

## **CAMH and Harm Reduction: A Background Paper on its Meaning and Application for Substance Use Issues**

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### **Introduction:**

When the ad hoc committee on harm reduction was formed and asked to prepare a document setting out "the CAMH approach to harm reduction," what the members had in common was many years of thought and application of this concept in their own work. The diverse composition of this committee reflected every major area of CAMH's endeavours, ensuring that the perspectives of the wider addictions community would also be incorporated. While we explored many facets of harm reduction, and reached consensus in the points presented herein, we do not claim that this is a universal, all encompassing portrayal of harm reduction. It is far too dynamic and broadly applied a concept to be easily pinned down to a "one-size-fits-all" definition that would satisfy all practitioners; nor do we believe that would be desirable. What we sought is a workable explication of harm reduction to guide CAMH's diverse activities in preventing and responding to addiction problems.

There are a number of different, established interventions in the field of addictions in a spectrum that ranges from prevention through treatment and from programs that require complete abstinence to harm reduction approaches that accept ongoing use. Harm reduction is grounded in the empirical knowledge of a continuum of drug use, where harm may occur at any level. The extent of use, or use itself, is not the issue. The primary focus of harm reduction is on people who are already experiencing some harm due to their substance use. The most appropriate interventions, whether macro or micro, are those geared to movement from more to less harm. Thus, the definition of harm reduction is "Harm reduction is any policy or program designed to reduce drug-related harm without requiring the cessation of drug use. Interventions may be targeted at the individual, the family, community or society." Examples of proven harm reduction programs are: server intervention programs which decrease public drunkenness; needle and syringe exchange programs which prevent the transmission of HIV among injection drug users; and, environmental controls on tobacco smoking which limit the exposure to second hand smoke (Gliksman et al., 1993; OTRU, 2001; Strathdee et al., 1998). In the general population, harm reduction may help to focus efforts where real harm potential lies and guide scarce prevention resources there rather than to areas of less serious risk.

Having said this, not all interventions that aspire to minimize the adverse consequences of substance use are automatically harm reduction (Berridge, 1993). Harm reduction strategies may be considered the best alternative for those persons for whom treatment, prevention or criminal sanctions have not been effective.

The origins of harm reduction lie in the more than a century old public health movement aimed at protecting the entire community from harm. From the 1960's onwards there was growing awareness that the adverse effects of the widely used licit drugs could not be addressed solely at the individual consumer level, but required a broader societal response. By the late 1980's, the concepts and tools of public health, sharpened on alcohol and tobacco, began to appear in discussions about illicit drug problems. The growing crisis of hepatitis and HIV infection among injection drug users in many countries, and the more general threat posed to the community at large, provided the impetus for a new emphasis on interventions geared to limiting harm rather than stopping use (Riley & O'Hare, 2000). The modern harm reduction movement, launched at the first international conference in Liverpool in 1990 (O'Hare et al., 1992), saw the theory and practice of harm reduction evolve to provide a more integrated public health perspective in the ensuing decade. Canada's Drug Strategy declared harm reduction to be its overall aim, and the US National Association for Public Health Policy, the Canadian Centre on Substance Abuse and the World Health Organization endorsed the principles of harm reduction in key documents (NAPHP, 1999; CCSA, 1998; WHO, 1999).

A major challenge in applying a public health approach in addictions is the negative moral evaluation, or stigma, attached to those who appear to lack control over their drug use. This assessment is amplified when the behaviour is also illegal. This aspect introduces confusion over what harm reduction actually refers to, as well as controversy over the implications of different versions - what programs or policies qualify? who decides which harms are the most important? can harms be reduced without the unintended consequences of creating worse ones? does harm reduction advocate a particular legal policy? what balance can be found between individual autonomy and community protection? is harm reduction applicable to non-drug areas? do harm reduction programs remove incentives to seek treatment (Single, 1995)?

Our purpose in this paper is to define the concept of harm reduction and set out its principles or core elements as they relate to the mandate and activities of CAMH. We will provide illustrations of its practice in relation to other activities in treatment, prevention and enforcement, and identify areas where research evidence is substantial and where more needs to be done. We focus on the substantive areas of alcohol, tobacco, and illicit drugs while recognizing its relevance to some aspects of concurrent disorders within mental health treatment.

## **I. Definition**

While there has been debate in the harm reduction literature about the limits to which this term is applied (Strang, 1993), most sources would agree with the core aspect of this

definition: "Harm reduction is any program or policy designed to reduce drug-related harm without requiring the cessation of drug use." This separates harm reduction clearly from zero tolerance approaches to drug use. Further, while urgency may have directed many programs thus far at drug users who are currently experiencing harm, harm reduction is applied at all levels and all stages of use: "Interventions may be targeted at the individual, the family, community or society." While other refinements of the definition emphasize the pragmatic and proven requirements of effective harm reduction (Single, 1999), we consider that these ingredients constitute the guiding principles of harm reduction outlined below. Those who have been instrumental in developing the theory and practice of harm reduction generally adhere to this basic definition and underlying themes (Heather et al., 1993), but as in any dynamic movement, there are ongoing debates about priorities, terms and different program and policy options.

Empirical assessments have always been central to public health, and to harm reduction (Ogbourne & Birchmore-Timmey, 1999), though core values also play a crucial role. In an organization like CAMH, committed to evidence-based best practice, it is reasonable to require that harm reduction programs and policies must demonstrate that they have the desired impact without producing unacceptable unintended consequences. If its evaluation reveals no support for the reduction of specified adverse consequences, or shows the unintended consequences are too serious, the program should not be considered part of a harm reduction approach and other alternatives should be developed. This may seem like stating the obvious, but in fact most criminal justice based interventions against illicit drug use are costly, have no supporting evidence of effectiveness and can be shown to augment harm to health and social functioning (Inciardi & Harrison, 2000; Single, 1998). The evidence available in support of various strategies differs widely depending on the status of research funding and the current priorities of funding agencies. Depending on the intervention under consideration the approach to evaluation may range from randomized clinical trials to other methods of social impact analysis (Fischer et al., in press; Heather et al., 1995; Krausz et al., 1999).

