Paper Presented to the ECAD Meeting Killarney 2012

From Harm Reduction to Abstinence: A Journey in Drug Treatment Policy

Neil McKeganey
Professor of Drug Misuse Research
Centre for Drug Misuse Research
19 Keith Street
Glasgow G11 6QQ

Introduction

The journey from harm reduction to abstinence within UK drug policy has given rise to some of the most heated debates to have occurred in the addictions field over the last twenty years in which fundamental questions have come to be asked about the aims of drug misuse treatment, the effectiveness of treatment, the funding of treatment, and the role of the media and politics in shaping drug treatment. It is a journey that is very much in the process of unfolding and where the outcomes are by no means certain even if the direction of travel is reasonably clear-cut.

The Rise and Rise of Harm Reduction

Over the last twenty-five years the notion of reducing the harm associated with the use of illegal drugs has exerted an unparalleled influence on drug policy and drug services within many countries. During that time harm reduction has grown from being a radical new idea challenging the addictions establishment in the UK and elsewhere to becoming a global social movement with its own distinctive set of ideas, evidence base, politics, professional practice, internal conflicts, international conference and academic journal. In addition to being hugely influential, harm reduction has also been hugely controversial, sitting as it does at the intersection of public health protection and drug law reform, and

being seen by some as a Trojan horse leading ultimately to the legalisation of all drugs.

The key document setting out what became the distinctive approach of harm reduction in drug policy and provision was the 1988 "AIDS and Drugs Misuse" report from the UK Advisory Council on the Misuse of Drugs. That report contained a sixteen-word sentence that virtually overnight changed the entire direction of UK government drug policy. That sentence authoritatively stated that:

> "The spread of HIV is a greater danger to individual and public health than drug misuse" (ACMD 1988).

In the wake of the fear that large numbers of injecting drug users might become HIV positive, and might spread infection to the wider non drug-injecting population, the focus of government attention shifted from viewing drug use as a criminal justice matter to viewing it as a public health threat. Confronted by that threat, the primary aim of drug policy became one of reducing drug users chances of acquiring and spreading HIV infection. Gerry Stimson, a sociologist at the University of London, who would go on to become the Executive Director of the International Harm Reduction Association, identified the "game changing" impact of AIDS and HIV on British drug policy:

> A key issue in shaping drug policies is the choice that has been posed between two targets: between the prevention of HIV transmission and the prevention of drug abuse. Preventing the physical disease of AIDS has now

> been given priority over concerns with drug problems. In this paradigm prevention takes on a new meaning- the key prevention task is not the prevention of drug use, but the prevention of HIV infections and transmission. (Stimson 1990:333)

Within its "AIDS and Drugs Misuse" Report the Advisory Council on the Misuse of Drugs set out a hierarchy of goals for services working with injecting drug users. These were to:

1) Reduce the shared use of injecting equipment by drug users.
2) Reduce the incidence of drug injecting
3) Reduce the use of street drugs.
4) Reduce the use of prescribed drugs.
5) Increase abstinence from all drug use.

In the wake of the ACMD's report the conservative government under Prime Minister Margaret Thatcher accepted the case for developing a network of needle and syringe exchange services, recognising that whilst the government had no wish to be seen to condone an illegal activity, the fear of an imminent epidemic of HIV infection was of much greater concern. Subsequently, the New Labour government identified harm minimisation as a key part of its own updated drug strategy – a strategy that underlined just how influential harm reduction ideas had become:

> All problematic drug users must have access to treatment and harm minimization services both within the community and through the criminal justice system (Updated Drug Strategy 2002, 3).

> Nearly all Drug Action Team areas (97%) have harm reduction services and 87% provide access to drug prescribing services (Updated Drug Strategy 2002:53)

Within the context of the New Labour's harm reduction influenced drug policy, treatment rather than enforcement became the central plank of government attempts to tackle the UK drug problem. Funding for drug treatment expanded massively from some £390m a year in 2002 to £800m a year in 2007. Similarly, the numbers of drug users in treatment increased from around 85,000 in 1998 to 207,580 in 2008/09 (NTA 2009). Over 70% of the drug users in treatment were, according to the National Treatment Agency, being prescribed the opiate substitute drug methadone. Methadone maintenance had come to be seen as a core element of the harm reduction approach (National Treatment Agency 2008). Although there has never been an audit of the number of dependent drug users being prescribed methadone in Scotland, the Scottish government has estimated that there may be around 22,000 heroin addicts on methadone out of a total estimated problematic drug using population of just over 55,000 (Scottish Executive 2005). Since it would be unusual for any country to have much more than half of its total addict population in treatment at any one time the Scottish government estimate would suggest that virtually all drug users in treatment in Scotland are receiving a methadone prescription.

