Harm Reduction:

Finding Power Through Compassionate Care

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Abstract

Harm reduction is any kind of method or action used to reduce harmful consequences while taking part in high risk activities. Historically, it is best known as an alternative approach to addressing substance abuse. The harm reduction model originated in Europe during the 1980s as a way to address both the drugs and AIDS crises, with the Dutch drug policy and the Merseyside Harm Reduction model. Harm reduction has not been implemented in U.S. drug policy to the same extent, because the United States has a historical tie to the prohibition model, leading to the War on Drugs. The US drug policy focuses on prohibition, enforcement, eradication, and interdiction. Many negative consequences have stemmed from the War on Drugs, which still impact the country to this day. The harm reduction model was introduced in the United States shortly after its beginnings in Europe, also to address the AIDS crisis, but faced excessive setbacks due to lack of funding and initiative. Now, services such as needle exchange programs are slowly beginning to increase in number in the United States. These programs have been proven to benefit drug users, as they promote safer drug use. Many of these programs are run by grass root organizations and activists. In order for the harm reduction model to continue to be implemented in the US, more federal funding and policy making must be done. In this paper, I present the history of harm reduction, US drug policy, and the ways that harm reduction have been implemented within the US, as an argument for its continued implementation.

Introduction

Harm reduction, at its core, is any kind of method or action used to reduce harmful consequences while taking part in high risk activities (Marlatt 1999). Harm reduction is best known for being an alternative approach to substance abuse and sexual activity. In the context of

drug abuse, harm reduction is a pragmatic, approachable path to recovery that does not ask for the complete ceasing of drug use (Marlatt 1999). The harm reduction philosophy emphasizes the importance of educating people about safer drug use, which can include programs such as clean needle exchanges and narcan training, which is used to reverse opioid overdoses. Because the harm reduction model was created by drug users, it emphasizes the importance of providing support to substance users who are not ready or interested in entering rehabilitation. In programs that use the harm reduction model, the use of substances is recognized and accepted (Marlatt 1999). The approach to rehabilitation for substance abuse that is most widely accepted in the United States is the 'abstinence only method', which expects the person to fully abstain from drugs when entering recovery. The reasoning behind this is the belief that there is no safe amount of drug use, and so recovery must start with fully ceasing drugs (Marlatt 1999). In 2020, nearly 92,000 people died from drug overdose in the United States, skyrocketing from 70,000 cases reported in 2019. Specifically, synthetic opioid overdoses continue to rise, with over 55,000 cases reported in 2020 (U.S. Department of Health and Human Services 2022). It is safe to say that there is an overdose crisis happening in the United States, and harm reduction is a potentially incredibly useful tool to curb these deaths. Policies regarding substance abuse & harm reduction vary greatly across the United States, but as a whole, the US is significantly lagging behind other countries regarding harm reduction policies. This research paper will explore the origins of the harm reduction model and evaluate the impact that harm reduction policies have had on substance abuse within the United States.

Literature Review

Historical Overview

The origins of harm reduction lie outside of the United States, beginning in Europe with both the **Dutch model** and the **U.K. (Merseyside) model.**

Dutch Model

In general, the Netherlands has a liberal and permissive approach to both drugs and sex (Duncan, Nicholson 1997). This is strikingly different from the 'moral model' that has been popularized within the United States. Marijuana products are legal and can be purchased in coffee shops. On drug use in Amsterdam, Dutch sociologist E.M. Engelsman says, "The Dutch being sober and pragmatic people, they opt rather for a realistic and practical approach to the drug problem than for a moralistic or over-dramatized one. The drug abuse problem should not be primarily seen as a problem of police and justice. It is essentially a matter of health and social well-being." (Marlatt 1996: 783). Dutch drug policy is built on principles of separation of markets, low threshold treatment, and normalization of treatment, working as "a compromise between legalization and the war on drugs" (Duncan, Nicholson 1997). The Dutch prioritize servicing addicts by running programs such as 'methadone buses', which travel the city providing methadone (a medication used to treat opioid addiction), condoms, and sterile syringes (Duncan, Nicholson 1997). The legislative basis for modern Dutch drug policy began in 1976 when the Opium Act was revised. The Dutch Opium Act was originally enacted in 1919, causing the prosecution of marijuana users during the 50s and 60s. In the 1960s, a growing number of officials called for a reevaluation of the Dutch policy. Amsterdam police faced backlash from the public due to use of excessive force during student riots of 1966, which made them sensitive to public opinion (Duncan, Nicholson 1997). This resulted in a more nuanced approach to drug use,

