Fraser Institute Digital Publication / April 2001
Sensible Solutions to the Urban Drug Problem

edited by Patrick Basham

Drugs, Violence and Public Health

What Does the Harm Reduction Approach Have to Offer?

Patricia G. Erickson

Urban drug-related violence as a public health problem

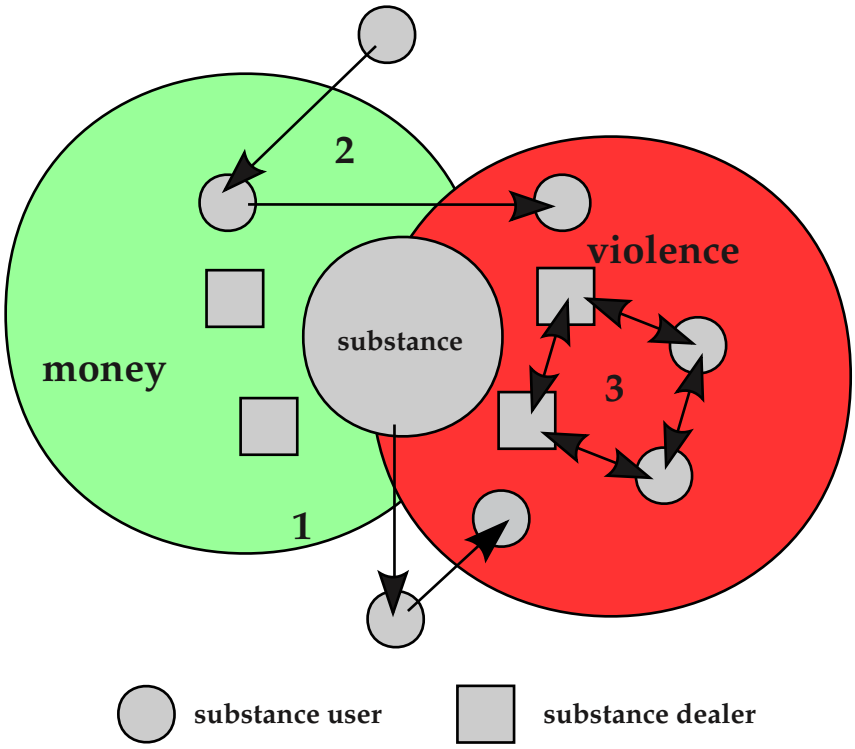
This chapter considers the topic of drug-related violence—that is, violence on our streets and in our communities—as a serious and urgent aspect of the problem of urban drugs. While violence has traditionally been considered a problem for criminal justice, a matter for the police and courts to respond to, a public-health model also offers a way of understanding, dealing with, and perhaps preventing, violence in urban areas. Harm reduction provides a framework to discuss new options that may be part of a "sensible solution" to the urban-drug problem. I will consider: (1) the fundamental issue of how drugs and violence are related; (2) the effectiveness of the harm-reduction approach and of criminal justice in dealing with violence; and (3) the need and likelihood of adopting this type of solution in Canada.

What is the relationship between drugs and violence?

This section draws heavily on the documents reviewed for, and final [draft] report of The Drugs-Violence Task Force of the US Sentencing Commission, on which I served (Drugs-Violence Task Force 1997).[1] The analytic model adopted as a framework for reviewing relevant research, one that has become generally accepted in the field, is based on the work of Paul Goldstein (1985). This Tri-Partite Model rejected the view that there was one simple form of the relationship between drugs and violence, and rather identified three different ways in which drugs could cause interpersonal violence. These three distinct expressions of the connection between drugs and violence are: (1) the psycho-pharmacological, which attributes violence to the effects on behaviour of the ingestion of a substance, when, for example, an individual becomes irrational, agitated, or irritable and engages in spontaneous violent actions); (2) the economic compulsive, in which acts of violence are the result of crimes committed by addicted or dependent users to get money for the purchase of drugs to support their personal consumption; and (3) the systemic, in which violence is seen as endemic in the illegal drug market, prompting participants to engage in acts of threat, intimidation, and punishment as a system of conflict resolution alternative to that displayed in legally regulated markets (Goldstein 1989: 24–30).

