, such as thiamine to alcohol beverages, as has been proposed now for some years but for which there has never quite been a sufficient push for the idea to be translated into practice. Or what about the provision of hepatitis B immunisation to injecting drug users who are so far uninfected. In the UK 50% of injecting drug users in many cities have still not been infected with hepatitis B, which is an entirely preventable disease with a significant both morbidity and mortality.

From the point of view of harm reduction, the case for such interventions seems incontestable. They stand as examples of virtually all benefit and virtually no cost. These surely stand as excellent vanguard projects for a harm reduction movement.

**And if your heart is just not into such obvious but uncontroversial harm reduction measures, then why not give some thought to the idea of distribution of supplies of naloxone, the opiate antagonist, to opiate users who may at some later date be able to give a life-saving injection of naloxone to a fellow opiate-user who has inadvertently overdosed.**

So why do we not concentrate on these ideas? They may be less glamorous but they offer the prospect of very real benefit for large numbers of drug users at low cost. Whether in a clinical, policy or political setting, the advocate of harm reduction practices would be more assured of winning the case when arguing for such straightforward harm reduction initiatives, and such initial successes may then set the tone for subsequent more difficult considerations.

Thus it is disappointing to see the limited extent to which these more clear-cut benefits of harm reduction have not been achieved, and it is particularly disappointing to see the low level of advocacy for such incontestable developments. What irony, the advocate of harm reduction often overlooks
these obvious proposals and chooses instead to invite opposition to proposals which are seen as more controversial.

Let me conclude.

We are probably all members of the crew who sail under the flag of harm reduction, but we must now move from just believing in the flag. I shall summarise with three particular points.

Firstly, the lack of a clear set of concepts and definitions of harm reduction is likely to stand as a distinct problem in the development of this area of policy and practice. Notwithstanding the existence of impassioned and sometimes articulate advocates, for this different perspective on drug taking, the lack of what I understand is termed as a legitimising ideology, will stand as an obstacle to the longer term development of harm reduction as a credible, and perhaps dominant, perspective on drug use, and hence it will stand in the way of its incorporation into strategies of practice, research and training at the levels of both personal and public health policy. In particular, if we are serious in our intention to promote policy and practice, which leads to reductions in harm, we need to be clear about which harms are being considered and perhaps what framework is required to explore the various dimensions of harm. For example, could we not develop measurements along these dimensions, and measurements that were friendly enough to be routinely applied in your and my clinical and policy practise.

Secondly, we need to be clearer about the central identity of the harm reduction movement. What about forging links with other lobbying or advocacy groups in the drugs field? Acceptable it may be to form alliances with those who hold other views, but this can only be on a conditional basis, subject to evidence that is at least indicative that the proposed associated approach does indeed reduce harm, and probably still reduces harm even
when considered across populations and over time. I have no problem with including either legalisation or prohibition or any proposal in between, with my preferred strategy for harm reduction, once I am satisfied that the proposed approach does indeed reduce harm. Indeed, if I am to take the policy and practice of harm reduction seriously, then I have no choice but to be driven by the evidence which will become available in the future on the efficacy of these different approaches as harm reduction strategies.

And thirdly, and finally, I hope that we all move forward with action on some of the more easily implementable, and less controversial, proposals for harm reduction. For example, should we not all go back to our workplaces with a determination to make hepatitis B testing and vaccination universally available, and without any requirement for the clients necessarily to enrol in our own favourite programme?

Xxxxxx
Xxxxxx

John Strang, March 1992