Harm Reduction: Concepts and Practice

CCSA National Policy Working Group[1]
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A. Background

1. Context

Harm reduction is a public health approach to dealing with drug-related issues that places first priority on reducing the negative consequences of drug use rather than on eliminating drug use or ensuring abstinence. This approach has been the focus of both heightened interest and considerable controversy in recent years. Over the last decade, harm reduction has become a subject of growing discussion and debate within the addictions community and, increasingly, by the media and the general public. A primary catalyst for this surge of interest in harm reduction has been the emergence of AIDS, linked to drug use through sharing of injection equipment. Many countries now take the public health-based perspective that the dangers of the spread of AIDS among drug users and from drug users into the general population pose a greater threat to health than the dangers of drug use itself.

Harm reduction has emerged as an alternative approach to abstinence-oriented drug policy and programming. A significant degree of confusion and controversy has also attended its rise to prominence. Harm reduction focuses on reducing the adverse consequences among persons who cannot be expected to cease their use of drugs at the present time, but it can be compatible with an eventual goal of abstention. This paper attempts to clarify the issues regarding the definition and practice of harm reduction and makes recommendations to guide further policy and program development in the harm reduction area.

2. Definition of Harm Reduction

At present there is no agreement in the addictions literature or among practitioners as to the definition of harm reduction.[2] As currently used, "harm reduction" may be a broad or narrow term, with multiple meanings. There is confusion about its meaning among both harm reduction practitioners and critics. Some harm reduction advocates consider the reform of laws prohibiting drug possession to be an integral part of harm reduction, while others do not. Some people consider the imprisonment of drug users for simple possession to be a form of harm reduction. Practitioners dedicated to abstinence may also think of themselves as reducing the harms of substance abuse.

As these examples illustrate, there is considerable confusion and a lack of conceptual clarity concerning the meaning of harm reduction. It may help to clarify the term to distinguish between harm reduction as a goal and harm reduction as a strategy. As a general goal, all drug policies and programs aim to reduce the harm associated with drug use. As a general goal, harm reduction is a very broad term. Virtually all drug policies and programs—including criminalization of users and abstinence-oriented programs—have a goal of harm reduction.

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[1] This policy discussion document was prepared by the CCSA National Policy Working Group, consisting of Peter Conley, David Hewitt, Wayne Mitic, Christiane Poulin, Diane Riley, Robin Room, Ed Sawka, Eric Single (chair) and John Topp. The views expressed in this document do not necessarily reflect those of the organizations to which members of the National Policy Working Group belong.

[2] In the literature, other terms are sometimes used interchangeably with harm reduction. These include "harm minimization", "risk reduction" and risk minimization".

In this document, we use a more narrow definition of harm reduction as a strategy rather than harm reduction as a goal. As a specific strategy, the term harm reduction generally refers to only those policies and programs that aim to reduce drug-related harm without requiring abstinence from drug use. Thus defined, harm reduction strategies would not include strategies such as abstinence-oriented treatment programs or the criminalization of illicit drug use—even though these policies and programs share the same goals as harm reduction strategies. In other words, all drug policies and programs aim at reducing drug-related harm, but not all policies and programs with a goal of harm reduction are harm reduction strategies.

Harm reduction approaches are restricted to those strategies that place first priority on reducing the negative consequences of drug use for the individual, the community and society while the user continues to use drugs, at least for the present time. In harm reduction approaches, the use of drugs is accepted as a fact and focus is placed on reducing harm while use continues. A harm reduction approach to a person's drug use in the short term does not rule out abstinence in the longer term. Indeed, harm reduction approaches are often the first step towards the eventual cessation of drug use. Many possible strategies can be used to address drug-related problems, including harm reduction and abstention.