Goldstein provided new data, based mainly on research on homicide in New York, highlighting the major contribution of the systemic aspect in accounting for much, if not most, of drug-related violence (Goldstein et al. 1989). A number of other studies have validated his findings and also assessed the other two aspects of his model.[2] They cannot all be summarized here but I shall high-light some key findings, focusing on the most common illicit street drugs, cannabis, heroin, and cocaine (including crack).

Figure 1 The tripartite model
(1) psycho-pharmacological; (2) economic-compulsive; (3) systemic



Psycho-pharmacological violence

The notion that the psychoactive (i.e. mood modifying or "mind altering") properties of certain drugs lead those taking them to commit violent acts, *that they would not have done otherwise*, is likely what most people think of when this topic is broached. Indeed, this assumption about the relationship of drugs to violence provides much of the rationale, both current and historical, for current drug policies. The usual argument is based on the observation that the majority of prison inmates have long standing drug problems and histories of heavy use of intoxicating substances (though most often of alcohol), often prior to the commission of the particular crime for which they have been incarcerated.[3] Such is the presumed causal connection that such intoxication may be offered in mitigation of sentence (Erickson, Cohen, and Allen 1996). Yet the totality of the evidence is complex, difficult to assess, and far from conclusive.

Beyond the simple deterministic notion that drugs cause people to become violent, there are many subtleties that may affect such an outcome. These include the various ways the drugs are taken (i.e. the particular drug, its form, dose, mode of administration, frequency and duration), the expectation of the user, his or her perceptions of the expe-

rienced effects, the social situation of the drug-taking event, and the broad social cultural context of drug-use practices. All of these combine in ways that may overshadow the basic pharmacological properties of the substance. As one early commentator commented:

> the drugs which most people use safely, even if illicitly, and which some people use and in doing so become violent, are also capable of benign effects. Thus almost every substance for which hurtful or violent outcomes are claimed is also claimed to have benefits, and thus has led to widespread approved use . . . in medical practice . . . [including] the control of violence. The contradictions in effects are more apparent than real; powerful agents can affect behaviour; how they affect it depends on how they are used and by whom, in what settings and in what amounts. (Blum 1969: 1513)

Siegel (1996) suggests that cocaine, with its long history of peaceful use in South America and its current notoriety as a cause of violent crime in the United States, is an excellent illustration of both the pattern of use and the importance of the social cultural context. Similar observations can be made about the traditions of opium smoking, though, even in the United States in the 1920s, physicians had promoted the soothing effects of opiates as inhibitors of violence (Inciardi 1992). It is also an obvious truism to state that most drug-use episodes (like those of alcohol) are not followed by violence. There is also a long list of biological and psychological characteristics, as well as early formative experiences, that may predispose someone both to violence and to drug taking (Buka and Earls 1993). Thus, the sequence, and the possible interaction between, drug use and violent impulses could be extended back for some considerable period, even *in utero*, in order to unravel fully the complexity of the relationship in any particular episode and for a given individual. This is, of course, difficult if not impossible to do in most instances and, thus, a simple observation that drug use and violence coexist may lead to unfounded conclusions about causality. As Blum concluded, "no drug presently known will inevitably cause violence . . . it is the human and not the drug which acts violently" (Blum 1969: 1467).

If we subject the claims of high rates of drug use among prison inmates to closer scrutiny, the picture that emerges is that violent offenders (i.e. cases of homicide or assault) are *less* likely to report being under the influence of a drug at the time of their crimes than those convicted of non-violent crimes (Beck et al. 1993; Harlow 1991) Not surprisingly, drug offenders (those in jail for crimes of illicit possession or sale) have the highest rates of self-reported drug use, followed by robbers and property offenders. In the rare studies when careful assessment of particular incidents has led to a valid assessment that drug use is psycho-pharmacologically associated with homicide cases (a small proportion, 1.4 percent to 7.5 percent of the total cases), the substances involved

are far more likely to be alcohol or pharmaceuticals than heroin, cocaine, or cannabis (Boyd et al. 1991; Goldstein et al. 1989; Kleck 1996). Thus, while it may be a correct generalization that offenders use illicit drugs (and tobacco and alcohol) at higher rates than the general population, and that a substantial proportion have consumed drugs in a period proximal to the crime, it does not follow that the drug's effects were causally related to its commission.

