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Commentary

# Public Health and the origins of the Mersey Model of Harm Reduction

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ABSTRACT

In the mid-1980s in Liverpool, and the area surrounding it (Merseyside and Cheshire), harm reduction was adopted on a large scale for the first time in the UK. The harm reduction model was based on a population approach to achieve the public health goal of reducing the harm to health associated with drug use. The particular concern at that time was the risk of HIV infection, but there was also the issue of the health of a group of young people who were under-served by health services. To achieve the goal, services were developed that would attract the majority of those at risk within the community, not simply the few who wished to stop using drugs, and which would enable contact with the target group to be maintained so as to bring about the necessary changes in behaviour required to maintain health and reduce risk. This Commentary describes some of the background to the development of the Mersey Model of Harm Reduction from the memories and perspectives of two people who promoted harm reduction within the health service and the region.



## The early days

In 1984, John Ashton, then Public Health Consultant for the Mersey Regional Health Authority published his annual Public Health report (Ashton, 1984). In the report the question of drug use merited only a small section, however, the report noted that action was needed to monitor this growing problem. This showed foresight because within 12 months, against a background of increasing unemployment, Merseyside discovered that it was in the middle of a heroin epidemic (Parker, Keith Bakx, & Newcombe, 1988). Liverpool was re-branded as "smack city". Liverpool was one of many cities to experience a rapid increase in the number of young people using heroin in the early 1980s. The key period was probably between 1979 and 1981 when heroin use took off in many towns and cities in Scotland and the north of England, and for the first time there were clear links between heroin use and unemployment and deprivation (Pearson, 1987).

Action was needed, but it was soon realised that this would not be without conflict. This came in the form of a city council dominated by Trotskyite politicians from the political group Militant (who saw the social disruption caused by large scale drug use as necessary because it would help to stimulate a proletarian revolution) and mental health clinicians who saw abstinence as the only legitimate goal for drug services.

Our description in this Commentary is very much from the perspective of two people who tried to encourage and support all the grassroots and frontline work that occurred in the space of a few years in Merseyside. To aid our memory, some of the events and activities described in this article are taken from Seymour and Eaton (1997). There are many aspects to what happened and we hope that others will add their own histories.

In the face of the situation in the mid-1980s an informal alliance developed of key players from different sectors. It included the authors of this Commentary—John Ashton, the newly appointed Public Health Consultant and England's first Regional Health Promotion Officer, Howard Seymour. Our aim was to build a new public health by taking the rhetoric of World Health Organisation's *Health for All by the Year* 2000 and turning it into effective action (World Health Organization, 1978, 1981). At the heart of this approach was an emphasis on primary care, multi-agency working and public engagement. We outlined this approach in our book The New Public Health (Ashton & Seymour, 1988). The alliance also included the Mersey Regional Health Authority Chairman, Sir Donald Wilson, a friend of Prime Minister Margaret Thatcher, a man who was committed to the interests of patients and who was prepared to make and implement unpopular decisions. Also important were the local church leaders Derek Warlock, David Sheppard and John Newton who were determined to work to partnership to heal the problems caused by urban deprivation.

With this alliance in place, the first key pieces of the jigsaw, that became the Mersey Model of Harm Reduction, were created. In 1985, we met the San Francisco Director of Health Education, Glen Margo. He had first-hand experience of the tsunami of AIDS that had hit the gay community. Glen persuaded us that the most effective

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actions they had taken usually involved direct involvement of the people at risk.

On the initiative of the church leaders, Sir Donald agreed to set up the new Mersey Drug Training and Information Centre (MDTIC). Numerous others were involved. Dr John Marks, who still followed the British approach to the treatment of drug problems recommended by the 1926 Rolleston Committee (Departmental Committee on Morphine and Heroin Addiction, 1926), was appointed as the temporary medical director to the associated clinic. The Rolleston Committee had endorsed – in certain circumstances – the prescribing of opiate drugs to people addicted to them. With the aim of involving the people most affected, we appointed Alan Parry, a charismatic educator and former drug addict, as its director. It was Alan who, after meeting Glen, recognised that, unlike the USA, a syringe exchange programme could be set up here, and based it on the Dutch model from Amsterdam. Following promises from the police not to deter clients from using it, we set up the service at the MDTIC in a low key way, promoted by word of mouth rather than advertising. The Editor of the Liverpool Echo newspaper was briefed, and an agreement reached that no story would be run until we were ready, but when we were ready to go public it would be exclusively with that newspaper. The Maryland Syringe Exchange Programme opened its doors in spring 1986. It was one of the first three needle and syringe exchanges in the United Kingdom. The thinking behind harm reduction was rapidly developing, as also the evidence base. Russell Newcombe, a leading theorist of harm reduction published the first ever paper on harm reduction (Newcombe, 1987).