A central tenet of harm reduction that is compatible with CAMH's mission and client-centered philosophy is the respect for individual decision-making and responsibility (Cheung, 2000; Marlatt et al., 2001). This is also a key aspect that distinguishes harm reduction from criminal justice interventions, which augment stigma and impose punishment as an undifferentiated response to any level of use (Killias & Rabasa, 1997).

## **II. Harm Reduction in Relation to Treatment, Prevention and Enforcement**

Harm reduction is incorporated into a wide range of programs for early and late stage problem users of various substances. At the individual level, harm reduction policies and programs are offered to those not willing or able to cease their drug use in the short-run; however, this philosophy remains compatible with an eventual goal of abstinence. Programs requiring abstinence as an immediate goal cannot be considered harm reduction. Though not all clinicians agree with this approach, particularly when the client may be ready to accept abstinence, the clinicians who do practice harm reduction take a

neutral, non-judgmental stance when treating a user "not ready to quit." These clinicians may still, however, hold views on the benefits of non-use and view it as a desirable long-term goal.

It is useful to think of a continuum of prevention efforts, geared to level of use, personal and social characteristics of drug consumers, and potential for harm. The most basic form of prevention, stopping the problem before it happens, may be better thought of as total risk reduction rather than harm reduction. Much of what is considered prevention in harm reduction involves reducing harms to high-risk users by providing greater access to services and safer ways to use drugs. Basically, harm reduction education as a form of prevention emphasizes informed consumers and wiser personal habits - persuasion over coercion - rather akin to health promotion.

Prevention may also target the communities in which the drug users congregate, through initiatives to reduce disorder on the streets and fear of victimization among the public. When evidence of serious negative outcomes, as has been well illustrated by the health impacts of smoking, points to non-use as the most desirable way to reduce harm, some prevention efforts may be targeted differently at smokers and non-smokers. However, in some settings such as raves, it is not possible to know who is using drugs and who isn't, so harm reduction initiatives may target all those attending. Universal education messages are a general feature of a public health approach to alcohol and tobacco use and other possibly detrimental "lifestyle" choices.

Harm reduction is not synonymous with legalization, and in adopting a harm reduction philosophy CAMH is not expressing support for legalization (CAMH, 2000). Harm reduction recognizes a balance between control and compassion within a framework of respect for individual rights. However, drug policy reform that is compatible with harm reduction initiatives has already been determined as worthy of support by CAMH (e.g. its official endorsement of the development of an evidence based cannabis policy, to replace the present reliance on criminalization of possession).

Enforcement of criminal or regulatory laws may also be directed at reducing harm (Erickson, 2001; Hellowell, 1995). Although cannabis, cocaine and opiates are governed by Canadian criminal law while the provinces regulate alcohol and tobacco, some overlap can occur when drug consumption is combined with a risky activity (e.g. impaired driving). Public health perspectives have a greater affinity for regulatory laws over criminal sanctions. In public health, laws are not moral absolutes, but are instruments that are used to set standards and achieve health objectives for individuals, communities and society. In deciding between criminal and regulatory law, a harm reduction stance asks for proof of what policy components are most effective for reducing specific drug-related harms. Punitive sanctions would then be reserved for those drug use behaviours that pose a threat to the safety or well being of others, such as smoking in offices, selling to minors or providing a contaminated product. Public health regulation generally provides more flexibility than criminal law in fitting the solution to the problem.

### **Confusion over similar terms:**

The lack of an accepted standard definition of harm reduction partly stems from the multiple terms that are used somewhat interchangeably with harm reduction: "risk reduction", "harm minimization", and "risk minimization". The confusion over definitions also leads some individuals to propose that any drug policy or program designed to have an impact on harm is therefore harm reduction. This is not the case; the definition stated above clearly distinguished harm reduction from other drug use-related interventions imposing abstinence or imprisonment. We prefer to adhere to the term "harm reduction" and avoid the others noted above.

What is unique about harm reduction, in contrast to abstinence-based and criminal justice models, is that it is more use-tolerant and seeks to reduce the stigma associated with substance use. Some consensus has been reached on the following guiding principles, articulated by many writing about the theory and practice of harm reduction. These general principles may be applied to a number of other areas in public health, including gambling. It is their application to substance use that identify them as harm reduction from our perspective.

### **III. Guiding Principles or Underlying Themes of Harm Reduction**

#### **Pragmatism**

Harm reduction accepts that some use of mind-altering substances is inevitable, and that some level of drug use in society is normal, though this assessment varies considerably by country and cultural values. It also recognizes the considerable research evidence that experimental and controlled use is the norm for most of those who try any substance with abuse potential. Harm reduction seeks to reduce the more immediate and tangible harms of substance use rather than embrace a vague, abstract goal related to some future ideal like a drug free society. Just as the ongoing debate on cannabis control policy is at odds with the evidence that cannabis use has become endemic and unlikely to decline significantly, so harm reduction emphasizes reducing the harms of criminalization and living with a certain level of use in society.

#### **Focus on Harms**

The focus of harm reduction policy and programs is the reduction of harmful consequences without necessarily requiring any reduction in use, since a change in mode of administration or pattern of use may also reduce harm. Although a lower prevalence of drug use is not the goal of harm reduction, it may be an outcome that helps reduce harms. These harms may be related to health, social, or economic factors that affect the individual, community and society as a whole. The building of community social capital may also help to reduce the vulnerability of certain populations to the most destructive forms of substance use.

### **Prioritization of goals**

Harm reduction strategies prioritize each individual's goals with an emphasis on an immediate and realizable reduction in drug-related harm rather than hoped for long-term outcomes. Some users' eventual goal may be abstinence, but they are not required to be drug-free from the outset. Although the goals of community and individual improvement may sometimes appear to conflict, the attempt to reconcile them is very different from victim blaming and punishment of individual users. Harm reduction also recognizes the central role of the consumer in determining the extent and nature of health care services.

### **Flexibility and maximization of intervention options**

Harm reduction initiatives are flexible in design that allow for human variation and the re-evaluation of individual set goals. The reduction of drug-related harm involves a holistic approach, creativity and innovation. Harm reduction initiatives should provide a maximum range of options for users, front line workers, law enforcement officers and others dealing with drug-related problems. For example, police can have the option of diverting users to alternative community-based measures; physicians can offer a variety of treatment options such as drug substitution, drug maintenance and interventions that adopt safer methods of use.