3. Features of Harm Reduction

The essence of harm reduction is embodied in the following statement: "If a person is not willing to give up his or her drug use, we should assist them in reducing harm to himself or herself and others".[3]
The main characteristics or principles of harm reduction are as follows:

- *Pragmatism*: Harm reduction accepts that some use of mind-altering substances is a common feature of human experience. It acknowledges that, while carrying risks, drug use also provides the user with benefits that must be taken into account if drug-using behaviour is to be understood. From a community perspective, containment and amelioration of drug-related harms may be a more pragmatic or feasible option than efforts to eliminate drug use entirely.
- *Humanistic Values*: The drug user's decision to use drugs is accepted as fact. This doesn't mean that one approves of drug use. No moralistic judgment is made either to condemn or to support use of drugs, regardless of level of use or mode of intake. The dignity and rights of the drug user are respected.
- *Focus on Harms*: The fact or extent of a person's drug use *per se* is of secondary importance to the risk of harms consequent to use. The harms addressed can be related to health, social, economic or a multitude of other factors, affecting the individual, the community and society as a whole. Therefore, the first priority is to decrease the negative consequences of drug use to the user and to others, as opposed to focusing on decreasing the drug use itself. Harm reduction neither excludes nor presumes the long-term treatment goal of abstinence. In some cases, reduction of level of use may be one of the most effective forms of harm reduction. In others, alteration to the mode of use may be more effective.
- *Balancing Costs and Benefits*: Some pragmatic process of identifying, measuring, and assessing the relative importance of drug-related problems, their associated harms, and costs/benefits of intervention is carried out in order to focus resources on priority issues. The framework of analysis extends beyond the immediate interests of users to include broader community and societal interests. Because of this rational approach, harm reduction approaches theoretically lend themselves to evaluation of impacts in comparison with some other, or no, intervention. In practice, however, such evaluations are complicated because of the number of variables to be examined in both the short and long term.
- *Priority of Immediate Goals*: Most harm reduction programs have a hierarchy of goals, with the immediate focus on proactively engaging individuals, target groups, and communities to address their most pressing needs. Achieving the most immediate and realistic goals is usually viewed as first steps toward risk-free use, or, if appropriate, abstinence.

[3] Ernst Buning, Presentation at the panel on defining harm reduction, Fifth International Conference on the Reduction of Drug-related Harm, Toronto, 1993.

B. Examples of Harm Reduction Programs and Policies

1. Syringe Exchange and Availability

Needle and syringe exchange programs are, to many people, the epitome of the harm reduction approach. They were first established in a few European countries in the mid-1980s and by the end of the decade were operating in numerous cities around the world. The rationale behind syringe exchanges is that many people who are currently injecting are unable or unwilling to stop, and intervention strategies must help reduce their risk of HIV infection and transmission to others. Provision of sterile needles and syringes is a simple, inexpensive way to reduce the risk of spreading HIV infection. It is also a way of providing contact with drug users through outreach services. The strategy is based on a knowledge-and-means approach to behavioural change: people are provided with the information about the changes that are needed and also with the means to bring about this change (sterile needles, syringes, other "works" and condoms).

Some exchange programs provide outreach services in the form of mobile vans or street workers to deliver services to drug scenes or to users' homes. In Amsterdam, police stations provide clean syringes on an exchange basis. Automated syringe exchange machines are now being used in many European and Australian cities. These vending machines release a clean syringe when a used one is deposited. Such machines are fairly inexpensive and accessible on a 24-hour basis. The machines, however, decrease the important personal contact between drug users and health-care workers.

Bleach kits (containing bleach and instructions for cleaning equipment) can be distributed as another way to make drug injection less dangerous. While bleach is not totally effective in eliminating HIV and it does not kill the pathogen that causes hepatitis, such kits do help to reduce the likelihood of infection being passed through sharing of dirty equipment.

In Canada there are now more than 100 syringe exchanges, with more being established. In a number of provinces, pharmacists are becoming actively involved in syringe exchange programs. There is now clear evidence that attendance at syringe exchanges and increased syringe availability is associated with a decrease in risk (e.g., decreased sharing) as well as a decrease in harm (e.g., lower levels of HIV infection).

2. Methadone Programs

While North America is not usually thought of in connection with harm reduction, the United States has been home to a very significant harm reduction strategy in the form of methadone maintenance programs, which began in the 1960s. Many of the US programs have been criticized, however, for their failure to provide the flexibility and range of services necessary for widespread outreach and impact.

In the Netherlands, methadone is used for three purposes—to contact heroin users, to stabilize heroin users, and to detoxify and treat users. By providing methadone without too many impediments—"low-threshold programs"—contact can be made with large sections of the heroin-using population. For example, there is a "methadone bus" program where buses are used to distribute methadone throughout the drug-using community (no take-home dosages are provided). The primary disadvantages of the Dutch programs appear to be that often clients are not maintained on levels of methadone sufficient to prevent the use of heroin, and the programs do not provide any alternative to oral methadone. Some of these problems have been addressed in certain regional programs in England, where methadone and other drugs are available through clinics, and in Switzerland, through an experimental program providing heroin and other drugs.

