Compassionate Pragmatism on the Harm Reduction Continuum:
Expanding the Options for Drug and Alcohol Addiction Treatment in Japan

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Abstract
Harm reduction is considered to be a powerful approach to enhance the intervention options for addiction problems and has been introduced to the majority of the countries that report drug use problem. The term "harm reduction" itself was first brought to Japan in the early 1990s. Yet the discussion on integrating the harm reduction approach to the Japanese situation didn't start until recently. The authors discuss (i) the four salient features in regard with the acceptance of and the resistance to the idea of harm reduction, and (ii) the importance of the peer-led initiatives in Japan, then, (iii) indicate the possibility of practice based on "compassionate pragmatism."

Key words
harm reduction, penal populism, peer-led initiatives

1. Introduction

This brief article is to describe the current situation regarding the interventions for drug and alcohol addiction in Japan, addressing "compassionate pragmatism" on the continuum of harm reduction and zero-tolerance/abstinence. Harm reduction is a conceptual framework and a practice model for public health and social policy that aims to mitigate to the fullest extent the life-long

health damage to individuals caused by drug use and to minimize the impact of drug problem on society. Historically, this approach emerged as the alternative to "zero-tolerance" or "abstinence only" policies in the 1970's Europe [Eng 2007]. Harm reduction encompasses interventions and policies that seek primarily to reduce the harm of substance use or particular behaviors (*e.g.* pathological gambling) *without necessarily requiring abstinence* from it. In the process of implementation, policy resistance is often raised [Rhodes et al. 2010].

In the intervention under the harm-reduction approach, the elimination of risky behaviors is not necessarily pursued. For instance, safer use of drugs with medical supervision (*e.g.* heroin-assisted treatment, *see* Blankan et al. [2010]) would be the primary goal, rather than the immediate secession of drug use. It is considered an abstinence-oriented approach when being sober or clean is set as the treatment goal of drug and alcohol addiction.

It may seem contradictory in the short-term that continued use of drugs could be a method of drug addiction treatment. However, being connected with a harm reduction program may later lead the drug-using clients to further healthcare resources before the severity of their addiction intensifies. The client may then be motivated to quit drug use. The evidence shows that individuals on harm reduction program are less likely to utilize emergency medical services, generating less medical expense [McCarty et al. 2010], are more likely to have a job, and less likely to commit minor criminal conducts [Rogers and Ruefli 2004]. This is one example of how harm reduction works to minimize overall risk and damage [Nuts et al. 2010] to individuals and to society.

In Japan, the abstinence-oriented treatment model has long been the standard of addiction care. As for the judicial policy for illicit drug use, zero-tolerance has been consistently applied since late the 1940s up until the present. There is a belief in the validity of zero-tolerance/abstinence both within the community of specialists and in society in general. This belief may be changing but it seems steadfast at the moment.

The term "harm reduction" itself was first introduced to Japan through the HIV/AIDS specialists in the early 1990s [Misago 2007: 206-210]. Yet the discussion on integrating the harm reduction approach to the Japanese context didn't start until recently [*e.g.* Ishizuka 2013; Koto et al. 2006]. In the following sections, the authors outline some arguments about the addiction and drug use problem in Japan and then, discuss the possibility of integrating the idea of harm reduction to the existing measures and resources in Japan.

2. The acceptance of harm reduction

Addiction is a multi-faceted health problem and the areas of interventions range widely — public health, medicine, social welfare and law enforcement. Accordingly, the practice under the harm reduction approach includes a variety of activities.

In the research by Ritter and McDonald [2008], one hundred and eight interventions for drug problems were counted and thirteen of them were coded and categorized as "harm reduction" in "Four Pillar" taxonomy — prevention, law enforcement, treatment, harm reduction. Meanwhile, Kellogg [2003] identified 26 interventions for drug and alcohol as harm reduction. In the both lists, social care services such as drop-in centers, peer-led activities or outreach are included as well as needle exchange for preventing HIV and the use of drug consumption room (Table I). The heroin

maintenance and the other substitution maintenance are classified in the category of “treatment” in the Four Pillar taxonomy, but are categorized as harm reduction in Kellogg’s list.