Government support for the harm reduction approach has continued within the UK even in the face of the low level of HIV infection recorded amongst injecting

drug users – thought to be around 1.5% in the UK. There are two reasons for this. First, there has been a recognition of the need to reduce other blood borne infections with particular attention being directed at Hepatitis C which is thought to have been contracted by more that 50% of current injecting drug users within the UK (Health Protection Agency 2010). Second, methadone maintenance has been viewed as a key plank of the government's attempts at reducing drug related crime.

The success of the harm reduction approach in shaping drug policy and provision within the UK has been nothing short of remarkable. Services such as needle and syringe exchange, outreach condom provision, and the provision of advice to drug users on safer injecting techniques that were initially regarded as risky and radical have come to be seen as a commonplace part of the drug services in many countries. Despite the widespread impact of harm reduction ideas on drug policy and practice a continuing fault line in the consensus around the importance of reducing drug related harm has been the degree to which the approach has really embraced the notion of "drug use reduction" alongside the aim of "drug harm reduction".

Reducing Harm and Reducing Drug Use- A Growing Divide

In the period following the ACMD's initial exposition of the harm reduction approach the degree two which harm reductionists subscribe to the goal of reducing drug use itself has become increasingly questionable. In 1996 the Canadian Centre for Substance Abuse published a definition of harm reduction

that accorded only a minor role to the goal of drug user abstinence. Harm reduction, according to the Canadian Centre:

> Does not focus on abstinence: although harm reduction supports those who seek to moderate or reduce their drug use, it neither excludes nor presumes a treatment goal of abstinence. Harm reduction approaches recognise that short-term abstinence oriented treatments have low success rates, and, for opiate users, high post-treatment overdose rates (CCSA 1996).

More recently the International Harm Reduction Association has offered a definition of harm reduction that similarly shows how far the goal of drug use reduction has moved from the centre stage of harm reduction thinking:

> 'Harm Reduction' refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption (IHRA 2009)

The marginalisation of drug use reduction within the harm reduction cannon can be clearly seen in the emphasis which harm reductionists have given to the principle of "incrementalism". That principle refers to the view that small changes in behaviour on the part of large groups of drug users (for example, reducing the shared use of injecting equipment) are more important and more influential than "heroic changes" on the part of small numbers of individual drug users. Since the journey towards abstinence can be characterised as something of a "heroic change" on the part of the individuals involved, it is easy to see how

abstinence has come to be seen as a marginal element of the harm reduction approach to drug treatment. With regard to drug treatment harm reduction ideas have rather marginalised the notion of drug users being helped to become drug free. Robert Newman, for example, one of the leading harm reductionist doctors within the United States has commented on the approach to drug users in treatment who are seeking to become drug free:

> Addicts who embrace an ultimate goal of enduring abstinence should be assisted in every way possible, but they must be advised with brutal frankness of the low prospect of success - and the grim, potentially fatal, consequences of failure (Newman 2005:266).

The marginalisation of abstinence as a policy goal within harm reduction has however involved a good deal more than the prioritisation of small changes on the part of large groups of people over "heroic changes" on the part of the few. As the initial fears over the spread of HIV infection have receded, harm reductionists have increasingly turned their attention to the goal of reducing other drug related harms -including the harms that are seen to arise from the illegality of the drugs themselves. Drug law reform has become an increasingly central part of the harm reduction approach.