### **Autonomy**

Given some level of drug use in society is accepted as normal, the drug user's decision to use is also acknowledged as a personal choice, for which they take responsibility. Since the use of drugs is not intrinsically immoral, sick, or criminal, drug users are not stigmatized as deviants, since "drug users are people too." The user is as an active rather than passive entity, illustrated by the fact that many harm reduction programs have originated with drug users themselves. Reintegration is emphasized over social exclusion. This has been expressed eloquently by the Aboriginal Community: "The philosophy of harm reduction encourages us to reach those outside of the circle and welcome them back in...[we] recognize that everyone in the circle is affected and thus has a responsibility to make this circle whole." (Aboriginal Peer Project, 2000)

### **Evaluation**

In practice harm reduction initiatives must reduce drug-related harm and priority must be given to those policies and programs that demonstrate their effectiveness within the limits imposed by available resources. Innovation and creativity must be encouraged within a harm reduction philosophy but it is also imperative that evaluation of existing programs be conducted. Current and future programs and policies should have clearly stated mission statements, goals and an identification of what "harms" are being addressed so that thorough evaluations of their effectiveness can be conducted. Both the health and functioning of the individual and the net impact on harm indicators in the community are important indicators of the success of harm reduction.

#### **IV Evidence, Needs and Future Directions**

This section provides some illustrations of how harm reduction has been utilized, and with what results, in several areas of CAMH's work. As well, we will indicate some areas in which we believe more research is needed, plus some new topics that could be pursued within a harm reduction mandate. An extensive bibliography covering general and major topic areas follows.

While many people think of harm reduction initiatives in relation to controversial proposals such as that for safe injection rooms, many well established programs in the alcohol area take harm reduction for granted. ARF, and now CAMH, have undertaken a number of individual, community and broader policy programs directed at "identifying those circumstances in which harm occurs and acting to reduce those harms." Underlying them is the respect for individual choice that recognizes that most persons consume alcohol responsibly and derive benefits from doing so. Some initiatives, including impaired driving laws and their enforcement, alcohol control policies which focus on availability and cost, server intervention and graduated licensing programs, have been extensively evaluated over some years (Bondy et al., 1999; Mann et al., 2001; Narbonne-Fortin et al., 1997). Other newer ones, such as "Safer Bars," are being examined as a way to reduce violence in public drinking establishments. Others like "First Contact" try to reduce consumption, targeting youth as new drinkers who may experience increased risk even at lower levels of consumption. While many people working in the alcohol field may not have identified their activities as harm reduction a decade or two ago, now there is a considerable literature around alcohol and harm reduction (Single, 1997).

Like other drugs, tobacco does not lend itself to "absolutely safe" levels of use or circumstances. The reality of its legal availability means that reducing some of the risks of use both for those smokers who will not or cannot quit, and for those in their vicinity, is a quest for harm reduction. Much of past ARF and OTRU research has monitored changes in consumption, especially among the younger cohorts, and led to policy recommendations for higher prices and less attractive advertising. Some initiatives like nicotine gum and patches could lead to significant harm reduction, but have not as yet been shown to appeal to substantial numbers of smokers. The reasons for this and ways to improve their utilization could be important new research directions in harm reduction for tobacco (IOM, 2001).

Many initiatives in the community, by CAMH staff and stakeholders, have covered the whole gamut of substances and diverse target populations. Certainly the increased availability of methadone, particularly at the low threshold level, has been a long-standing and successful harm reduction program in which CAMH has been a major player (Fischer, 2000; Brands et al., 2000). The real possibility now of other forms of opiate substitution trials in Canada builds on its successes (Kuo, 2000). The research on HIV transmission among injection drug users in Toronto and the province tends to have fallen more to the Public Health Sciences Department at U of T, though often with collaborators at CAMH. Ongoing evaluation of needle and syringe exchange, at both the client and agency levels, is crucial in order to improve the system and also to understand

the users' reasons for compliance and non-compliance. The support given to groups aimed at creating safer rave venues is also noteworthy, but in need of more evaluation (Weber, 1999). Although a substantial body of research on cocaine and crack use has been done by CAMH researchers (Erickson et al., 1994), little progress towards harm reduction for this substance has been accomplished to date. Community based initiatives like the "crack kit" is one recent proposal that shows promise but has not yet been evaluated. One point emphasized in our group is that CAMH staff often have the opportunity to partner with community contacts to develop harm reduction tools, but finding the resources to also provide evidence of effectiveness can be difficult. Hence, many possible strategies go unevaluated and "lost" to the larger community of harm reduction.

The treatment of substance use disorders is a vast area that encompasses many established and new approaches (Skinner & Drake, 1997). The distinctive contribution harm reduction makes is in its commitment to a client-centred "therapeutic alliance." The therapeutic alliance is an agreement between a client and their clinician about the treatment approach to be taken based on the expressed needs and desires of the client.) Grounded in the knowledge that their very relationship has the power to facilitate positive change, the health care professional accepts that the client may make less than optimal choices for their health in the short term. Yet by respecting these choices and being available to deal with their consequences, the therapist intentionally strengthens the therapeutic alliance. Rather than seeing this as enabling the client to keep harming himself, the therapist understands that he or she cannot realistically prevent a client from making particular choices at the given moment. But by keeping the door open and helping to ameliorate adverse consequences when they occur, the clinician can strengthen the motivation of the client to behave in a less harmful way, and facilitate their engagement in further treatment when the client is ready to move closer to a less harmful pattern of use or abstinence.

From a more general addiction treatment perspective, harm reduction oriented programs have for some time offered the client goal choice, from abstinence, to the reduction in use of their primary drug, to abstinence from their primary drug but continued use of other drugs. The relapse policy has been that a single lapse, several occasions of use, or a return to more regular use is not regarded as a reason to exclude or discharge a client from treatment. The review of treatment goals is therefore ongoing between client and therapist.

