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Tough on drugs, soft on evidence?

A commentary on the implications for research and service delivery of the Australian federal government approach to drug policy

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The return of the conservative Liberal Government in Australia at the 2004 federal election brought with it a renewed commitment to the 'Tough on Drugs' policy rhetoric that was introduced by the same administration in 1997. Alongside the Tough on Drugs approach, at both state and federal levels, was also explicit commitment to harm minimisation in drug, hepatitis C and HIV strategies.

The Consortium for Social and Policy Research on HIV, Hepatitis and Related Diseases convened a workshop in Sydney in November 2004 to examine the dichotomy between an official Australian Government strategy based on harm minimisation principles and a Tough on Drugs approach promoted by the same conservative national government. An aim of the workshop was to examine the impact on research, policy and service delivery of working within these contradictory paradigms. The workshop brought together drug user organisations, hepatitis councils, researchers, clinicians, individuals who used or injected drugs, and people who worked in service delivery and public policy. The following commentary examines some of the main themes that emerged from the workshop and focuses on the successes of harm reduction strategies in the current political context.

In 1985 Australian governments made a commitment to a harm minimisation approach to address the HIV epidemic. More recently, 'harm reduction' is one of three elements of a broadened harm minimisation philosophy that underpins health strategies in the illicit drugs and blood-borne virus area.[1] The other two elements of harm minimisation are 'supply reduction' and 'demand reduction'. Although the National Drug Strategy argues for a 'balance' between the three elements of harm minimisation, a Tough on Drugs approach is characterised by a high investment in supply reduction (e.g. law enforcement) with relatively few funds directed to either of the other domains.[2]

A recent report has quantified the success of the harm reduction approach in Australia in terms of lives and money saved by averting deaths from HIV and hepatitis C.[3] However, the commitment to a popularist Tough on Drugs approach in Australia, akin to the decades-long 'War on Drugs' mounted by the USA[4], has been increasingly promoted since 1997 by the conservative federal government. The march of approaches to drug issues steeped in the metaphor of combat is not only a phenomenon in Australia and the USA; such approaches to drug issues influence drug policies, and community reactions to other approaches, all over the world. The United Nations' position is dominated by the prohibitionist policies of the USA[5, 6], and UN drug programs are funded by the USA. The safer injecting facility recently opened in Vancouver, Canada, was criticised by the United States' Office of National Drug Control Policy, which suggested that the facility would increase HIV transmission and lead to a migration of injectors to Vancouver. This criticism generated significant negative coverage in the local media.[7] Although the United Nations International Narcotics Control Board has stated that programs to prevent HIV among injecting drug users are not inconsistent with major international drug treaties, some countries may be of the view that implementing harm reduction programs may contravene these policies.[8] In an Australian example, the Medically Supervised Injecting Centre in Sydney was singled out from other injecting centres by the International Narcotics Control Board, which advocated the closure of the facility.[9]

With the recent re-election of the conservative government in Australia, we believed it timely to examine the tensions between the national drug policy of harm minimisation and the popularist Tough on Drugs approach. In this workshop we sought to highlight the challenges that such a tension poses to workers in the field and to examine some of the strategies they have found successful in surmounting these challenges. Our aim is to provide direction and inspiration for others facing similar situations in other contexts.

Six main themes emerged from the discussions:

1 The impact of rhetoric on reality

Conflicting opinions were put forward on whether or not stated government policy was reflected in funding and practice at the coalface. While the federal government's rhetoric on drugs has tightened under Tough on Drugs and shifted from 'harm reduction' to 'drug use prevention', significant enhancements in funding have occurred to consolidate some harm reduction services such as needle and syringe programs. This seeming contradiction between rhetoric and reality elicited the question: is it worth fighting the war on harm reduction or can the new rhetoric of 'drug use prevention' incorporate what harm reduction seeks to achieve?