This conclusion has been reached by several evidence-based reviews of the criminal justice research on drugs and violence in recent years. What follows is a sampling.

> [T]here is only limited evidence that consumption of . . . cocaine, heroin or other substances is a direct, pharmacologically based cause of crime. (Fagan 1990: 243)

> [U]sually the effects of drugs . . . do not directly give rise to violence . . . property offenders are more likely than violent offenders to be drug users. (US Dept. of Justice 1992: 5–7)

> [T]here is certainly no basis for a blanket assertion that taking any of them [drugs] causes people to behave violently (Reiss and Roth 1993: 182–83).

Such summaries may also be examined in relation to specific drugs. Some of this literature has involved controlled, laboratory studies with animals and human subjects, as well as large-scale criminal justice databases. While much more research has been done on alcohol than on other drugs (see Graham, Schmidt, and Gillis 1996), sufficient evidence is available from a variety of commissions and reports to draw the following conclusions about the violence-producing pharmacological effects of cannabis, heroin, and cocaine (see especially the appendices for Reiss and Roth 1993).

One of the strongest and most consistent relationships has been found for cannabis, namely that it is more likely to *decrease* violent or aggressive behaviour—the only qualification to this benign tendency in human subjects is that marijuana may aggravate a preexisting condition in an already unstable individual, such as someone suffering from a mental illness. Similarly for opiates, the weight of evidence over several decades is that opiate intoxication is an inhibitor rather than a precipitant of violence, particularly in low to moderate doses. For humans, the exception can occur during opiate withdrawal, with an increased likelihood of agitated, impulsive, behaviour. For cocaine, there is no solid body of evidence that taking cocaine increases violent behaviour, at least at low doses; indeed, among laboratory animals, cocaine increases defensive reactions to stress but not aggressive behaviour (Miczek et al. 1994). Among humans, the main exception may be a cocaine psychosis (an effect of acute and prolonged cocaine intoxication) in which violence could result during the paranoia or hallucinations of this psychotic state,

but even this outcome is highly variable (Siegel 1996). In sum, among normal, mentally stable adults with no predisposition towards violence, the knowledge base does not support a psycho-pharmacological relationship in which ingestion of cannabis, heroin, or cocaine accounts for an increased likelihood that individuals will engage in violent acts.

Economic compulsive violence

This aspect of Goldstein's model is based in the notion that desperate, drug-addicted individuals, lacking other sources of income, are primarily motivated to commit income-generating crimes to obtain funds for the purchase of drugs. While some of these acts may be intrinsically violent (e.g. muggings or armed robbery), the violence may often result as the by-product of other factors in the social context in which the crime is perpetrated, such as when a victim returns home or wakes up during a break-and-enter, when the intended victim resists, or when bystanders intercede; such unanticipated occurrences may lead to an escalation in what could have been completed as a nonviolent crime. Much urban crime and fear of crime is fueled by this expression of drug-related violent crime.

Most research in this area has examined mainly heroin addiction, and, more recently, cocaine. While some of the earlier studies indicated that addicts engaging in this type of crime tried to avoid violence and focused more on theft than robbery (Goldstein 1989), more recent commentators have suggested that robberies with weapons accompanied by gratuitous assaults may have increased, at least in the United States (Inciardi 1992; Miller 1998). The prospect of imminent drug withdrawal during the commission of the crime is thought to add pressure to get money as quickly as possible. Police statistics and media accounts often attribute large proportions of both violent and property crime to drug addicts (Cain 1994). Thus, one rationale for existing drug policies has been to remove drug-addicted offenders from circulation through imprisonment for lengthy periods in order to prevent further predations.

More recent variants of this approach have been the increased emphasis on compulsory treatment of addicts instead of, or during, imprisonment in order to remove their presumed motivation to commit crimes, namely their addiction (Wild 1999). Somewhat paradoxically, one impetus for drug policy reforms incorporating treatment with methadone, expansion of drug prescribing and decriminalization of possession and sale of small amounts (Cain 1994; Health Canada 1997) has been this presumed association between drugs and predatory crime. Just how strong is the evidence for the economic-compulsive link between drugs and violent crime?