Although harm reduction is implicit in much of the practice in mental health, it is not a generally used term in the field. However, it does have some direct applicability in the area of concurrent disorders. Clearly a significant proportion of mentally ill individuals consume alcohol and other drugs for a variety of reasons, but this is an area in need of further elaboration and research. Since many in this co-morbid population are poor, homeless, under-housed and otherwise marginalized, this is an area that touches on the broader potential of harm reduction as a response to the inequities of health and social policy.

A considerable amount of past ARF and current CAMH research has focused on illicit drugs and the role and impact of the criminal justice system. Given that one of the serious harms of cannabis use is the potential acquisition of a life-long criminal record, evaluating its impact on cannabis offenders has been an important component in supporting the case for the modification of penalties and the elimination of the offence for possession (Erickson, 1980). The scope of research gaps and opportunities remains large. Any new legal measures introduced by the federal government could continue the CAMH tradition of socio-legal evaluation of drug policy. Recommending harm reduction strategies for cannabis that might be accepted by users would require research on its long-term health impacts. Drug treatment court as an initiative to keep seriously dependent users out of prison, provide treatment, and help to integrate them back into the community needs to be further evaluated (LaPrairie et al., in press). The implementation and evaluation of harm reduction strategies for drug use in prison is another area of concern to be pursued. The issue of inmates who are denied methadone treatment, regularly use contaminated injection equipment and expose themselves and others to diseases is too serious to be ignored.

## **V. Conclusion**

Harm reduction is thriving in its second decade of diffusion and widespread application, and is integral to numerous programs at the Centre for Addiction and Mental Health. In the field, greater consensus is emerging on the boundaries of the concept and the behaviours to which it may legitimately be applied. Nevertheless, we recognize the limitations of harm reduction and do not expect it to be all things to all people. In our commitment to client-centred care, harm reduction remains but one approach in a broader spectrum that also embraces programs with an abstinence-based philosophy.

While our primary task is to inform the CAMH audience, provoke discussion, and build consensus on how we use the term within our own organization, we also hope that the community at large will be prompted to engage us in further dialogue.

Although there is a growing body of empirical evidence endorsing various harm reduction approaches, more research is required on both some of the established, as well as the newer and more controversial interventions whose aim is to reduce the harm associated with alcohol and drug use.

There is evidence that programs that reduce the short and long term harm to substance users benefit the entire community through reduced crime and public disorder, in addition to the benefits that accrue from the inclusion into mainstream life of previously marginalized members of society. The improved health and functioning of individuals and the net impact on harm in the community are notable indicators of the early success of harm reduction. CAMH believes that public policy should be guided by the principles outlined in this paper to support innovative strategies that most effectively respond to the needs of substance users and their communities. CAMH therefore calls on government and other relevant agencies to fund the development, trial, evaluation and implementation

of a full range of harm reduction programs to be included among other proven successful interventions for those with substance use problems.

## **Select Bibliography**

### **General**

Berridge, V. (1993). Harm Minimization and Public Health: An Historical Perspective. In Heather, N., Wodak, A., Nadelmann, E. and O'Hare, P. (Eds.) *Psychoactive Drugs and Harm Reduction: From Faith to Science*. London: Whurr Publishers. pp. 55-64.

Bruneau, J., Eduardo, F., and Lomothe, F. (1997). Addressing Harm Reduction Strategies: The Dilemma of Observational Studies. *American Journal of Epidemiology* 146: 1007-1010.

Canadian Centre on Substance Abuse [CCSA]. (1998). National Working Group on Addictions Policy. *Harm Reduction: Concepts and Practices*, Ottawa: CCSA.

Cheung, Y.W. (2000). Substance Abuse and Developments in Harm Reduction. *Canadian Medical Association Journal* 162(12): 1697-1700.

Erickson, P.G. (1995). Harm Reduction: What it is and is not. *Drug and Alcohol Review* 14(3):283-285.

Erickson, P.G. (1999). (Ed.) Special Issue on Harm Reduction. Introduction: The Three Phases of Harm Reduction. An Examination of Emerging Concepts, Methodologies, and Critiques. *Substance Use & Misuse* 34 (1): 1-7.

Erickson, P.G., Riley, D.M., Cheung, Y.W., and O'Hare, P.A. (Eds.) (1997). *Harm Reduction: A New Direction for Drug Policies and Programs*. University of Toronto Press.

Hathaway, A.D. (2001). Shortcomings of Harm Reduction: Toward a Morally Invested Drug Reform Strategy. *International Journal of Drug Policy* 12(2):125-137.

Heather, N., Wodak, A., Nadelmann, E. and O'Hare, P. (Eds.) (1993). *Psychoactive Drugs and Harm Reduction: From Faith to Science*. London: Whurr Publishers.

Health Canada (1998). *Canada's Drug Strategy*. Ottawa: Minister of Public Works.

Inciardi, J. and Harrison, L. (Eds.) (2000). *Harm Reduction: National and International*

Perspectives. Thousand Oaks: Sage.

Kalant, H. (1999). Differentiating drugs by harm potential: the rational vs. the feasible. *Substance Use & Misuse* 34(1):25-34.

Nadelmann, E.A. (1993). Progressive Legalizers, Progressive Prohibitionists and the Reduction of Drug-Related Harm. In Heather, N., et al. (Eds.) *Psychoactive Drugs and Harm Reduction: From Faith to Science*. London: Whurr Publishers. Pp. 34-45.

National Association for Public Health Policy (1999). A public health approach to mitigating the negative consequences of illicit drug abuse. *Journal of Public Health Policy* 20(3):268-281.

Newcombe, R. (1992). The Reduction of Drug-Related Harm: A Conceptual Framework for Theory, Practice and Research. In O'Hare, P.A., et al. (Eds.). *The Reduction of Drug-Related Harm*. London: Routledge. Pp. 1-14.

Ogborne, A. and Birchmore-Timney, C. (1999). A framework for the evaluation of activities and programs with harm reduction objectives. *Substance Use & Misuse* 34(1):69-82.

O'Hare, P.A., Newcombe, R., Matthews, A., Buning, E.C., and Drucker, E. (Eds.) (1992). *The Reduction of Drug-Related Harm*. London: Routledge.