The contrasting view was that erosion of the language of harm reduction has a significant negative impact on the ability of services and organisations to continue or expand their roles in the area or to develop new initiatives in harm reduction. The importance of the language in drug policy was described in the following scenario. By creating confusion around the terms 'harm reduction' and 'harm minimisation', the federal government creates opportunities for policy shifts by stealth. From the confusion, a new framework of 'prevention' emerges. The new policy framework allows de-funding of 'old' programs seen as hangovers from the outdated harm reduction model of service delivery. Programs are seen to have lost priority because of the shift in policy emphasis.

Although the official government policy includes a clear commitment to harm reduction, the view was expressed that the population and the media were largely unaware of this fact and of the nuances of the philosophies of harm reduction and harm minimisation. The popular dis-ease about illicit drug use feeds the success of the simplistic Tough on Drugs rhetoric and promotes abstinence as the dominant discourse of service delivery and community expectation in the illicit drug sector.

2 The partnership approach in the response to blood-borne viruses

The partnership approach to HIV prevention in Australia has been recognised as one of the pillars of the successful response to the epidemic.[10] The main partners in the response to HIV were the affected community, researchers, government and the health care sector. The same model has been applied to the hepatitis C strategies for Australia and NSW. This 'cut and paste' approach to strategic development disregards the very significant differences between the main communities affected by the two diseases.[11, 12] Those affected by hepatitis C are mainly people who have ever injected drugs, and there is a major barrier to their successful mobilisation for political and social impact—the ongoing illegality of the one element of their collective identity. An expectation of active engagement in partnership does not take into account the cost to the affected communities of speaking up or being involved. Besides the one shared behaviour of having ever injected, there is little that could be seen to constitute a 'community' affected by hepatitis C. In the case of HIV, the partnership model has been supported by substantial funding to community-based organisations. Hepatitis C organisations, on the other hand, receive comparatively low funding, and minimal funding is earmarked to support implementation of hepatitis C policy initiatives. A Tough on Drugs policy framework, it was argued, works against the involvement of affected communities in strategic and service delivery responses.

3 Strategies to deal with challenges

A main aim of the workshop was to explore the pragmatic and innovative ways in which the communities affected by hepatitis C have worked in an environment of seemingly conflicting policy viewpoints to successfully deal with these challenges.

One speaker described her ongoing struggle to explain, justify and celebrate the success of harm reduction services. In discussing the issue of disposal of injecting equipment,

she had been asked why needles and syringes distributed by programs did not have inbuilt global positioning or barcode technology so that the movements of drug users could be traced. Her response to this was to manoeuvre herself onto as many committees as possible so that she could be a consistent and positive advocate for harm reduction and affected communities.

There were a number of allusions throughout the workshop to the attribute of 'rat cunning', the ability to effectively read the mood of the community and political representatives to best optimise the pursuit of one's own agenda. This attribute was not generally acknowledged or rewarded within services, research institutions and community-based organisations. There was some suggestion that people working in the field could benefit from skills development or assistance in this area to counter the perceived community fear of illicit drugs and the people who use them.

Although partnerships in some contexts can be costly to those involved, encouraging partnerships between different government service delivery agencies was seen as a fruitful strategy. For example, closer relationships between the 'alcohol and other drug' agencies and the needle and syringe programs could create a 'coalition' to counter claims made by Tough on Drugs aficionados and to encourage the formulation of evidence-based drug policy.

A strategy adopted by one agency was to commission a community survey to explore the level of community opposition to a new initiative of the service. This allowed the agency to counter the views expressed (views driven by anecdote and personal agendas) of alleged widespread community opposition. Again, a partnership was central to the success of this strategy, with the service delivery agency and a research centre working together to produce targeted and timely results to assist in advocacy for the new service.

4 Attribution of the success of programs

To obtain funding under the Tough on Drugs approach, services are required to have a primary focus on drug use prevention, rather than on the reduction of harms associated with drug use. It was suggested that, as a result, some services have included the language of prevention in their applications for funding, but have carried on providing much the same harm reduction services that they have always provided. This has meant that, when evaluating the success of such programs, success is now credited to the drug use prevention model, rather than to the harm reduction approach.