The International Harm Reduction Association has outlined the commitment on the part of harm reductionists of challenging the harms that are seen to flow from the fact that certain drugs are illegal:

> Many policies and practices intentionally or unintentionally create and exacerbate risks and harms for drug users. These include: the criminalization of drug use, discrimination, abusive and corrupt policing practices, restrictive and punitive laws and policies, the denial of life-saving medical care and harm reduction services, and social inequities. Harm reduction policies and practice must support individuals in changing their behaviour. But it is also essential to challenge the international and national laws and policies that create risky drug using environments and contribute to drug related harms. (IHRA2009)

What started as a determined attempt to develop interventions aimed at reducing the spread of HIV infection, and which in its earliest formulation combined the aims of drug user risk reduction and drug use reduction, has taken on an increasingly drug law reform agenda in which the drug laws themselves are seen as the major source of drug harm – a harm which can only be effectively reduced through some form of legalisation or drug decriminalisation.

This shift in focus has led some harm reductionists to ask the question as to "which comes first" in harm reduction -public health or drug law reform? For example, Neil Hunt, a prominent supporter of the harm reduction movement in the UK, has asked the question whether harm reduction is first and foremost concerned with the health needs of individual drug users or is principally about supporting the rights of the individual to use drugs of his or her choice. Other prominent harm reductionists have cautioned against the attempt to clarify the harm reduction agenda and have argued instead for the "political" benefits of maintaining a degree of ambiguity as to the aims of the harm reduction movement:

> The (harm reduction) movement has succeeded where other attempts have failed partly because it blended human rights and public health... Just as ambiguity is functional for nation states… ambiguity is functional for the harm reduction/drug law reform movement. Ambiguity helps create a large political tent under which our unwieldy coalition can fit, maximising our appeal, increasing membership, and allowing for local autonomy so that unique local conditions can be addressed. …The public health principles that under gird harm reduction practices have afforded much needed political legitimacy to controversial policies. This legitimacy is a precious resource, some of which might be jeopardized if the movement were to give loud primacy to the right to use whatever drugs one desires and to make legalization its principle policy objective (Reinarman 2004:240)

Whether the goal of drug law reform is regarded by harm reductionists as the central thrust of their efforts, or one priority alongside a number of others, what is clear is that the harm reduction approach, evident within such quotes, has shifted markedly from the ACMD vision of a realm that combines the twin aims of drug harm reduction and drug use reduction.

Harm Reduction Under Attack

Over the last five years the harm reduction approach in drug policy and provision has been subjected to more critical scrutiny than at any time in the past twenty-five years. That criticism has involved academic researchers, the media, politicians and influential think tanks and has led to two key outcomes. First there has been a reassessment of the role of harm reduction in drug policy and second there has been a reappraisal of the importance of ensuring that abstinence is the goal of drug misuse treatment.

Research

In 2004 McKeganey and colleagues reported the results of one of the largest surveys of drug users in treatment within the UK. This research identified that the majority of 1007 drug users interviewed were contacting drug treatment services seeking help to become drug free. Only a tiny proportion of drug users identified harm reduction goals as the main reason for their contacting drug treatment services; for example 7.4% of drug users starting a new episode of drug treatment said that stabilising their drug use was their key goal, and only 0.7% said that finding a "safer way to use their drugs" was their primary goal from treatment. This research raised the very real prospect that the harm reduction orientation of many drug treatment services within the UK was out of step with the personal aspirations of the majority of those in treatment. The findings from this study were subsequently confirmed by the National Treatment Agency whose 2006 drug user satisfaction survey, completed by 8765 drug users in treatment, found that 77.5% of those using heroin stated that their goal from treatment was to cease using the drug; 72.9% of those using crack cocaine stated that goal was to cease using the drug; and 59.7% of those using amphetamines stated that their goal was to stop using the drug (NTA 2007). On the basis of these two surveys, abstinence, rather than harm reduction, appeared to be the primary goal underpinning drug users decisions to contact drug treatment services.

Despite the goal of becoming drug free, research has revealed that only a tiny proportion of drug users leaving treatment were doing so on the basis of having achieved that goal. McKeganey and colleagues reported that only 8% of drug users (5.9% of females and 9.0% of males), followed up 33months after having

initiated a new episode of drug treatment, had a 90-day drug free period in advance of being interviewed. In this Scottish study the researchers were able to compare the 90-day abstinence rates across the different treatment modalities included within their survey. In the case of those drug users who had received methadone maintenance at some point over the past 33-months only 3.4% had a 90-day drug free period in advance of being interviewed, whereas amongst those drug users who had received residential rehabilitation over the last 33-months 29.4% had enjoyed a 90-day drug free period. The findings from this study led to a groundswell of concern that the single most widely provided treatment to dependent drug users within the UK was associated with one of the lowest rates of recovery defined in terms of the cessation of drug use.