especially in locations where young people were known to use drugs. Cannabis arrests were deemphasized as well. In the early 1970s, opium was introduced to the Netherlands, largely by West Germany (Duncan, Nicholson 1997). This, along with changing ideas about drug use, caused the government to compose the Narcotics Working Party, which consisted of experts from various disciplines. The Narcotics Working Party published a document concluding that the basic premises of drug policy should be congruent with the extent of the risks involved in drug use (Marlatt 1996: 784). This change in policy led to a revision of the Dutch Opium Act, which marked a distinction between drugs of "unacceptable risk" (heroin, cocaine, amphetamines, and LSD), and "lower risk" (marijuana, hashish). Possession of marijuana was now a 'petty offense', and the amendment also encouraged prosecutors to refrain from instituting criminal proceedings if there were weighty public interests to be considered (Duncan, Nicholson 1997). On this revision, Engelsmann comments, "In this regard the Dutch prove very pragmatic and try to avoid a situation in which consumers of cannabis suffer more damage from the criminal proceedings than from the use of the drug itself." (Marlatt 1996: 784). These policy changes resulted in no increase in drug use within the Dutch population.

There are **six guiding principles** of Dutch drug policy (Duncan, Nicholson 1997):

1. The creation of a network of medical and social services and local and regional levels.
2. Accessibility of services.
3. Promotion of the social rehabilitation of addicts and former addicts.
4. Greater and more efficient use of nonspecialist services such as primary care physicians and youth welfare centers.
5. Coordination of aid facilities.
6. Integration of drug education into general health education campaigns.

A key part of Dutch drug policy has to do with the second principle, accessibility of services (Duncan, Nicholson 1997). 'Low threshold treatment' means that the Dutch make sure that there are little to no barriers for someone who is seeking treatment. There is minimal paperwork or requirements for those seeking treatment, but these low-stakes treatment programs often funnel clients into more demanding programs over time (Duncan, Nicholson 1997). For example, an addict might initially enter a methadone program with little requirements for their clients, and later wish to enter a more intensive program that might require additional treatment such as weekly group therapy sessions. A successful low threshold program that has been implemented in Amsterdam is the "Methadone bus project" . Two mobile clinics cruise the city daily, making stops at six different locations. The bus keeps a registry of patients within the city, allowing them to distribute methadone to clients as well as exchanging syringes and supplying condoms (Duncan, Nicholson 1997). A recent concept that has been implemented within Dutch drug policy is the normalization of drug abuse treatment (Duncan, Nicholson 1997). This concept is an extension of the third and fourth principles, which focus on rehabilitating drug users and former drug users within society. The main feature of this policy has been the reintegration of addiction treatment into routine medical practice. General practitioners in Amsterdam are able to provide methadone to their patients, making it significantly easier for addicts to receive treatment without fear of being stigmatized by going to a treatment center (Duncan, Nicholson 1997).

After this move towards a more compassionate approach to drug use, a trade union called "Junkiebond" (Junkie League) was created in Rotterdam by concerned hard drug users who wanted to look after the interest of fellow drug users (Duncan, Nicholson 1997). This union

would meet with government officials in order to advocate for their needs, which included methadone, sterile syringes, policing, and housing. The creators of Junkiebond strongly believed that drug users should be the one advocating for each other, because they know best what the community needs (Duncan, Nicholson 1997). This grassroots approach is a core part of the harm reduction model to this day. These Junkiebonds spread throughout Amsterdam and local groups can be found in most major cities. Addicts who provided input to Junkiebonds contributed to the first legal needle exchange in Amsterdam in 1984. These needle exchanges increased as the Aids crisis rose during the 80s, rising from 100,000 in 1985 to 720,000 in 1988 (Duncan, Nicholson 1997). Around the same time, the Merseyside harm reduction model was being developed as a response to the Aids crisis.