All the activities on the lists serve to accomplish one or more of the following; (i) the reducing of an individual’s health risks in order to prevent from early death, (ii) maintenance or enhancement of the level of social integration of drug users, and (iii) the minimization of social disturbance and minor crimes related to drug use.

(Table I) Harm Reduction Intervention

Typology of Harm Reduction Intervention	Staying alive	Maintaining health	Getting better	Harm Reduction in Four Pillar Taxonomy
Designated Drivers	●			Peer-led advocacy and support programs
Earlier Liquer Store Hours to Prevent Non-beverage Alcohol Consumption	●			Needle Syringe Programs
Naloxone Distribution	●			Outreach programs
Overdose and Safe Injection Information	●			Peer education for users
Low Threshold Methadone Treatment	●	●		Regulations (and/or legislation) in relation to drug paraphernalia
Dance Drug Testing	●	●		Overdose prevention programs Peer administered naloxone
Safe Use/Injection Rooms	●	●		Peer administered naloxone
Low Bevarage Alcohol	●	●		HIV prevention and education programs
Safety Glassware in Bars		●		HIV/hepatitis coluntary counselling and testing programs
Server Training		●		Supervised Injecting facilities
Needle/Syringe Exchange Prevention Model		●		
Needle/Syringe Exchange Risk Model		●	(●)	
Heroin Maintenance		●		
Motivational Interviewing		●	●	
Harm Reduction Psychotherapy		●	●	
Medium/High Threshold Methadone Treatment		●	●	
Acupuncture and Herbal Treatments		●	●	
Substance Use Management		●	●	
Moderation Interventions		●	●	
Drop-in Centers		●	●	
Buprenorphine-Naloxone Treatment			●	
Naltrexone (Alcohol)			●	
Standard Methadone Treatment			●	
Contingency Management Approaches Based on Gradual Use Reduction			●	
Drug and Alcohol Education	●	●	●	

The practice of harm reduction was originally developed as a practical response to the drug problem. But only after a decade have societies became convinced of its utilitarian effect. The areas that harm reduction approach can be applied to are expanding to include alcohol, smoking, safe abortion *etc*. [Ritter and Cameron 2006; Eldman 2011].

As to country coverage, of the 158 countries reporting injecting drug use, ninety 91 include harm reduction in national policy [Stone 2014]. The harm reduction approach is central in Europe, Canada and Oceania, and insufficiently implemented in Russia and the United States where the resistance to it is strong. In nineteen Asian countries including China, Thailand and India, explicit supportive reference to harm reduction is found in the national level policy documents. Harm reduction packages are developed in order to facilitate the implementation by the Joint United Nations Program on HIV/AIDS (UNAIDS), the United Nations Office on Drugs and Crime (UNODC) and the World Health Organization (WHO).

Japan and the United States are the two big anti-harm reduction advocates while being major donors to UNODC. In fact, Japan was the only country to express directly doubt about needle exchange, concerned that distribution of needles might increase drug abuse at the 48th session of the UN Commission on Narcotic Drugs (CND) in 2005 [Jelsma 2005]. Obviously, Japan is one of a few remaining countries resistant to the idea of harm reduction even after the majority of countries have turned away from the old paradigm of zero-tolerance.

3. The four salient features of the drug problem in Japan

In Japan, the drug problem is considered to remain a small scale issue at present[1]. The statistics show low levels of lifetime use of illicit drugs [Ministry of Health, Labour and Welfare 2011] (Table II). According to the biennial survey conducted in 2013, only 1.3 % of the population aged fifteen to sixty four nationwide responded that they had ever used illicit drugs in their lives. And it is estimated that the prevalence rate of drug addiction is under 0.1% in the past year [Kawakami et al. 2005]. This is certainly a contributing reason why harm reduction is not much of concern in Japan.