Concern over the low rate of recovery on the part of those receiving drug dependency treatment was further underlined by the findings Kimber and colleagues study on the impact of methadone prescribing to dependent drug users which found that those drug users who had been prescribed methadone were significantly less likely to have recovered from their drug use than those who had not been prescribed the drug:

> Opiate substitution treatment was associated with an increased duration of injecting (that is, time to long term cessation): for each year of treatment, before adjustment, duration was increased by 11%..... For patients who did not start opiate substitution treatment, the median duration of injecting was five years (with nearly 30% ceasing within a year) compared with 20 years for those with more than five years of exposure to treatment (Kimber et al 2010)

This study raised the concern that the corner stone of the UK harm reduction approach to drug treatment (methadone maintenance) was actually reducing rather than increasing individual's likelihood of recovering from their drug dependency.

Criticism from the Media

The media have played a key role in questioning the impact of harm reduction ideas in drug treatment within the UK. The key element of the media coverage has been a series of three interviews on the BBC flagship current affairs "Today" programme between the BBC Home Affairs Editor, Mark Easton, and the Head of the National Treatment Agency, Paul Hayes. In the first of these interviews Mark Easton reported that as a result of an additional £130m spent on addictions treatment in England during the period 2004/5 to 2006/7, only 70 more people had become drug free. On that basis, Easton argued, each individual case of recovery had cost the taxpayer around £1.8m. Immediately following the BBC broadcast the National Treatment Agency released a press statement to the effect that the "BBC got its numbers wrong" and that in fact, out of 66,123 drug users who left drug abuse treatment in 2006/7 5,829 or 8.8% were drug free (NTA 31/October 2007). The NTA press release also outlined that overall 180,000 drug users had been treated in the year 2006/07 which would mean on the NTA's own figures that only around 3.2% of those treated had indeed become drug free.

In the second interview, the BBC addressed the role of "contingency management" in the treatment of dependent drug users. Contingency

management involves providing drug users (and clients of other services) with small rewards, for example, food vouchers, as an encouragement for positive changes in their behaviour. Although the practice of rewarding drug users for positive changes in their behaviour had been positively evaluated by the National Institute for Health and Clinical Excellence (NICE 2007), a BBC report revealed that as many as one third of drug agencies were rewarding drug users by providing them with additional amounts of the opiate substitute drug methadone. Within the context of the BBC interview, Paul Hayes initially denied any knowledge that such a practice was occurring or was widespread. However when Easton identified that the evidence for this practice was contained in a report from the National Treatment Agency itself Hayes was clear in his comment that medication should not be used in this way as a reward for behaviour change. Following Hayes on the Today programme, the Health Minister (Dawn Primarolo MP) described the practice of using medication in this way as being wholly, "unethical".

In the third of the series of three interviews on the Today programme Easton contrasted the widespread use of methadone in England (prescribed to around 147,000 drug users in 2007) with the fact that only around 5000 drug users (i.e. 2% of those in treatment) were provided with residential rehabilitation (BBC 2008). According to the National Treatment Agency the use of methadone was entirely congruent with a recent National Health and Clinical Excellence review that had identified the benefits of methadone prescribing to dependent drug users (NICE 2007). Despite the NTA's' reassurances as to the value of methadone

the outcome of this series of interviews was clear for all to see– the UK drug abuse treatment industry was in a state of disarray:

> Is it fair to say our field is in crisis at this point in time? Unfortunately I believe it is. I believe that this is because of two things. First, I think we are divided within. Second, increasingly there are attacks on drug treatment from outside- and these are becoming more virulent, sustained, and widespread. (Ian Wardle quoted in Great Debate 2009:7)

The Centre for Social Justice

The debate about the nature and effectiveness of drug treatment that began in 2004 with the publication of the "abstinence or harm reduction" report, and which was amplified in 2007 by the media in the series of "Today" interviews between Mark Easton and Paul Hayes, was further developed in the contribution from the Centre for Social Justice where Kathy Gyngell chaired a working group looking at the impact of the drugs problem in the UK, and the effectiveness of the drug treatment system developed under the New Labour government:

> The last ten years of drugs policy under Labour have marked a fundamental shift in objectives. They have seen the introduction of an additional route into treatment, a new target population, and a doubling of the numbers in treatment. However, there has been no parallel shift in what is deemed appropriate and effective treatment. Under Labour, abstinence has been lost in the hierarchy of goals for treatment. Harm education and harm minimisation services, not recovery and rehabilitation, dominate national and local treatment provision. (Centre for Social Justice 2007: 25)

The group highlighted, amongst other things, the enormous growth in the use of methadone in the UK. According to the reports author Kathy Gyngell, the ubiquity of methadone as a treatment for drug addiction in the UK had been driven in large part by the performance measurement culture that had evolved under New Labour:

> Our analysis is not that methadone does not and cannot have a useful and positive role in the treatment of addiction. Its routine and mass prescription is hard to justify on either clinical or ethical grounds and is entrenching rather than solving addiction. The rapid expansion of its prescription appears to be as much an outcome of political pressure and target driven policy as of a dispassionate clinical response to the treatment needs of a particularly vulnerable population. We have found the current mass prescription of methadone to be the cause of deep disquiet amongst drugs workers and addicts alike. (Centre for Social Justice 2007: 25)

Within Scotland the leader of the Scottish Conservatives (Annabel Goldie), coined the term "parking" to express her concern at the length of time some drug users were being left on methadone without any clear expectation that they would become drug free:

> "It is a well known fact that methadone is more addictive than heroin, yet this is virtually the only option open to many drug addicts across Scotland. Every pound spent on this so-called harm reduction route is a pound not spent on rehabilitation and the real fight against drugs."(Annabel Goldie quoted on BBC Monday, 14 November 2005)

Methadone Related Deaths

Concern over methadone prescribing in the UK not only centred on the numbers of drug users prescribed the drug, and the small number becoming drug free, it also focussed on the data showing that an increasing number of addicts deaths in Scotland and England were connected in some way to the drug. In Scotland, for example, the proportion of addict deaths associated with methadone increased from 22% in 2004 to 36% in 2010:

Addict Deaths and Methadone (Scotland)

Year	Total Deaths	Related to Methadone	% of Total Related to Methadone
2010	485	174	36
2009	545	173	32
2008	574	169	29
2007	455	114	26
2006	421	97	23
2005	336	72	21
2004	356	80	22

(Figures extracted from General Register Office For Scotland 2011)

In England a similar picture emerged with the number of addict deaths involving methadone increasing some 85% over the five-year period 2005 to 2009.

Number of deaths in England and Wales from drug-related poisoning where selected substances were mentioned on the death certificate

	2005	2006	2007	2008	2009
All Deaths	2762	2570	2640	2928	2878
Heroin/Morphine	842	713	829	897	880
Methadone	220	241	325	378	408
Cocaine	176	190	196	235	202
MDMA	58	48	47	44	27
Benzodiazepines	190	177	207	230	261

Rediscovering Abstinence and Recovery in Drug Policy

In the wake of the various criticisms of drug misuse treatment within the UK there has been a marked shift in emphasis with government policy stressing the importance of ensuring that drug treatment services are working towards enabling drug users to become drug free. Within Scotland the "Road to Recovery" drug strategy (Scottish Government 2008), contained a clear commitment on the part of government to ensuring that abstinence not harm reduction was at the heart of drugs misuse treatment:

> In the government's view recovery should be made the explicit aim of services for problem drug users in Scotland. What do we mean by recovery? We mean **a process through which an individual is enabled to move on from their problem drug use, towards a drug free life as an active and contributing member of society.**. (Bold text in original- Scottish Government : The Road to Recovery 2008:23)

In 2010 the UK government issued its new drug strategy "Reducing Demand Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life" (HM Government 2010). In the introduction to that strategy the Home Secretary, Theresa May MP, outlines the distinctive approach the government is taking towards tackling illegal drug use and the shift they are instituting from the previous strategy's emphasis on reducing the harm associated with individuals drug use:

> A fundamental difference between this strategy and those that have gone before is that instead of focussing primarily on reducing the harms caused by drug misuse, our approach will be to go much further and offer every support for people to choose recovery as an achievable way of dependency (2010:2)

The strategy itself contains a clear commitment to promoting abstinence and drug free outcomes over the previous of reducing drug harm:

> Our ultimate goal is to enable individuals to become free from the dependence; something we know is the aim of the vast majority of people entering drug treatment. Supporting people to live a drug free life is at the heart of our recovery ambition (2010:18)

The strategy contains a clear commitment to ensure that those drug users who are being prescribed methadone are not parked on such medication for many years without engaging with the prospect of full recovery:

> (f)or too many people currently on a substitute prescription, what should be the first step on the journey to recovery risks ending there. This must change. We will ensure that all those on a substitute prescription engage in recovery activities and build upon the 15,000 heroin and crack cocaine users who successfully leave treatment every year free of their drug(s) of dependence. (2010:18)

The extent of the shift in government thinking away from the primacy of harm reduction was nowhere more evident than in the changed stance on the part of the National Treatment Agency towards the policy of maintenance prescribing- a cornerstone of the harm reduction approach to drug treatment:

> No-one should be parked indefinitely on methadone or similar opiate substitutes without the opportunity to get off drugs. New clinical guidance

> has introduced strict time-limits to end the practice of open-ended substitute prescribing in prisons. This principle will be extended into community settings. New clinical protocols will focus practitioners and clients on abstinence as the desired outcome of treatment, and time-limits on prescribing will prevent unplanned drift into long-term maintenance. Sound evidence-based clinical judgement endorsed by clinical governance will be able to identify cases where the approach would not be appropriate, but the intent is to see a fundamental shift in the balance of treatment for opiate addiction, away from long-term maintenance towards abstinence and long-term recovery. (NTA 2010)

In 2011 the UK Home office, Dept of Health, Department of Work and Pensions Ministry of Justice Communities, Treasury, Education Department and Cabinet Office were cosignatories to the document "Putting Full Recovery First" which provided further flesh to the drug strategy's focus on recovery and abstinence:

> The vision of recovery articulated in the Drugs Strategy puts a new hope for individuals and families at the heart of the system. The aim of any such recovery-oriented system should be to enable individuals to become free from their dependency; something we know is the aim of the vast majority of people entering drug treatment…Whilst we recognise that substitute prescribing can play a part in the treatment of heroin dependence, both in stabilising drug use and supporting detoxification, it will not be the final outcome paid for in Payment by Results… No longer, therefore will addicts be parked on methadone or similar opiate substitutes without an expectation of their lives changing. We must ensure all those on a substitute prescription engage in recovery-driven support to maximise their chances of being free from any dependency as soon as is practicable and safe (Home Office 2011:10)

Harm Reduction and Abstinence?

At a time of economic austerity it is perhaps inevitable that there will be anxieties within the drugs treatment field at the possibility of a reduction in

funding. That anxiety is heightened in a situation where government is seen to be ushering in a shift in the direction of drug treatment policy from harm reduction towards drug user abstinence and recovery. However there are sound arguments for why the future of drug misuse treatment policy and provision may more probably entail a combination of these approaches than a replacement of one by the other.

First, recovery from dependent drug use is a long-term process as individuals are engaged in the business of rebuilding lives that have been profoundly damaged by the years of their drug addiction. It is questionable whether any treatment system has the capacity that would be required to provide the intensive, recovery oriented, support to drug users numbered in the tens and hundreds of thousands. Second it is by no means certain that the current drug treatment workforce is appropriately skilled to deliver the intensive high-quality abstinence and recovery oriented support that could sustain a whole-scale shift in emphasis from harm reduction to abstinence and recovery. Third, there are likely to be many drug users currently in contact with drug treatment services who would not wish to engage with a recovery focussed drug treatment system even if that system were widely available. Fourth whilst there has been a change in government within the UK nevertheless the civil service machinery remains largely intact and as a result there is likely to be a strong inclination towards incremental rather than revolutionary change in the thrust of drug policy and provision within the UK. For these various reasons there is likely to be a continuing need for a combination of both harm reduction and abstinence focussed drug treatment services within the UK.