U.K. (Merseyside) model

The Mersey Health Region, which consists of the counties of Merseyside & Cheshire, is known for its "radical and pioneering approach to dealing with the problems connected to drug use" (O'Hare 2007: 141). The United Kingdom pioneered the 'medicalization' approach to drug abuse by prescribing addicts 'maintenance' drugs. Prescribing drugs to addicts in the UK dates back to the 1920s, when British physicians recommended, in some cases, prescribing narcotics to reduce the harm of drug use and allow users to lead normal, useful lives (O'Hare 2007: 141). Although this practice lost favor over the years, it is still practiced in Merseyside. The Mersey Harm Reduction Model began to develop during the 1980s, focused in the city of Liverpool. In the mid 80s, Josh Ashton, who was working in the Department of Public Health, began developing ideas for the New Model for Public Health. Ashton aimed to combine old concepts such as environmental change & preventative care, with a new recognition of the importance of "those social aspects of health problems which are caused by lifestyles. In this way it seeks to

avoid the trap of victim blaming" (Ashton & Seymour 1988: 21). Ashton wanted to apply these ideas to both the drugs & aids problems of the time, and began to create community based projects aimed at promoting healthier lifestyles. Around this time, an influx of "cheap brown heroin" (O'Hare 2007: 141) was introduced in the Mersey region. The need for a new approach to public health grew increasingly more apparent.

Besides Ashton, a few key individuals who contributed to the Mersey Harm Reduction Model include Sir Donald Wilson, chairman of Mersey Regional Health Authority, Dr. John Marks, a psychiatrist, and Allan Parry, a health program worker. Together, these individuals facilitated the implementation of a harm reduction approach to drug use in the Mersey region, with a focus on reducing the threat of HIV through needle sharing. This was based on the public health principles that influenced later recommendations of the UK's Advisory Council in the Misuse of Drugs' report in 1988 (O'Hare 2007). A core part of Mersey's approach is having information about safe drug use completely accessible to the public. In 1985, services were introduced to the public that gave consumers drug information, with an emphasis on injection safety. The Mersey Drug Training and Information Centre, a drop in center for information about HIV awareness, was opened during this year. The year before, Liverpool Drug Dependency Unit was created, which aided in the increase & accessibility of methadone prescriptions. Similar to the Dutch, Mersey worked to approach the threat of HIV through a pragmatic lens. For example, when it was found that HIV was disproportionately affecting intravenous drug users, Mersey worked to provide clean needles. They even followed the Netherland's example and started their own needle exchange service in 1986, two years after the Dutch implemented their first official NE program. Low threshold treatment was also adopted in the UK after the Dutch. In 1990, the

first international conference on harm reduction was held in Liverpool under the sponsorship of Merseyside Health Authority. (O'Hare 2007)

Overall, the key idea of the development of the Mersey Harm Reduction Model was to identify, contact, and care for the specific needs of the target population at risk (O'hare 2007). This approach aimed to target the population as whole instead of individuals. There is a hierarchy of objectives, with reducing risk behavior being the most important. The other objectives are to reduce needle sharing, reduce injection drug use, reduce street drug use, and, if possible, increase abstinence. The methods used include needle exchange, prescription of methadone, outreach, and the provision of information. In the first 10 months of needle exchange programs being implemented, 733 people made 3117 visits. In the first 2 years, 1090 people attended the Drug Dependency Unit. Before this, 200 people per year coming to a traditional agency would have been the norm (O'hare 2007: 142).