(Table II) Lifetime use (%)

	Year	Population	Cannabis	Amph/ M-Amph	MDMA	Coccaine	Heroin	Novel Psychoactives
GER	2009	18-64	25.6	3.7	2.4	3.3	-	-
FRA	2010	15-64	32.1	1.7	2.4	3.7	-	-
ITA	2008	16-64	32.0	3.2	3.0	7.0	-	-
UK	2006	16-59	30.2	11.9	7.5	7.7	-	-
USA	2010	12-	41.9	5.1	6.3	14.7	1.6	-
JPN	**2013**	**15-64**	**1.1**	**0.5**	**0.3**	**0±**	**0±**	**0.4**

When it comes to alcoholism, on the other hand, it is estimated 2.3 million (one out of every twenty six drinkers) are alcoholic including undiagnosed cases. If that is combined with the number of pathological gambling cases, the potential number in need of proper intervention cannot be viewed as small anymore. Accordingly, it is presumed that there are emergent health needs not yet covered by the existing resources both in quantity and in quality.

To improve resources to meet these needs, it could be a possible solution to enhance intervention options by introducing the harm reduction approach. Henceforth, the authors are going to discuss four salient features related to the social resistance against harm reduction.

3.1 Public health: *Population approach* rather than *high risk* approach

In the public health discussion, preventive intervention is understood as a balance between two schemes – *population approach* and *high risk approach* [Rose 1993]. When a health problem still remains small, it is more effective to give higher priority and concentrate on measures for the people facing at risk (*high risk group*) rather than for the general population. This theory is not well incorporated into the policies and their implementation for the addiction problem in Japan.

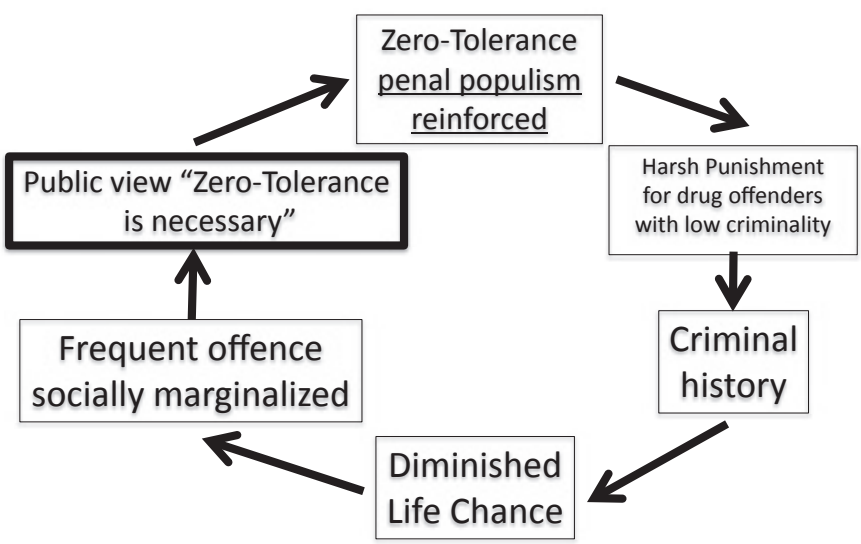
For example, as one of the measures for the national level primary prevention, the Ministry of Health in cooperation with the Ministry of Law has been practicing the "*Dame, Zettai* (No, you never do it!)" mass media campaign for twenty years. This campaign message is widely known in the country and has contributed to the formulation of a social norm that drug use is evil, which would appear to be a good outcome, apparently.

But, this success at the same time kept the drug use and addiction problem confined to an issue in the moral and criminal context rather than being addressed in the health arena. With moral punishment prevalent in the society, the importance of early public health intervention for the individuals at immediate risk would be understated and given the lowest priority. This idea is of course related to the misunderstanding that strengthening the *high risk* approach and secondary prevention is wasting money on "future and current" drug users who are themselves to blame. This way of thinking is the current reality in Japan and mass-scale campaigns that are not followed by other type of interventions are related to two other negative consequences explained below.

3.2 Criminal justice: Zero-tolerance policy endorsed by penal populism

There is a routine discussion; harm reduction is not applicable to Japanese society because there is no legal backdrop to implement harm reduction programs. As noted in the previous section, Japan holds a zero-tolerance approach to the drug problem; laws are strictly enforced in drug-related crimes regardless of the level of criminality. Therefore, decriminalization of drug use hasn't yet been considered as an issue in the public domain. According to the latest criminal statistics, 20% of the prison inmates are drug-related offenders. They are often frequent offenders.