Riley, D. and O'Hare, P. (2000). Harm Reduction: History, Definition and Practice. In Inciardi, J. and Harrison, L. (Eds.), *Harm Reduction: National and International Perspectives*. 1000 Oaks: Sage. Pp.1-26.

Room, R. (1997). Harm Reduction, Human Rights, and the WHO Expert Committee on Drug Dependence. In Erickson, P.G., et al. (Eds.) *Harm Reduction: A New Direction for Drug Policies and Programs*. Toronto: University of Toronto Press. Pp. 119-130.

Schmoke, K.L. (1995). Medicalizing the War on Drugs. *Academic Medicine* 70(5): 355-358.

Single, E. (1995). Defining Harm Reduction. *Drug and Alcohol Review* 14:287-290.

Single, E. (1999). A Harm Reduction Framework for Drug Policy in British Columbia. A discussion paper prepared for the British Columbia Federal/Provincial Harm Reduction Working Group.

Strang, J. (1993). Drug Use and Harm Reduction: Responding to the Challenge. In: Heather N. (Eds.). *Psychoactive Drugs and Harm Reduction: From Faith to Science*. London: Whurr Publishers. Pp. 3-20.

United Nations International Drug Control Program [UNIDCP] (1997). *World Drug Report*. Oxford University Press.

World Health Organization. (1999). *Health for All in the 21st Century*. WHO: Copenhagen.

Zinberg, N. (1984). *Drug, Set and Setting: the Basis for Controlled Intoxicant Use*. New Haven: Yale University Press.

### **Illicit Opiates**

Bammer, G., Dobler-Mikola, A., Fleming, P., Strang, J., & Uchtenhagen, A. (1999). The heroin prescribing debate: Integrating science and politics. *Science*, 284, 1277-1278.

Battersby, M., Farrell, M., Gossop, M., Robson, P., & Strang, J. (1992). 'Horse trading': prescribing injectable opiates to opiate addicts. A descriptive study. *Drug and Alcohol Review*, 11, 35-42.

deBurger, R. (1997). Heroin substitution in Canada: A necessary public health intervention. *Canadian Journal of Public Health*, 88, 365.

Faupel, C. E. and Klockars, C. B. (1987) Drugs-crime connections: Elaborations from the life histories of hard-core heroin addicts. *Social Problems* 34(1): 54-68.

Fischer, Medved, Kirst, Rehm & Gliksman (2001). Illicit opiates and crime: Results of an untreated user cohort study in Toronto. *Canadian Journal of Criminology*, 43(2), 197-217.

Fischer, B., Medved, W., Gliksman, L., and Rehm, J. (1999) Illicit opiates in Toronto: A profile of current users. *Addiction Research* 7(5): 377-415.

Fischer, B. and Rehm, J. (1997) The case for a heroin substitution treatment trial in Canada. *Canadian Journal of Public Health* 88, 367-370.

Fischer, B., Chin, A., Kuo, I., Kirst, M., & Vlahov, D. (in press). Opiate users' views on methadone and other opiate prescription treatment in Canada: A qualitative focus group study. *Substance Use and Misuse*.

Gillespie, R. W. (1978). Heroin addiction, crime and economic cost: A critical analysis. *Journal of Criminal Justice*, 6, 305-313.

Grapendaal, M., Leuw, E., and Nelen, H. (1992) Drugs and crime in an accommodating social context the situation in Amsterdam. *Contemporary Drug Problems* 19, 303-326.

Hankins, C. & et al. (1997). HIV, AIDS and Injection Drug Use - A National Action Plan Ottawa: Health Canada

Killias, M. and Rabasa, J. (1997) Less crime in the cities through heroin prescription? Preliminary results from the evaluation of the Swiss Heroin Prescription Projects. *The Howard Journal of Criminal Justice* 36(4): 424-429.

Krausz, M., Uchtenhagen, A., & van den Brink, W. (1999). Medically indicated heroin prescription in the treatment of drug addicts: Clinical trials and developments in research in Europe. *Sucht*, 45, 171-186.

Kuo, I., Fischer, B., and Vlahov, D. (2000) Consideration of a North American Heroin-Assisted Trial for the Treatment of Opiate-Dependent Individuals. *International Journal of Drug Policy* 11, 357-370.

Le Dain Commission (1973) Final Report of the Commission of Inquiry into the Non-Medical Use of Drugs. Ottawa: Information Canada.

Nadelmann, E. & McNeely, J. (1996). Doing methadone right. *The Public Interest*, 123, 83-93

Schechter, M., Strathdee, S., Cornelisse, P., Currie, S., Patrick, D., Rekart, M., and O'Shaughnessy, M. V. (1999) Do needle exchange programmes increase the spread of HIV among injection drug users?: An investigation of the Vancouver outbreak. *AIDS* 13, F45-F51.

Strathdee, S., Patrick, D., Currie, S., Cornelisse, P., Rekart, M., Montaner, J., Schechter, M., & O'Shaughnessy, M. (1997). Needle exchange is not enough: lessons from the Vancouver injecting drug use study. *AIDS*, 11, F59-F65.

Strathdee, S. A., van Ameijden, E. J. C., Mesquita, F., Wodak, A., Rana, S., & Vlahov, D. (1998). Can HIV epidemics among injection drug users be prevented? *AIDS*, 12, S71-S79.

Wall, R., Rehm, J., Fischer, B., Brands, B., Gliksman, L., Stewart, J., Medved, W., and Blake, J.

(2001) The social cost of untreated opiate use. *Journal of Urban Health* 77:688-722.

## **Cocaine**

Arganaras, F.C. (1997). Harm reduction at the supply side of the drug war: the case of Bolivia. In Erickson, P.G. et al. (Eds.), *Harm Reduction: A New Direction in Drug Policies and Programs*. Toronto, University of Toronto Press. Pp.99-118.

Bottomley, T., Carnwath, T. Jeacock, J. et al. (1997). Crack cocaine - tailoring services to user need. *Addiction Research* 5:223-234.

Cheung, Y., Erickson, P.G. and Landau, T. (1991). Experience of crack use: findings from a community based sample in Toronto. *Journal of Drug Issues* 21(1):121-140.

Cohen, P. (1997). Crack in the Netherlands: effective drug policy is effective social policy. In Reinarman, C. and Levine, H. (Eds.), *Crack in America*. Berkeley: University of California Press. Pp.214-224.