When looking at what the Dutch and Mersey models have in common, it is apparent that there are a few common core ideals that were implemented into their policies: Easily accessible services that provide information about drugs and how to use them safely; low threshold treatment that allow people to seek treatment without barriers; decreasing the criminalization of drug use(rs); and providing direct care and service to the population most heavily affected by the risks of unsafe drug use. Pragmatism is essential to this and could be argued to be what makes both of these so different from the United States' historical approach to drug policy and substance abuse as a whole.

Overview of US Drug policy

Drug use has been present within the United States since the nation's beginnings. Puritans are often blamed for setting the precedent for the prohibition model due to their condemnation of

inebriation and advocating for the extension of religious codes into civil laws (Des Jarlais 2017), but the roots of modern US drug policy really began to grow at the start of the twentieth century. Concerns of narcotic use within the United States grew in the early 1900s, particularly criticizing the use of patent medication, which contained heroin and cocaine (Ryan 1998). The United States Congress passed the Harrison Narcotics Act in 1914, which, based on the taxing power given to Congress in the Constitution, provided increased regulation of the distribution of opiates and cocaine. Opiates now required prescriptions and the payment of a tax (Ryan 1998). When this act was first passed, it was viewed as a tax law, not prohibition. But, overtime, the government began to increasingly enforce the restrictions, leading to the Bureau of Narcotics prosecuting doctors who gave maintenance doses of opiates (Ryan 1998). A defining case of US drug policy was Webb v. US in 1919, in which the court held that the provision of narcotics to addicts is not proper medical practice (Ryan 1998).

The United States has experienced four major illegal drug use epidemics: Heroin (1968-1973), powder cocaine (1975-1985), crack cocaine (1982-1988), and methamphetamine (1990-2000) (Kilmer 2012). Illegal drugs is a $60 billion-per-year industry in the United States, used by over 16 million Americans (Kilmer 2012). The government's expenditures and policies created to address substance abuse in the country are mainly focused around enforcement (prohibition, supply reduction), but it has not led to a decrease in drug related issues (Caulkins 2005). In response to the growing issue of substance abuse in the US, 2 traditional approaches developed: the 'moral model' (War on Drugs), and the 'disease model of addiction'. From those two models, two reduction strategies emerged: supply reduction and demand reduction. Since the enactment of the Harrison Narcotics Act of 1914, supply reduction has been the dominant strategy within the United States (Duncan, Nicholson 1997). Supply reduction is associated with

the ‘moral model’ of rehabilitation. The strategy focuses on reducing the supply of illicit drugs within drug producing countries through law enforcement, interdiction, and eradication. This strategy assumes that stopping the supply from reaching the United States will increase the prices of illicit drugs, forcing users to stop. This approach has proven to be unsuccessful, as issues such as drug-related crime and HIV transmission through sharing needles increased due to supply reduction (Duncan, Nicholson 1997). It is theorized that supply reduction fails because it doesn’t actually curb demand, and instead provides more profit for traffickers within the black market. The War on Drugs “therefore functions, in practical fact, as a price support program for the enrichment of drug industrialists.” (Duncan, Nicholson 1997: 2) The second strategy, demand reduction, assumes that as long as there is a demand, there will always be a supply, even if the price greatly increases. It has a strong emphasis on primary prevention and treatment on demand. Demand reduction is significantly less prioritized than supply reduction, only receiving 30% of total Federal funding compared to supply’s funding. According to Jonathan Caulkins, author of How Goes the “War on Drugs”: an assessment of U.S. drug programs and policy, it is difficult to evaluate the success of the U.S.’ drug policy for a multitude of reasons. When looking at trends of drug use over many years, there seems to be no significant or consistent change.