Measures introduced to combat the spread of AIDS in Australia included a marked expansion of methadone programs. The criteria for admission to these programs were also made less stringent, and many more spaces

were allowed for maintenance of clients with little motivation to change drug-using behaviour. These changes to drug programs have been supported by changes in national and state policy towards drug abuse that give the highest priority to the containment of HIV.

In the United Kingdom, Europe and Australia, methadone is available from clinics as well as from general practitioners who provide health care and counselling. In a number of European cities, more than 25% of all general practitioners prescribe methadone. Users pick up their prescription from pharmacies. Amsterdam, Barcelona, Frankfurt and other cities distribute methadone through methadone buses or mobile clinics. Opiate substitute programs in Canada are currently very limited both in terms of size and options available to users.

Numerous studies have shown that methadone maintenance reduces morbidity and mortality, diminishes users' involvement in crime, curbs the spread of HIV and helps drug users to gain control of their lives. One of the key factors underlying the success of methadone as a harm reduction measure is that it brings users back into the community rather than treating them like outsiders or criminals. Methadone programs work best if they are numerous, accessible and flexible. Further expansion of methadone programs should take into account the need for such programs in prisons as well as the advantages of offering methadone treatment as an alternative to imprisonment and other forms of criminalization.

3. Education and Outreach Programs

Drug education materials with a harm reduction focus aimed at high-risk populations are readily available in a number of countries, including the United Kingdom, Holland and Australia. However, such educational materials remain extremely controversial and often unavailable elsewhere. While not promoting drug use, such materials tell the user how to reduce the risks associated with using drugs, teaching such things as safer injecting practices. In some countries, such as the United Kingdom, these techniques are taught by nurses at clinics.

In many countries, outreach workers contact persons such as drug injectors and prostitutes at risk of becoming infected with HIV. These workers distribute educational material, syringes, condoms and bleach kits and help users contact other services.

4. Law Enforcement Policies

Harm reduction approaches have been adopted by some law enforcement agencies. The Merseyside Police in the northwest of England have devised a harm reduction approach known as "Responsible Demand Enforcement". Merseyside Police have developed a cooperative harm reduction strategy with the Regional Health Authority to improve the prevention and treatment of drug problems, particularly with respect to the spread of HIV infection among injection drug users. The police are represented on Health Authority Drug Advisory Committees and employ Health Authority officers on police training courses involving the drugs/HIV issue. They have also supported the Health Authority by agreeing not to conduct surveillance on program clients, referring arrested drug offenders to services, not prosecuting for possession of syringes that are to be exchanged, and publicly supporting syringe exchange.

One of the most important features of the Merseyside Police strategy has been to place priority on the enforcement of laws against drug trafficking while using a "cautioning" policy toward drug use. "Cautioning" involves taking an offender to a police station, confiscating the drug, recording the incident, and formally warning the offender that any further unlawful possession of drugs will result in prosecution in court. The offender must also meet certain conditions, such as not having a previous drug conviction and not having an extensive criminal record. The offender is also given information about treatment services in the area, including syringe exchanges. The first time an offender is cautioned, he or she is not given a criminal record. On the second and third occasions, offenders are sent to court where they are typically fined for possession of small quantities and sentenced for possession of large amounts. If an

addict becomes registered through getting in touch with service agencies, then he or she is legally entitled to carry drugs for personal use. The overall effect of this policy is to steer users away from crime and possible imprisonment. Cautioning has been recommended by the Attorney General of the United Kingdom as an appropriate option for cannabis possession. In recent years the approach has been extended to ecstasy, amphetamine and cocaine as well as heroin.

In the Netherlands, police have long been supportive of harm reduction programs, including tolerating on-premise cannabis sales in selected coffee shops. Enforcement efforts are concentrated on large-scale traffickers and on ensuring a safe and peaceful environment. In Amsterdam, police stations will provide clean syringes on an exchange basis. In Hamburg, Germany, a recent policy shift to harm reduction has been reflected in co-operation by police, health officials and drug user groups in working together to help drug users access social services.

In Canada, the general approach towards drug use has been criminalization, although diversion of users to treatment is increasingly employed. The recent shift toward community policing in a number of cities may allow for the application of more harm reduction measures by local enforcement authorities in the near future.