Erickson, P.G. (1993). The prospects of harm reduction for psychostimulants. In Heather, N. et al. (Eds.), *Psychoactive Drugs and Harm Reduction: From Faith to Science*. London: Whurr. Pp.184-210.

Erickson, P.G., Adlaf, E., Smart, R.G. and Murray, G.F. (1994). *The Steel Drug: Cocaine and Crack in Perspective*, 2nd ed. New York: Lexington Books.

Erickson, P.G., Butters, J. and German, B. (2002). Flexing crack in Toronto: a deviant pathway for poor, homeless drug users. Ashgate (in press).

Erickson, P.G., Butters, J., McGillicuddy, P., and Hallgren, A. (2000). Crack and prostitution: gender, myths and experiences. *Journal of Drug Issues* 30(4):767-788.

Erickson, P.G. and Cheung, Y. (1999). Harm reduction among cocaine users: reflections on individual intervention and community social capital. *International Journal of Drug Policy* 10:235-246.

Erickson, P.G. and Weber, T. (1994). Cocaine careers, control and consequences: results from a Canadian study. *Addiction Research* 2(1):37-50.

Geter, R.S. (1994). Drug user settings: a crack house typology. *International Journal of the Addictions* 29:1015-1027.

Harrison, L. (1994). Cocaine using careers in perspective. *Addiction Research* 2(1):1-20.

Mugford, S. (1997). Crack in Australia. In Reinarman, C. and Levine, H. (Eds.), *Crack in America*. Berkeley: University of California Press. Pp.194-213.

Peele, S. and Degrandpre, R. (1998). Cocaine and the concept of addiction: environmental factors in drug compulsion. *Addiction Research* 6:235-263.

Toneatto, T., Sobell, L. and Sobell, M. (1999). Natural recovery from cocaine dependence. *Psychology of Addictive Behaviours* 13(4):259-268.

Waldorf, D., Reinarman, C. and Murphy, S. (1991). *Cocaine Changes: the experience of using and quitting*. Philadelphia: Temple University Press.

World Health Organization [WHO] (1995). Cocaine Project. Geneva: Program on Substance Abuse.

### **Ecstasy [MDMA, XTC]**

Beck, J. and Rosenbaum, M. (1994). Pursuit of Ecstasy: The MDMA Experience. Albany: SUNY Press.

Fromberg, E. (1992). A harm reduction educational strategy towards Ecstasy. In O'Hare et al. (Eds.), *The Reduction of Drug-Related Harm*. London: Routledge. Pp.146-153.

Kalant, H. (2001). The pharmacology and toxicology of 'ecstasy' (MDMA) and related drugs. *Canadian Medical Association Journal* 165(7):917-928.

McDermott, P., Matthews, A., O'Hare, P. and Bennett, A. (1993). Ecstasy in the United Kingdom: recreational drug use and subcultural change. In Heather, N. et al. (Eds.), *Psychoactive Drugs and Harm Reduction: From Faith to Science*. London: Whurr. Pp. 230-246.

Spruitt, I. (1999). Ecstasy use and policy responses in the Netherlands. *Journal of Drug Issues* 29(3):653-678.

Vastag, B. (2001). Ecstasy experts want realistic messages. *JAMA* 286(7):777.

Weber, T. (1999). Raving in Toronto: peace, love, unity and respect in transition. *Journal of Youth Studies* 2(3):317-336.

Wijngaart, G. van de, Braam, R., de Bruin, D., Fris, M., Maalste, N. and Verbraeck, H. (1997). *Ecstasy and the Dutch Rave Scene*. Utrecht: Centrum voor Verslavingsonderzoek Universiteit Utrecht.

### **Alcohol**

Bondy, S.J., Rehm, J., Ashley, M.J., Walsh, G., Single, E. and Room, R. (1999). Low-risk drinking guidelines: The scientific evidence. *Canadian Journal of Public Health*, 90, 264-270.

Gliksman, L., Douglas, D., Rylett, M. & Narbonne-Fortin, C. (1995). Reducing problems through municipal alcohol policies: The Canadian experiment in Ontario. *Drugs: Education, Prevention & Policy*, 2, 105-118.

Gliksman, L., McKenzie, D., Single, E., Douglas, R., Brunet, S. and Moffatt, K. The Role of Alcohol Providers in Prevention: An Evaluation of a Server Intervention Programme, *Addiction*, 88, pp. 1195-1203, 1993.

Mann, R.E., Stoduto, G., Macdonald, S., Shaikh, A., Bondy, S. and Jonah, B. (2001). The effects of introducing or lowering legal per se blood alcohol limits for driving: An international review. *Accident Analysis and Prevention*, 33, 61-75.

Marlatt, G.A. and Baer, J.S. (1997). Harm reduction and alcohol abuse: a brief intervention for college-student binge drinking. In Erickson, P.G. et al. (Eds.), *Harm Reduction: A New Direction for Drug Policies and Programs*, Toronto, University of Toronto Press. Pp.245-264.

Narbonne-Fortin, C., Lauzon, R., Douglas, R.R. (1997). Reducing Alcohol-Related Harm in Communities: A Policy Paradigm. In Erickson, P.G. et al. (Eds.), *Harm Reduction: A New Direction for Drug Policies and Programs*. Toronto: University of Toronto Press. Pp.228-244.

Plant, M. (1997). Reducing alcohol-related harms: towards a balanced and disaggregated perspective. In Erickson, P.G. et al. (Eds.), *Harm Reduction: A New Director for Drug Policies and Programs*. Toronto: University of Toronto Press. Pp.203-212.

Rush, B.R., & Allen, B. (1997). Attitudes and beliefs of the general public about treatment of alcohol problems. *Canadian Journal of Public Health*, 88, 41-43.

Single, E. (1997). The Concept of Harm Reduction and its Application to Alcohol: The 6th Dorothy Black Lecture. *Drugs: Education, Prevention And Policy* 4(1): 7-22.

Single, E. (1997). Towards a harm reduction approach to alcohol problem prevention. In Erickson et al. (1997), *Harm Reduction: A New Direction for Drug Policies and Programs*. Toronto: University of Toronto Press. Pp.195-202.