> The percentage of the population reporting past-month use of some illicit drug declined by half between 1985 and 1992. While drug use by that measure is up by about a third since then, meaningful decreases in the number of cocaine users continued through the mid-1990s. Since 1990 the number of frequent users of cocaine (and of heroin) has declined modestly, according to official estimates. Such trends might be read as reflecting success in getting users to quit or in keeping prospective users from starting, or both. However, keeping kids from starting drugs is separately measured, and initiation of marijuana, cocaine, and hallucinogens went up in the 1990s and has stayed there. Furthermore, current use of marijuana by teenagers increased substantially in the mid- to late 1990s. (Caulkins 2005: 5)

Caulkins is not alone in their critique of the success of the war on drugs. Eva Bertram, one of the authors of Drug War Politics: The Price of Denial, claims that there are three major flaws to the 'prohibition model' that makes achieving its goals impossible (Bertram 1996): the 'profit paradox', the 'hydra effect', and the 'punish-to-deter fallacy'. The 'profit paradox' states that whatever success that drug enforcement achieves in artificially raising the prices of street drugs translates into the inflation of drug profits, resulting in the encouragement of suppliers to remain in the trade (Bertram 1996). The 'hydra effect', also known as the 'push down/pop-up' phenomenon, states that any attempts to stamp out drug production often just spreads the problem elsewhere (Bertram 1996). 'Pushing down' in one community, inevitably 'pops up' in another community . The entry barriers for illicit drugs are extremely low, meaning that suppliers are able to easily relocate and resume profiting even after law enforcement interferes. The 'punish-to-deter' fallacy asserts that the deterrent theory has an unsound argument. The deterrent theory states that the threat of punishment will deter drug users from using in the first place, and that enforcing severe punishment will deter continued use. Bertram says that there is no evidence which shows that drug users respond like rational consumers seeking to satisfy desires in the free market. Social, psychological, and situational forces make users extremely unlikely to respond to the threats of punishment. In fact, the threat of serious punishment may drive users even more underground, forcing them to turn to even more dangerous situations (Bertram 1996).

Alongside the reasons in which the war on drugs failed to reach its goals, Bertram also lists the unintended negative consequences resulting from the prohibition model. The war on drugs exacerbated the crime problem in the United States by criminalizing users and giving buyers an incentive to turn to "economic-compulsive" crime (crimes committed to gain drugs or money to buy drugs) (Bertram 1996). Increased enforcement also resulted in the wild expansion

of the black market, as suppliers had to find increasingly inconspicuous ways to continue selling (Bertram 1996). Health and healthcare was undermined. Needle sharing increased, as users were pushed to adopt unsafe habits in order to stay hidden. Pregnant users avoided prenatal care, which led to the spread of fetal health issues (Bertram 1996). One of the most serious consequences of the war on drugs was the deepening racial and class divisions. The war on drugs quickly morphed into a war against communities consisting of primarily poor communities of color, specifically in the inner city (Bertram 1996). Kevin F. Ryan, author of Clinging to Failure: The Rise and Continued Life of U.S. Drug Policy says:

> The evidence of racial discrimination in the drug war…is persuasive and disturbing. While whites make up the vast majority of regular users of illegal drugs in the United States, blacks are four times more likely to be arrested on drug charges, making up 41% of all those arrested on drug charges in 1991… In New York City in 1989, 92% of people arrested for drug offenses were African American or Latino. And these differentials cannot be explained by either greater minority use of drugs or minority dominance of the drug trade… It appears that blacks and Latinos are not significantly more likely to use drugs than are whites… Despite this, law enforcement attention to the drug trade tends to be concentrated in inner-city, minority neighborhoods, yielding vastly more arrests of minorities than of whites, and fostering the public impression is almost entirely the domain of black and Hispanic youth. (Ryan 1998: 226)

Harm Reduction's Beginnings in the US

Similarly to its beginnings in Europe, the harm reduction model was introduced in the United States as a response to the increasing number of HIV/AIDS cases. According to Don C. Des Jarlais, author of *Harm Reduction in the USA: The Research Perspective and an Archive to Dave Purchase*, there are a few reasons for harm reduction's slow start in the US. From a research perspective, scientists viewed substance use disorders as a disease, which was an opposition to public view. But, similarly to popular opinion, they believed that the only solution was total abstinence from drug use. On a social perspective, the major model in the United States