5. Prescribing of Drugs

In a tradition dating back to the 19th century, physicians in the United Kingdom prescribe drugs to users. In many regions, the services are provided through Drug Dependency Clinics or Community Drug Teams. These services offer flexible prescribing regimes ranging from short-term detoxification to long-term maintenance. The majority of clients receive oral methadone, but some receive injectable methadone, others injectable heroin, and a small number receive amphetamines, cocaine or other drugs. These drugs are dispensed through local pharmacists.

In the Mersey Region of England, users may also be prescribed smokable drugs. Drug users who want to give up injecting often find that they are not able to switch immediately to oral prescriptions. Anecdotal evidence suggests that drug-related health problems seen by services and acquisitive crime have decreased as a result of these services. The level of HIV infection among drug injectors in the Mersey Region is very low.

Switzerland is currently carrying out a large-scale national experiment with prescribing of heroin and other drugs to users. The aim of the experiment is to determine whether prescribing of heroin and other drugs legally to users will reduce the users' criminal activity and their risk of contracting and spreading AIDS and other infections. The Swiss program started in January of 1994, with sites in eight cities. In each city, the program offers accommodation, employment assistance, treatment for disease and psychological problems, clean syringes and counselling. Users are in regular contact with health workers and links to drug-free treatment. Some programs started off by giving some users heroin and others morphine or injectable methadone. It was soon found, however, that most users preferred heroin, which is provided up to three times a day for a small daily fee. Two programs allow clients to take a few heroin laced cigarettes home each night. A preliminary report, released in September, 1994, suggests that heroin maintenance is efficacious, but there were insufficient data to draw conclusions about cocaine. The program has not resulted in a black market of diverted heroin and the health of the addicts in the programs has clearly improved. The authorities have concluded from these preliminary data that heroin causes very few problems when used in a controlled manner and administered in hygienic conditions. Based on these findings, the Swiss government plans to expand the program up to 1,000 users in 1995, with 800 places for heroin users and 100 each for morphine and injectable methadone users.

Holland will begin a heroin maintenance experiment in 1995 and several German cities are considering similar programs. The Australian Capital Territory is also preparing to institute a heroin maintenance program.

In Canada, a report on drug overdose by the British Columbia's Chief Coroner recommended more maintenance programs, and several public health agencies are working with community groups to determine the feasibility of prescribing programs as one part of their strategy to deal with drug-related harm in that province.

6. "Tolerance Areas"

Several European cities have developed facilities known as "tolerance zones", "injection rooms", "health rooms", or "contact centres", where drug users can get together and obtain clean injection equipment, condoms, advice and/or medical attention. These tolerance areas are often motivated by harm reduction, but they may also be for other purposes, such as social control and urban beautification. The majority of these places allow users to remain anonymous. Some include space where drug users, including injectors, can take drugs in a comparatively safe environment. This is regarded as better than the open injection of illicit drugs in public places or consumption of drugs in "shooting galleries" that are usually unhygienic and controlled by drug dealers.

In Switzerland, the first drug rooms were established by private organizations in Bern and Basel in the late 1980s. By the end of 1993 there were eight such facilities, mainly operated by city officials. Several other cities in the German-speaking parts of Switzerland opened drug rooms in 1994. An evaluation of three of these facilities after their first year of operation showed that they had been effective in reducing the transmission of HIV and the risk of drug overdose. Drug rooms are also provided by programs in Germany and in the United Kingdom.

Open drug scenes emerged in many European cities during the late 1980s. These were often in central areas near train stations, commercial areas and parks. In the Netherlands, an open drug scene called "Platform Zero" is located at the Rotterdam railroad station where it is supervised by police. Services available include syringe exchange and a mobile methadone unit. Rotterdam has also informally adopted a policy known as the "apartment dealer" arrangement. Following this policy, police and prosecutors refrain from arresting and prosecuting dealers living in apartments, providing they do not cause problems for their neighbours. This approach and Platform Zero are part of a "safe neighbourhood" plan in which residents and police work together to keep neighbourhoods clean, safe and free of "nuisances".

Open tolerance zones tend to be unstable and they are often short-lived. The first Swiss attempt at an open drug scene, "Needle Park" in Zurich, grew unmanageable and was closed in 1992. A second attempt also became uncontrollable and was closed in March, 1995.