Stockwell, T. (1997). Harm reduction and licensed drinking settings. In Erickson et al. (Eds.), *Harm Reduction: A New Direction for Drug Policies and Programs*. Toronto: University of Toronto Press. Pp. 213-227.

## **Tobacco**

Berridge, V. (1999). Histories of harm reduction: illicit drugs, tobacco and nicotine. *Substance Use & Misuse*. 34(1):35048.

Ferrence, R, Cape, D, MacCon, K, Ashley, MJ, Pederson, L, Cohen, J, et al.  
Environmental Factors  
in Relapse to Smoking. Poster presented to the 6th Annual Meeting of the Society for  
Research  
on Nicotine and Tobacco. Arlington, Virginia, 2000.

Health Canada. Exposure to environmental tobacco smoke. National Population Health Survey Highlights, 1999.

Institute of Medicine (IOM). Clearing the Smoke: Assessing the Science Base for Tobacco Harm Reduction . Advance Copy. Edited by Stratton K, Shetty P, Wallace R, Bondurant S. Committee to Assess the Science Base for Tobacco Harm Reduction, Board on Health Promotion and Disease Prevention, Institute of Medicine. National Academy Press, Washington, D.C., 2001.

Kozlowski LT. Reduction of tobacco health hazards in continuing users: individual behavioural and public health approaches. *Journal of Substance Abuse* 1989; 1:345-57.

Office of Environmental Health Hazard Assessment (OEHHA), California Environmental Protection Agency. Health Effects of Exposure to Environmental Tobacco Smoke: Final Report. Sacramento, California, September 1997.

Ontario Tobacco Research Unit (OTRU). Protection from Second-hand Tobacco Smoke in Ontario: A Review of the Evidence Regarding Best Practices. A report of the Ontario Tobacco Research Unit, University of Toronto, Toronto, Ontario, May 2001.

Resnicow, K., Smith, M., Harrison, L., and Drucker, E. (1999). Correlates of occasional cigarette and marijuana use: are teens harm reducing? *Addictive Behaviours* 24(2):251-266.

Russell, M.A.H. (1993). Reduction of smoking-related harm: the scope for nicotine replacement. In N. Heather et al. (Eds.), *Psychoactive Drugs & Harm Reduction: From Faith to Science*. London: Whurr Publishers, pp. 153-167.

Saffer H, Chaloupka F. The effect of tobacco advertising bans on tobacco consumption. *Journal of Health Economics* 2000; 19:1117-37.

Schaler, J.A. and Schaler, M.E. (Eds.). (1998). *Smoking: Who Has the Right?* New York: Prometheus Books.

Single, E. (1996). Harm reduction and nicotine. Presentation to workshop on harm reduction and tobacco, Heart and Stroke Foundation of Canada, Ottawa, October 29, 1996.

Stratton K, Shetty P, Wallace R, Bondurant S (Eds.). *Clearing the smoke: the science base for*

tobacco harm reduction-executive summary. *Tobacco Control* 2001; 10:189-95.

US Department of Health and Human Services (USDHHS) (1989). *Reducing the Health Consequences of Smoking: 25 Years of Progress. A Report of the Surgeon General.* US Department of Health and Human Services, Public Health Services, Centers for Disease Control. DHHS Publication No (CDC) 89-8411, 1989.

## **Treatment**

Brands, J., Brands, B., and Marsh, D. (2000). The expansion of methadone prescribing in Ontario. 1996-8-98. *Addiction Research* 8 (5): 485-496.

Cain, J.V. (1994). *Report of the Task Force into Illicit Narcotic Overdose Deaths in British Columbia.* British Columbia: Ministry of Attorney General.

Cheung, Y.W. and Ch'ien, J.M.N. (1999). Previous participation in outpatient methadone program and residential treatment outcome. *Substance Use & Misuse* 34(1):103-118.

Cheung, Y.W. and Cheung, N.W.T. (2000). *Social Capital and Recovery from Drug Addiction: Findings of a Study of Treated Drug Addicts in Hong Kong.* *Hong Kong Journal of Sociology* 1: 29-51.

Denning, P. (2000). *Practising Harm Reduction Psychotherapy: An Alternative Approach to Addictions.* New York Guildford.

Fischer, B. (2000) Prescriptions, power and politics: The turbulent history of methadone maintenance in Canada. *Journal of Public Health Policy* 21(2): 187-210.

Heather, N. (1995). Groundwork for a research program on harm reduction in alcohol and drug treatment. *Drug and Alcohol Review* 14(3):331-336.

Hunt, D., Lipton, D., Goldsmith, D., Strug, D., & Spunt, B. (1986). It takes your heart: the image of methadone maintenance in the addict world and its effects on recruitment into treatment. *International Journal of the Addictions*, 20, 1751-1771.

Langendam, M.W., van Brussel, G.H.A., Coutinho, R.A., Van Ameijden, E.J.C. (2001) *The Impact of Harm-Reduction-Based Methadone Treatment on Mortality Among Heroin Users.* *American Journal of Public Health*, 91 (5).

Le Dain Commission (1972). *Commission of Inquiry into the Non-Medical Use of Drugs - Treatment Report* Ottawa: Information Canada.

Marlatt, A.G., Blume, A.W., Parks, G.A. (2001) Integrating Harm Reduction Therapy and Traditional Substance Abuse Treatment. *Journal of Psychoactive Drugs*, 33 (1).

Rotgers, R. (1999). Client-driven, research-guided treatment for substance abusers: bringing harm reduction to clinical practice. In E.D. Dowd and L. Rugle (Eds.) *Comparative Treatments of Substance Abuse*. New York: Springer. Pp. 159-175.

Sanchez-Craig, M., Lei, H. (1986) Disadvantages of imposing the goal of abstinence on problem drinkers: An empirical study. *British Journal of Addiction*, 81, 505-512.

Skinner, W., Drake, J. (1997) Helping Cocaine and Heroin Users. In Harrison, S. and Carver, V. (Eds.), *Alcohol and Drug Problems: A Practical Guide for Counsellors*. Toronto: Addiction Research Foundation. Pp. 77-89.