5 The need to better promote both the evidence for harm reduction, and its success

Speakers suggested that all participants in the sector needed to be better skilled at promoting the evidence that supports the harm reduction approach to service provision. Although some sections of the general population were painted as 'data proof', evidence that harm reduction decreases crime and costs to society may be more persuasive in generating public and policy support than focusing on other outcomes such as the incremental improvements to the health of people who use illicit drugs.

To that end, the recent Return on Investment report provides overwhelming evidence for the economic advantage of harm reduction services such as needle and syringe programs in Australia.[3] The report documents that between 1988 and 2000, as a result of the introduction of needle and syringe programs, 25 000 HIV infections and 21 000 hepatitis C infections were prevented among people who injected drugs. Consequently, the report estimates that 90 hepatitis-C-related deaths and 4500 HIV-related deaths would have been prevented by 2010. This translates into cost savings of up to $783 million for hepatitis C treatment and up to $7025 million for HIV treatment. The estimated cost of needle and syringe programs to Australian governments between 1991 and 2000 was $150 million. European estimates also point to the potentially very significant costs of hepatitis C to the health care system, with 0.23% of the 2003 expenditure on health care in the European Union accounted for by hepatitis C infection related to drug use.[13]

It was proposed that the economic priorities of conservative governments will eventually lead to support for harm reduction services, which can show successful cost-benefit outcomes, over other strategies which cannot demonstrate their economic viability. The other components of harm minimisation (demand reduction and supply reduction) do not have such a weight of evidence behind them to demonstrate their effectiveness, yet currently have easy popular appeal. For example, an editorial in the *Lancet* estimated that the USA has spent billions of dollars on programs under Tough on Drugs, the outcomes of which are of questionable effectiveness.[4] Garnering community support for harm reduction services by putting forward the strong evidence that they are successful may go some way to inoculating these services against negative community responses to adverse incidents.

However, not all publicity is good publicity. Strike and colleagues argue that increasing the visibility of a service may also jeopardise it by increasing the potential for opposition to it on moral grounds[14]; community members may discount scientific evidence if they perceive that a health hazard has personal implications. Is it better to keep quiet in response to community protest, not try to advocate publicly for the service, and be prepared to sacrifice one service to protect the continued operations of all other services? In other words, is it better to guard against the closure of more services by allowing any adverse incident to be attributed to the operation of one centre than risk the possibility of public outcry extending to other facilities because of the shared approach to harm reduction services operating across the city, state and country?

6 Whole of government response

Numerous interdepartmental committees currently oversee the development, implementation and monitoring of the national drug strategy. Although this is administratively cumbersome, it does allow for a 'portfolio approach' in which some interventions ignored by individuals, because they are not in their area of interest, are picked up by others. However, the political machine has shifted the advice-giving bureaucracy into a 'responsive' mode, rather than allowing it to provide 'frank and fearless' counsel. The policy community, however, was seen as a resource to counter this. This community includes the various sections of government involved in the 'joined-up thinking' around drugs, researchers, service providers, the non-government sector and the communities affected by illicit drug use and associated harms.[15] The move towards Tough on Drugs, however, has a negative impact on the ability of some of these communities to participate in policy debate. Those who use drugs, or have information about drug use, are vulnerable in this political climate.

Conclusion

In this short commentary we have examined some of the impossible contradictions of current Australian drug policy. A Tough on Drugs approach conjures political and popular support but ignores the strong evidence that harm reduction is a valuable component of harm minimisation.

The differing positions of the speakers reflected, perhaps, their places within the political landscape. Those working within the system were optimistic that the impossible contradictions of Tough on Drugs forced a sensible stance in practice. Those most affected, personally and organisationally, by the Tough on Drugs policy voiced their concerns over whether harm reduction programs could continue to exist. Others suggested ways in which they had worked the system to their favour to effectively advocate for harm reduction programs.

We hope that by publicising the issues raised in this workshop we can contribute to the debate and provide some direction for those committed to harm reduction, without generating a backlash of unwanted attention for vulnerable services.

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