## Adopting a population model of harm reduction

From these roots the Mersey Model of Harm Reduction was developed. We set three guiding principles for the model: *make contact* with the whole population at risk, not just the few who were already in touch with health care services; *maintain contact,* in the belief that, at the very least, if they are in contact drug users may be influenced to change their behaviour; and *make changes* in their behaviour. These principles subsequently influenced the UK Advisory Council on the Misuse of Drugs (ACMD) in its landmark recommendations to government (Advisory Council on the Misuse of Drugs, 1988). The ACMD report endorsed the harm reduction approach (though did not use this term) with its key statements that '. . .the spread of HIV is a greater danger to individual and public health than drug misuse. Accordingly, services which aim to minimise HIV risk behaviour by all available means should take precedence in development plans' and that 'We must therefore be prepared to work with those who continue to misuse drugs to help them reduce the risks involved in doing so, above all the risk of acquiring or spreading HIV'.

A range of user-friendly and non-judgemental services, which were attractive to large numbers of drug users, were set up. This included needle and syringe exchange, a simple low-threshold, "no questions asked transaction" that was attractive to large numbers of people who were injecting drugs. It was simply commonsense to many in the alliance that such a service should be non-judgemental and treat drug users with respect (i.e. be user-friendly). Also that it should, where possible, be separate from, and unconnected to, any other treatment service. It also included what was then called substitute prescribing (opioid substitution therapy)—the provision of substitute drugs as a means of attracting drug users into services where we could meet their health care needs. We viewed methadone (and in some cases heroin) prescribing as a cost-effective means of helping people reduce their use of impure street drugs with all the associated health risks. Outreach developed as a strategy to get in touch with those drug users not attracted to other services and which would offer them, if nothing else, basic primary care interventions: information, advice and clean injecting equipment.

Drug users took up syringe exchange in large numbers. In the first 10 months, 733 came to the syringe exchange in Liverpool (Carr & Dalton, 1986). In 1987 the Liverpool syringe exchange services also became part of the government supported demonstration project to assess and evaluate the impact of syringe exchange (Stimson, Alldritt, Dolan, & Donoghoe, 1988). By 1988 we developed the Liverpool syringe exchange scheme into a new type of primary health care service for users, offering advice on safer injecting, treatment for abscesses, other injecting-related health problems and HIV testing (hepatitis vaccination was offered later). Drug users were also attracted to the Drug Dependency Unit in Liverpool which, soon after it was established, offered maintenance prescribing and not simply detoxification. In the first 2 years, 1019 opiate users came to the Liverpool Drug Dependency Unit (Fazey, 1988). Drug treatment services in Mersey were responsible for one-third of the methadone prescribed in England in the late 1980s. Between 1986 and 1993 syringe exchange schemes and drug treatment units were established throughout the region. We did not feel that we quite got outreach right, though others will disagree and there were some notable pioneer outreach workers such as Peter Cain and Lyn Matthews. But in many districts many workers and their managers never really understood that it was a strategy for making contact with the target group, those hard to reach, so as to be able to deliver primary care interventions rather than develop a deeper relationship with a few problem users.

We met some of our objectives. Over the next 5 years, by offering appropriate interventions, we estimate that we were in touch with 50% (10,000) of the high-risk drug-using population in Merseyside. The sharing of needles and syringes was reduced considerably (Stimson, 1988). Most drug users seeking treatment accepted oral substitute drugs, those who were not were offered injectables (about 10%). The use of street drugs reduced for people who used our services. An added bonus was that crime in Merseyside was reduced. In the early to mid-1980s Merseyside had one of the highest recorded crime rates in England and Wales. Crime declined from 1987, in particular, the acquisitive crimes of burglary dwelling and theft from vehicles. A Home Office report attributed this decline to the large scale methadone programmes (Parker & Kirby, 1996). We achieved little in the way of abstinence—we did not expect to!

On behalf of all the people who created harm reduction on Merseyside, we are proud of what developed in the space of a few years, and for the contribution that the Mersey Model of Harm Reduction – and the people involved – made to the development and acceptance of harm reduction in the UK, Europe, North America and Australia and the further internationalisation of harm reduction.

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