In Frankfurt, Germany, open drug scenes emerged during the 1970s and settled in two adjacent parks in the 1980s when police officials decided that their earlier attempts to suppress them had failed. Three crisis centres were established next to the drug scenes, along with a mobile ambulance to provide needle exchange services and medical help, first-aid courses to users, and a separate bus to assist prostitutes. The police maintained their policy of apprehending dealers, but initiated a new policy of tolerating an open scene within a clearly defined area of one of the parks. These activities were carried out along with efforts to draw users away from the drug scene by providing accommodations and treatment centres outside the city centre, and in 1992 the park drug scene was shut down. By 1993 it was thought that the policy had led to a significant reduction in the number of homeless drug users, drug-related crimes, and drug-related deaths in the city.

Toleration and regulation of open drug scenes and apartment dealers are forms of control similar to those used to regulate illegal prostitution. These controls are also compatible with the philosophy of community policing. In addition, local residents are chiefly concerned about the safety and peacefulness of their neighbourhoods, not with drug use itself. Public health and social service workers find that it is easier to provide services when drug users are readily accessible.

7. Alcohol Policies and Programs

Harm reduction has been a common approach to the prevention and treatment of alcohol problems. Prevention programs such as server intervention and designated driver programs aim to reduce the harms associated with alcohol use without necessarily requiring abstinence. With regard to treatment, controlled drinking programs attempt to teach people to consume alcohol in a moderate or sensible manner. A number of programs have been designed for problem drinkers. These programs are targeted toward people whose drinking seriously interferes with life in ways that disrupt close relationships, cause health concerns and impair driving.

8. Tobacco Policies and Programs

Harm reduction approaches to nicotine products focus on reducing the harms to the user as well as to the inhaler of second-hand smoke. They include a wide range of approaches from policies controlling smoking in public places to nicotine gum and nicotine patches. Restrictions on smoking in public places may be thought of as harm reduction measures to prevent the adverse effects of second-hand smoke.

C. Issues

1. Understanding "Harms"

What constitutes a harm? Who is harmed? What drug-related harms should be given priority? The literature describes a broad range of harms. Most are directly attributed to drugs and behaviours related to their use. Other harms may result as unintended consequences of efforts to deter drug use. Thus, in practice it can be very difficult to answer questions such as: What constitutes a harm as opposed to a benefit? To whom? What harms should be given priority and when should action be taken?

Another area of debate concerns whether or not dependence constitutes a harm *per se*. Many harm reduction proponents do not view dependence as the first priority. Practitioners of abstinence-oriented programs often view this as an unacceptable aspect of harm reduction.

Harm reduction requires a framework for identifying and assessing the relative effects of various kinds of drug use. This in turn rests on some classification of effects, some method for counting and costing the negative and positive outcomes of drug use, and a database from which to make comparative assessments of drug-related consequences for different types of drugs, target groups, and settings. The elements of such a framework exist in fragmented form only. Reliable estimates for drugs other than alcohol and tobacco do not exist even at the national level, much less in a form that reflects regional or community variations. In the absence of objective data, much of the planning and delivery of harm reduction programs to date has been based on subjective assessment of risks and perceived priority of interventions.

2. Relationship to Other Approaches

Despite the current prominence of harm reduction, the notion of reducing harms associated with drug use has a long history. The idea of minimizing the harm associated with drug use has been a feature of British drug policy in particular for many decades, periodically surfacing and then fading. This idea is firmly rooted in public health practice involving "secondary prevention" with "high risk" groups. Thus, harm reduction is neither a "new" nor an "alternative" approach so much as it is an extension and focusing of existing and accepted approaches.

Many harm reduction-based programs, such as needle exchange, are of more recent origin. Others, however, have a long and proven history; methadone programs, for example, date back to the 1960s and have demonstrated their effectiveness in assisting drug users to stabilize and normalize their lifestyles and in providing many with a bridge to abstinence from narcotic use. Helping people avoid harms has also been an

established part of the alcohol field for many years; examples include promotion of responsible drinking, controlled drinking interventions, avoidance of drinking and driving, and low alcohol content beverages.