Wild, T.C. (1999). Compulsory substance user treatment and harm reduction: a critical analysis. *Substance Use & Misuse* 34(1):83-102.

#### Diversity and Ethno-Cultural Context

Aboriginal Peer Project (2000). Harm reduction in the Aboriginal Community in the Greater Toronto Area. Working Paper, October 16, 2000.

Cheung, Y., Weber, T. and Biring, P. (1997). Alcohol and other drug use in the Punjabi community in Peel, Ontario: experiences in ethno-cultural harm reduction. In Erickson, P.G. et al. (eds.), *Harm Reduction: A New Direction in Drug Policies and Programs*. Toronto: University of Toronto Press. Pp. 365-382.

Daisy, F., Thomas, L.R., and Worley, C. (1998). Alcohol use and harm reduction within the native community. In Marlatt, G.A. (Ed.). *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors*. New York: Guildford. Pp. 327-349.

Erickson, P.G. (1994). Implications of harm reduction for substance abuse problems of native people. In McKenzie, D. (Ed.), *Aboriginal Substance Use: Research Issues*. Ottawa: Canadian Centre on Substance Abuse and National Native Alcohol and Drug Abuse Program. Pp. 65-68.

Henman, A. (1993). Harm-reduction or harm aggravation? The impact of the developed countries' drug policies in the developing world. In Heather, N. et al. (Eds.), *Psychoactive Drugs and Harm Reduction: From Faith to Science*. London: Whurr. Pp. 247-256.

Landau, T. (1996). The prospects of a harm reduction approach among indigenous people in Canada. *Drug and Alcohol Review* 15:393-401.

Lange, P. and Erickson, P.G. (1998). The scope of harm reduction: Benefits and misapplications for aboriginal peoples. Paper presented at the 9th International

Conference on the Reduction of Drug-Related Harm, Sao Paulo, Brazil, March 15-19, 1998.

Lauzon, R., McKay, I., Gregoire, T., Douglas, R. & Gliksman, L. (1998). Mattagami First Nation Policy to Reduce Alcohol-Related Harm. *Canadian Journal of Native Studies*. 18, 37-48.

Rana, S. (1997). Harm reduction in Asia. *The International Journal of Drug Policy* 8(3):132-136.

Samarasinghe, S. (1995). Harm reduction in the developing world. *Drug and Alcohol Review* 14(3):305-309.

Shinfuku, N. (1993). Harm reduction policies and programs in the developing world. In Heather, N. et al. (Eds.), *Psychoactive Drugs and Harm Reduction: From Faith to Science*. London: Whurr. Pp. 257-265.

Young, T.K. (1994). *The Health of Native Americans: Towards a Biocultural Epidemiology*. Oxford: Oxford University Press.

### **Criminal Justice**

Brochu, S. (1995). Estimating the Costs of Drug-Related Crime. 2nd International Symposium on the Social and Economic Costs of Substance Abuse (CASA), Columbia University.

Centre for Addiction and Mental Health [CAMH]. (2000). *Position on the Legal Sanctions Related to Cannabis Possession/Use*. Toronto: CAMH.

Dorn, N. (1992). Clarifying policy options on drug trafficking: harm minimization is distinct from legalization. In O'Hare, P.A. et al. (Eds.), *The Reduction of Drug-related Harm*. London: Routledge. Pp. 108-121.

Erickson, P.G. (1980). *Cannabis Criminals: The Social Effects of Punishment on Drug Users*. Toronto: Addiction Research Foundation Books.

Erickson, P.G. (2000). The Harm minimization Option for Cannabis: History and Prospects in Canadian Drug Policy. In Harrison, L., and Inciardi, J., (Eds.) *Harm Reduction: National and International Perspectives*. Sage Publications. Pp. 155-169.

Erickson, P.G. and Butters, J. (1998). The emerging harm reduction movement: The de-escalation of the war on drugs? In Jensen, E.L. and Gerber, J. (Eds.), *The New War on Drugs: Symbolic Politics and Criminal Justice Policy*. Cincinnati: Anderson Publishing and Academy of American Criminal Justice Sciences. Pp.177-196

Erickson, P.G. and Murray, G.F. (1986). Cannabis Criminals Revisited. *British Journal of Addiction* 81(1): 77-81.

Fischer, B.F. (1997). The Battle for a Canadian Drug Law: A Legal Basis for Harm Reduction or a New Basis for Prohibition? In Erickson, P.G., (Eds.) *Harm Reduction: A New Direction for Drug Policies and Programs*. Toronto: University of Toronto Press. pp. 47-68.

Fischer, B., Erickson, P., and Smart, R. (1996) The new Canadian drug law: One step forward, two steps backward. *The International Journal of Drug Policy* 7(3): 172-179.

Fraser, A. and George, M. (1992). The role of the police in harm reduction. In O'Hare, P.A. et al. (Eds.), *The Reduction of Drug-related Harm*. London: Routledge. Pp.90-94.

Hellawell, K. (1995). The role of law enforcement in minimizing the harm resulting from illicit drugs. *Drug and Alcohol Review* 14(3):317-322.

LaPrairie, C., Gliksman, L., Erickson, P., Wall, R., Newton-Taylor, B. Drug Treatment Courts - A Viable Option for Canada? (In Press, 2002). L, Harrison (Ed.), *Substance Use and Misuse*, Special Edition: Drug User Treatment Courts.

Lenton, S., Heale, P., Erickson, P.G., Single, E., Lang, E., and Hawks, D. (2000). The Regulation of Cannabis Possession, Use and Supply. Discussion document prepared for the Drugs and Crime Prevention Committee of the Parliament of Victoria. Perth: National Drug Research Institute.

Macdonald, S. and Erickson, P.G. (1999). Factors associated with attitudes toward harm reduction among judges in Ontario, Canada. *International Journal of Drug Policy* 10:17-24.

Pearson, G. (1992). Drugs and criminal justice: a harm reduction perspective. In O'Hare, P.A. et al. (Eds.), *The Reduction of Drug-related Harm*. London: Routledge. Pp. 15-29.

Single, E. (1998). The economic costs of illicit drugs and drug enforcement. *Policy Options* 19(8):3-6.

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