surrounding drug policy until this point was the moral/prohibition model, which contributed to the wide scale demonization of illicit drugs. Along with the demonization of drugs was the demonization of poor black and brown communities. The crack epidemic, which made the HIV epidemic incredibly difficult to combat, was focused in the inner city. The stigmatization of these communities led political leaders to be wary of supporting harm reduction programs, specifically needle exchanges, so they don't seem to "condone" drug use (Des Jarlais 2017). The initial opposition of the harm reduction model from the federal government resulted in a delay in widespread implementation for years, even though individual states are responsible for public health. This was because the federal government held the majority of funding for research. New York City's Department of Health attempted to implement 'pilot projects' in 1985, but were vetoed by the NYPD (Des Jarlais 2017). Despite strong opposition, the first pilot project was adopted in 1988. It produced positive results in getting users in long-term substance use treatment. Unfortunately, opposers of needle exchange programs added a provision to the funding bill of the Department of Health & Human Services which prohibited federal funds from supporting needle exchange programs until they were proven "safe and effective". Jarlais calls this situation a "catch-22", because, at the same time, the government was refusing to fund research on the effectiveness of these programs (Des Jarlais 2017). These delays in results led to very little federally supported needle exchange programs initially.

In the early to mid 1990s, as HIV/AIDS numbers continued to rise, state & local government, activist groups, and private foundations were forced to take matters into their own hands (Des Jarlais 2017). Dave Purchase was the mind behind the first public needle exchange project in 1988, which took place in Tacoma, Washington (NHRC 2022). Purchase saw that there was a need within the community to come together, receive mutual support, and provide mutual

exchange. Purchase truly embodied the principles of harm reduction, saying “We believe that drug users and other vulnerable people matter. They're sons, daughters, sisters, brothers, moms, dads, and grandparents. Each one is "somebody's someone" – and should be treated as such.” (NHRC 2022). Purchase also organized the first North American Syringe Exchange Convention (NASEC) in 1990, which led to the funding of the North American Syringe Exchange Network (NASEN) (NHRC 2022). NASEN had several critical components. It provided start up kits for those who wanted to start their own syringe exchange for their community, funded the annual NASEC convention in countless cities, provided a grants program to new syringe exchange programs, and created a buyer’s club in order to get the cheapest possible prices on syringes. (NHRC 2022) Purchase is known as a major proponent of the syringe exchange movement within the United States. NASEN’s programs grew from 50 in 1995 to over 100 by 1997 (Des Jarlais 2017). These programs provided more opportunities for research surrounding harm reduction. By 1998, the Secretary of Health & Human Services found that needle exchange programs were ‘safe and effective’ (Des Jarlais 2017). Over the years, needle exchange programs began to expand from its original purpose to reduce the transmission of blood borne infections. They began providing additional health & social services to drug users, such as condoms, treatment referral, HIV counseling & testing, and naloxone provision & education. (Des Jarlais 2017)

Findings

Needle Exchange Programs

The overwhelming majority of studies have found that needle exchange programs (NEP’s) are associated with beneficial outcomes (Strathdee, Vlahov 2001). In New York City, NEP’s are associated with a dramatic decline in HIV incidence (Strathdee, Vlahov 2001). In

fact, there is no published evidence of NEP's causing negative societal effects such as an increase in drug use or drug related crime (Strathdee, Vlahov 2001).