The reason why drug-related criminals tend to be frequent offenders is quite simple; they are addicted to the drug and they go back again to drug use after release, unless their addiction is treated. More important still are social reasons; a criminal history diminishes an individual's opportunities in life; ex-prison inmates are more likely to face difficulties in re-establishing their lives in terms of proper housing, work, income and social relationships. Substance use — drugs, alcohol



(Chart I) Cycle of Penal Populism

or something else, is chosen by an individual as a way to cope with the life. Committing further crimes may be motivated by the need for money to buy drugs. In the case that an individual is young and with low criminality, the harsh punishment based on the zero-tolerance policy could open the way for him or her to enter to the marginal population. In fact, quite apart from drug arguments, the matter of social rehabilitation and re-integration require immediate action for improvement.

The social view in which drug users are malevolent can be endorsed by the chain of frequent offense (see Chart I.). It justifies the social view that taking strict measures against the drug problem is necessary. In such a cycle of *penal populism*, the politicians and government decision makers are unwilling to move from a zero-tolerance stance. However, the judicial professions and the government officials in charge of correctional institutions are very much aware of this reproduction cycle of drug offence and the improvement plans have already been started.

3.3 Health and social care: Shortage of treatment for "addiction"

As explained before, the addiction problem has remained relatively small in scale in Japan. This resulted in the lack of interest in addiction treatment among medical professions. Naturally, it means the shortage of trained therapists for addiction treatment. In medical facilities, the focus is on detoxification and the treatment of psychotic symptoms related to drug/alcohol. They also provide patient education including peer support discussion, but the treatment for addictive behaviors is available only in the limited number of hospitals and clinics.

In recent years, some leading psychiatrists and clinical psychologists have been actively providing training courses for the psychotherapies such as motivational interviewing, cognitive behavioral therapy, anger management or social skills training. The situation surrounding individuals who seek for treatment is surely becoming better but those in need for treatment still surpass the therapists and group workers trained for the newly introduced therapies in number.

Sometimes, medical professionals support penal populism as they lack knowledge and experience, and misunderstand the addiction problem. Some of them avoid alcoholic or drug addicted patients, labeling them as problematic. Even worse, some call the police to inform them of illicit drug use, which is not mandatory. These episodes undermine help-seeking behaviors of those wishing treatment and recovery.

3.4 Peer-led initiatives

A lack of care resources provided by trained specialists resulted in giving key-role to peer-led initiatives. In Japan, social care and rehabilitation, — after being released from prison or after being discharged from the hospital — are mainly provided by peer-led organizations, the organizations run by recovering addicts and alcoholics.

There are more than seventy peer-led facilities for individuals with addiction problem all over Japan. The majority of them are the facilities with a few recovering staffs and have occupancy of less than ten residents. They provide housing support and residential/outpatient rehabilitation program based on twelve steps guidance. The twelve steps program is a typical abstinence-oriented approach. Accordingly, the ultimate goal of the programs provided by these peer-led facilities is the establishment of life without using harmful substance.

4. Harm reduction as “compassionate pragmatism”

On the other hand, in the daily practice of the peer-led programs, keeping abstinence is not always the absolute rule. For example, Relapse episodes are not regarded as a failure but as something that the clients learn about themselves from. The leaders and staff know from their own experience that recovery is a long process and that achieving stable abstinence is not easy. They encourage the clients to disclose when relapse happens. If the client is still wishing to recover from addiction, the relapse episode is embraced as something that inevitably happens in the recovery process.

In the peer-led initiatives in Japan, abstinence is the final goal of the treatment. But, as a matter of fact, their approach is (i) low-threshold and emphasizes (ii) keeping oneself on the recovery track (“*Keep coming back, it works!*”). Their practice resembles what Marlett [2011] calls “compassionate pragmatism.”