The likelihood of a combination of abstinence and harm reduction approaches in drug treatment however gives rise to the question of how well agencies with these different ideologies and professional practice are likely to find it working together? One possible area of difficulty may have to do with the question of how to allocate drug users to either the intensive, recovery focussed services or to the more harm reduction oriented services. To do this might entail some form of segmenting the treatment population- differentiating between those drug users who might benefit from the more costly, recovery oriented services, from those for whom recovery is not yet a realistic possibility and who would benefit from continued contact with harm reduction services. Within the UK this segmenting option is currently being considered by the National Treatment Agency. However this work is likely to be hampered in part by the lack of research within the UK (as opposed to the US) on the criteria that may be used to direct drug users into appropriate treatment.

Although the segmenting option might offer a possible solution to the inability of the drugs treatment system to provide intensive recovery oriented support to anything like the estimated 200,000 drug users currently in treatment, the degree to which this would succeed in practice will depend on whether the segmenting exercise were able to reduces the number of drug users who need the intensive recovery oriented services to a manageable size. If, after having undertaken a segmenting exercise, one is still left with a very large number of drug users seeking to become drug free then the issue may still arise as to the capacity of the drug treatment system within the UK to deliver abstinence

focussed support to clients even despite the level of governmental support for such a shift.

Within a future in which increasing emphasis is given to the need to ensure that drug treatment services are focussed on enabling drug users to become drug free there is also likely to be a growing debate as to how long services should seek to support individuals who are not necessarily committed to their recovery. Relatedly, there is also likely to be a growing debate as to how much pressure should be exerted upon drug users to encourage them to adopt a commitment to becoming drug free.

In resolving these issues it is likely that drug policy will need to clarify whether the primary aim of treatment is to help individuals become drug free, or whether in the absence of that goal on the part of the individual there are still benefits to society of engaging drug users in treatment (for example reductions in drug related crime). If there are seen to be benefits to society of engaging drug users in treatment (even where those individuals are not necessarily committed to their recovery), there may still be a powerful case for continuing to provide harm reduction services where there is little or no expectation that the individual is indeed committed to becoming drug free.

A further area of tension that may undermine the working relationship between abstinence and harm reduction services is the likely need to rebalance the drug

treatment budget and move some resources from harm reduction realm (which have grown markedly over the last twenty or so years) and towards the abstinence or recovery focussed services (which has attracted much lower levels of funding over the period that harm reduction ideas have been in the ascendancy. If there is to be a rebalancing of the UK drugs treatment budget this may be vigorously resisted by those who champion harm reduction services and whose support for the growth of more abstinence, recovery oriented services might remain only for as long as the funding of the recovery services is not seen as being dependent on a reduction in funding for the harm reduction services.

Finally, combining abstinence or recovery focussed drug treatment services with harm reduction services may also require a resolution of the question that some harm reductionists have posed as to whether the key aim of harm reduction is to reduce the harms associated with drug use or to lobby in favour of the rights of the individual to use whatever drugs they choose. Where the harm reduction approach is seen to be primarily oriented towards the promotion of the drug using lifestyle there may be a growing tension with those services that are seeking to support individual's attempts at becoming drug free. Effective joint working between abstinence and harm reduction services may require harm reduction to place much less emphasis on drug law reform and revert to its original public health agenda emphasising its commitment to reduce the health harms associated with illegal drugs use.

Conclusion

The tension between the two wings of addictions policy and provision (between abstinence and harm reduction) is more acute today than it has been over the last twenty-five or so years. It is impossible to judge at the present time whether the inclination towards abstinence and recovery will lead to a whole-scale reduction in the funding for harm reduction services. What seems likely is that there will be a level of rebalancing of the drugs treatment budget with the development of a more abstinence recovery oriented services being supported to an extent by a reduction in the level of support for harm reduction services. Whether such a rebalancing produces a level of conflict that undermines the capacity for joint working between abstinence and harm reduction services will in part depend on the reaction of those championing harm reduction services. If some level of budgetary rebalancing is seen as appropriate given the extent of the support harm reduction services have enjoyed over the last twenty-five years then the potential for joint working is unlikely to be undermined. In the future the capacity for joint working may depend on the willingness of those working within the drugs treatment sector to give greater weight to meeting the needs of their clients than adhering to some form of ideological purity.