The recent increase in interest in harm reduction is linked in part to an increase in the influence of public health-based approaches to drug use and AIDS. Harm reduction is closely linked to a public health perspective through the sharing of common concepts and tools. In particular, harm reduction fits well within the conceptual framework of health promotion, with the minimization of risks and harms forming one part of the broader continuum of strategies to promote health and avoid disease. Both approaches emphasize the importance of respecting individuals and empowering them to increase opportunities to maximize their health, whatever the circumstances. As such, harm reduction, like health promotion, fits well with approaches that emphasize the importance of understanding the broad determinants of health and ensuring cost-effective approaches to the well-being of the entire population.

With respect to legal approaches, harm reduction *per se* does not favour any one regulatory system over another. Rather, the issue is seen as an empirical one to be addressed through determining how best to regulate drugs in order to achieve a balance in minimizing harms to the individual, the community and society as a whole. Some have argued that harm reduction is tantamount to advocacy for drug legalization. While many harm reduction practitioners favour drug policy reform, harm reduction is not the same as legalization. As is obvious from the examples given above, there are ways in which drug users can be helped to use drugs in less dangerous ways under existing laws.

3. Challenges in Practice

Many health and addictions agencies in Canada remain ambivalent about harm reduction as it pertains to alcohol and other drugs. Some have positioned it closer to primary prevention and demand reduction, thus avoiding its more controversial applications. If an agency wishes to develop harm reduction approaches as part its programming, a number of challenges must be faced.

Harm reduction strategies often focus on addressing the needs of socially marginal or controversial groups, such as injection drug users, inmates, youth, the socially disadvantaged or ethno-cultural groups. A strong endorsement of harm reduction in any of these contexts could lead directly into the arena of advocacy and public debate on related social issues such as poverty and racial issues, and could jeopardize community and stakeholder support.

Harm reduction has provided an important stimulus to program innovation. This may encourage some agencies to embrace harm reduction. Some agencies, on the other hand, may be reluctant to adopt this approach because it may conflict with the perspectives of important stakeholders.

Furthermore, harm reduction strategies may impose special demands on addictions staff trained in the traditional abstinence framework. Staff may find themselves having to operate within conflicting frames of reference or trying to reconcile competing program goals.

D. Policy Considerations

1. A Clear Definition of Harm Reduction

In developing harm reduction strategies, a clear definition of harm reduction should be articulated from the outset. It is important to specify what harm reduction is in order to distinguish it from what it is not. The following definition of harm reduction strategies is suggested: "A policy or program directed towards decreasing the adverse health, social, and economic consequences of drug use without requiring abstinence from drug use".

2. Strategic Approach

In moving towards a harm reduction approach, it is suggested that addictions agencies and practitioners

- decide whether to adopt harm reduction as an agency goal or as a program strategy;
- determine the place of harm reduction objectives within their broader hierarchy of goals;
- consider the views and roles of key partners and stakeholders in program planning and delivery; and
- provide staff with programming direction, training, and support for planned harm reduction initiatives.

3. Program Priorities

Continued innovation and development of harm reduction policies and programs are needed in the following areas:

- *Syringe Exchange and Availability*: As a key element in preventing the spread of HIV by injection drug users, syringe exchange programs should be established as needed. Such programs can serve as the focal point for offering other services.
- *Methadone Programs*: Where needed, methadone programs should be made more numerous, flexible, and accessible. Such expansion should take into account the need for methadone programs in prisons. Low threshold programs should be considered on a pilot basis.
- *Education and Outreach Programs*: Educational materials based on harm reduction principles should be developed for appropriate target groups. The number and variety of outreach programs for injection drug users and other high-risk groups should be increased.
- *Law Enforcement Policies*: Law enforcement agencies, community groups and drug users should work together to develop harm reduction policies and programs that incorporate balanced responses to drug problems in Canadian communities. These would include such steps as referral of those in simple possession of a drug to helping services.

4. Research and Evaluation Needs

There is a clear need for improved research in order to

- determine the relationships between alcohol and other drug use and the full range of their health and social consequences;
- more accurately determine the prevalence of these consequences for all populations;
- improve the methodology and data base for conducting cost-benefit and cost-effectiveness analyses;
- enhance the base of policy and program evaluation studies as a guide to decision-making;
- determine the feasibility of carrying out carefully controlled experiments with the prescribing of heroin, cocaine and other drugs to dependent users; and
- determine the feasibility of drug rooms and other "tolerance areas" and determine their efficacy at reducing drug-related harms.

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