Harm reduction originated from a practical response for HIV among Injecting Drug Users (IDUs), and was an invention of peer-to-peer activities. Then, it was propagated and incorporated into the formal public scheme as a “pragmatic” approach that balances public health needs and public order. But in this context, its connotation is a “compromise” to the complexity of the drug problem. At the beginning, harm reduction was a practice of self-help and empowerment, which seems to have disguised. But the practice similar to its original philosophy of harm reduction is now recognized in the peer-led activities in Japan. The rehabilitation programs in the peer-led organizations provide safe environments for recovery; the staff, and of course, the clients never say “*Yes*” to drug use but one is not blamed for using drugs.

In the first place, we should note that harm reduction and abstinence-oriented interventions form a continuum and that they are not mutually exclusive [Kellogg 2003]. The harm reduction approach focuses on the benefits to the individuals who have not yet sought treatment and it functions as a bridging component to the abstinence-oriented treatment. Recognizing this point should allow one to separate the discussion on harm reduction from the moral judgment and victim blaming.

(Table III)

Six Core Ideas in Harm Reduction [Tatarsky 2003]

1 Meeting the client as an individual
2 Starting where the patient is.
3 Assuming the client has strengths that can be supported
4 Accepting small incremental changes as steps as the right direction
5 Not holding abstinence as the necessary preconditions of the therapy before really getting to know the individual
6 Developing a collaborative, empowering relationship with the client

5. Conclusion: Communication-Design Input

In this article, the authors described the Japan's drug situation in regard with possibility of introducing harm reduction approach. The followings are discussed; (i) in Japan, the treatment and rehabilitation needs for addiction outnumbers the supply and the care options available are still limited, (ii) in the cycle of the zero-tolerance policy endorsed by penal populism, drug and addiction problems raise less public concerns, and (iii) in this circumstance, the peer-led organizations began the support activities for addiction problems with their own "compassionate pragmatism" which is the very basic of the harm reduction approach.

The authors conclude this brief article with a suggestion for the *Communication-Design* regarding the addiction problem in Japan. The purpose of the communication is to activate discussions to change the cycle of penal populism and to overcome the binary decision making of "*let use or not*" so as to enhance intervention options:

The Information, Education, and Communication (IEC) strategy for alcohol and drug addiction problem should be planned with the following two principles constructing the meta-message.

(I) *People-first principle*: when an individual is facing a crucial health risk, it is not judicial intervention but appropriate treatment and care that should come first.

(II) *Equality of human rights*: harm reduction is not a final salvation for those in miserable condition caused by addiction. Giving care and support for the people who need help is not a charity but we are obliged to do so in terms of human rights justice. Seeking health is a basic human right.

Notes

1) However, the recent epidemiological studies on substance misuse imply changing patterns of drug use behaviors and clinical manifestations. Among the generation under 40, use of cannabis and novel psychoactive drug (so-called designer drugs) is rapidly increasing while methamphetamine is the choice of the older [Wada et al. 2014]. Matsumoto et al. [2011] indicated the increase in addiction or misuse cases of prescribed medicine (*e.g.* benzodiazepines, methylphenidate). These research findings suggest that it is urgent to raise public awareness of this newly emerged drug problem. The current situation calls for early stage response.

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Japanese Abstract

共感的プラグマティズムとハーム・リダクション連続体：日本における薬物・アルコール依存症ケアの選択肢を増やすために

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キーワード
ハーム・リダクション、厳罰要求、当事者運動

本稿では、日本における依存症からの回復支援に、ハーム・リダクションの考えがどのように寄与するか、その可能性を検討する。ハーム・リダクションを導入することの根拠は、飲酒・薬物乱用等による健康被害が進んだり、生活再建が著しく困難になったりする前に、個人をケア資源にむすびつけ、依存の深刻化を防ぐことができるということである。他方、日本のアルコール・薬物依存症への介入理念（ポリシー）は、長い間、禁酒・断薬、司法における厳罰主義が標準とされてきた。それゆえ、日本では、ハーム・リダクションについての誤解と抵抗が専門家の間でも見受けられることがある。本稿では、日本における依存症者と依存症介入における4つの特徴を指摘する。そして「共感的プラグマティズム」と「ハーム・リダクション連続体」の考え方を紹介して、日本の当事者運動から生まれたサポート・プログラムを位置づける。