One study that explores the effectiveness of a local NEP is detailed in *The Significance of Harm Reduction as a Social and Health Care Intervention for Injecting Drug Users: An Exploratory Study of a Needle Exchange Program in Fresno, California* by Kris Clarke, Debra Harris, John A. Zweifler, Marc Lasher, Roger B. Mortimer & Susan Hughes. It was a small-scale quantitative study conducted by a team of physicians and social work professors, located in Fresno, California. Fresno has one of the highest rates of IDU (injection drug use) in the United States, and is incredibly impoverished. The study examined how injection drug users reported the impact of NEP's on lowering infection risk and enhancing safety, and took place between December of 2010 and March of 2011. The NEP in which the study took place served about 100-150 people each week, every Saturday for 2 hours. 106 respondents answered an anonymous, close-ended questionnaire. The results reported (Clarke, Harris, Zweifler, Lasher, Mortimer, Hughes 2016): on needle sharing, 43% of respondents denied sharing needles before, and 48% reported ceasing needle sharing after attending NEPs. On needle reuse, 18% who reused needles before stopped after attending NEPs. On infection control, 83% reported using alcohol wipes, 67% reported using cotton, 55% reported using soap & water, and 91% reported using sterile syringes. 70% of respondents reported obtaining clean needles at least every two weeks. The lessened impact of NEP on needle reuse compared to needle sharing suggests that "further research and education may be needed regarding the dangers of introducing skin-borne infections such as methicillin-resistant Staphylococcus aureus, and the increased potential for transmission of blood-borne pathogens if used needles are then shared." (Clarke, Harris, Zweifler, Lasher, Mortimer, Hughes 2016: 404). The conclusion of this article found that "this

study demonstrated that IDUs are willing to use clean needles when they are available and that available clean needles reduce infections related to sharing behaviors; therefore, NEPs are a valid public health tool." (Clarke, Harris, Zweifler, Lasher, Mortimer, Hughes 2016: 405)

A review that further discusses the effectiveness of NEPs is Straight to the point: A systematic review of needle exchange programs in the United States, authored by Rebecca A. Vidourek, Keith A. King, Robert A. Yockey, Kelsi J. Becker, Ashley L. Merianos. The purpose of this study was to examine the efficacy of NEPs within the United States. The methodology of the study consisted of a comprehensive literature search of various online databases from the period of 2007-2017. Some, but not all, of the search terms included heroin, opioids, injection drug use, harm reduction, syringe exchange, and needle disposal. Only studies conducted within the United States were included. A total of 12 articles fit the criteria. The major findings in each of the articles seemed to vary in some aspects and remain consistent in others. For example, 4 of the 12 studies reported in their major findings that the NEPs were shown to reduce injection risk behaviors (Huo, Oullet 2007; Holtzman 2009; Knittel, Wren, Gore 2010; Fuller, Galea, Caceres, Blaney, Sisco, Vlahov 2007), but specific studies recorded the ways their programs were being impacted by factors such as fear of law enforcement interference (Heller, Paone, Siegler, Karpati 2009) and lack of funding & staff (Des Jarlais, McKnight, Goldblatt, Purchase 2009). Overall, the review concluded that "NEPs have a positive effect on health outcomes among IDUs. Increasing strong methods in research evaluations would enhance the current research and increase evidence of effectiveness." (Vidourek 2019: 9).

From the results of the NEPs evaluated, it is quite evident that these programs are creating a positive impact within their communities. NEPs often provide other harm reduction services to the community, such as condoms and STD testing. Many programs struggle with

funding and a lack of staff support. It seems that NEPs are in need of further support, specifically financially. The varied results of many of these studies could suggest the need for further research, specifically on what components in NEPs enhance or reduce their effectiveness.

Conclusion

As time progresses, drug use will continue to have a place in society, as will addiction. The research shows the plethora of shortcomings and negative outcomes of the United States' war on drugs (Duncan, Nicholson 1997; Caulkins 2005; Ryan 1998; Bertram 1996) . The research also shows the success of policies and programs based on the harm reduction model outside of the United States (Duncan, Nicholson 1997; O'Hare 2007; Eaton, Seymour, Mahmood 1998). It is imperative that the United States dedicates more funding, research, and initiative into harm reduction programs. Harm reduction acts as an alternative, more pragmatic approach to the problem of drug abuse, treating it as a social issue instead of a moral failing, such as the prohibition model. By presenting the beginnings of the harm reduction model in both the Netherlands and Merseyside, an overview of the history of the United States' drug policy, and evaluating the effectiveness of various harm reduction programs within the United States, my hopes is that this research project expands the conversation of harm reduction within the United States, and encourages the continuation of research, policy making, and empathy based care. There is an abundance of power in compassionate care.

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