While there is considerable agreement among experts in the drug field that regular users of expensive, illegal, addictive drugs do engage in economically motivated crime, particularly in periods of heavy, intensive use or sudden loss of supply, a number of

qualifications are made about this relationship, primarily, that its magnitude has been exaggerated (Drugs-Violence Task Force 1997). First, the majority of heroin and cocaine addicts do not commit predatory crimes to get money for drugs (Benson et al. 1992). Social class is important: middle-class and upper-class users can pay for their supply from income, borrow money legitimately, or find other channels of gaining access to drugs such as prescriptions. The Bureau of Dangerous Drugs in Ottawa, Canada, recorded for many years a separate log of medical and professional opiate addicts, as distinct from street ones, who obtained supplies by virtue of their health needs or positions in the health-care system (Giffen, Endicott, and Lambert 1991).

Though less research has been done on cocaine, heavy users who are otherwise conventional, employed citizens can also usually finance their own habit or find non-criminal ways of doing so, though some reach the point of bankruptcy and ruin (Erickson and Weber 1994; Waldorf, Reinarman and Murphy 1991). Even when a financial boundary is crossed and available resources are not sufficient to pay for the drugs, middle-class and upper-class addicts are more likely to engage in the white-collar crimes, such as fraud, that are more accessible to them, rather than suddenly to begin mugging strangers. But, even the underclass of street addicts has been found to engage in a wide range of activities to get drug money—begging, borrowing but not necessarily stealing: part-time work, collecting refundable products like bottles, bartering goods, offering low-level services in the drug market, and trading sex for drugs (Johnson et al. 1985; Inciardi and Potteiger 1991). A comparison of poor addicts in New York and Amsterdam found that the American heroin users were more likely to obtain income from crime while those in the Netherlands derived a substantial portion of their (low) incomes from social assistance (Grund et al. 1992). Clearly, many, if not most, users and addicts will seek and utilize other money sources—social aversion to being a "real criminal" does not evaporate in the wake of drug exposure or dependence—and this is an important constraint on economic compulsive crime.

Moreover, as mentioned above, when crimes are committed to get money for drugs, these are more likely to be property offences such as theft from a car or a home, selling drugs, or prostitution rather than violent crimes like robbery or assault (Inciardi and Potteiger 1991). The American studies that looked specifically at homicide found only two percent (Goldstein, Brownstein, Ryan, and Bellucci 1989) and 3.5 percent (Kleck 1996) to result from economically compulsive drug-related violence. This estimate could be low if the drug factor is not always known or recorded and the same limitation applies for robberies and property crimes. Nevertheless, it is not valid to assume that any acquisitive crime committed by a drug addict is economically driven, any more than it is pharmacologically driven. For some individuals, crime is a way of life, and the choices of what to spend the proceeds on may include drugs or other commodities of short-term gratification (Gottfredson and Hirschi 1990). It is also likely that the price inelasticity of

heroin is over-rated, as many heavy users go through cycles when they use less or cease for periods of time, and the same has been observed for cocaine (Faupel 1991; Johnson et al. 1985; Erickson, Adlaf, Smart, and Murray 1994).

The data-base as it presently exists is not sufficient to derive accurate estimates of economically motivated (or other drug-related) violent crime in Canada (Brochu 1997). However, the view that drug use starts an inexorable progression to serious, violent crime is questioned by studies of youth over time: "as youthful users of illicit substances approach adulthood, they are likely to continue to use drugs, but they are less likely—not more likely—to commit predatory crimes" (Chaiken and Chaiken 1990: 215). It is quite clear from research on delinquents and also from studies of adult "career" addicts that a small minority of heavily drug-using offenders, who are also involved in serious predatory crime, can account for a very high proportion of all offences committed in a relatively short time (Nurco et al. 1988; Hagan and McCarthy 1997). Among practitioners in treatment or enforcement, particularly those in the criminal justice system who see these offenders every day, this fuels the perception that all addicts must be engaged in crime as a way of life and that a major proportion of violent crime is attributable to their desperate need for money.[4]

In sum, the available research does not reveal a major economic compulsive component of drug-related violence. Most drug users, and even most addicted users, in the population overall do not resort to crimes of violence in order to support their habits. A smaller group of addicted criminal offenders, however, are so engaged and their extensive predations may readily lead to an over-estimation of this type of drug-related violence. Nevertheless, even if addicts' illegal efforts are focused on income-generating property crimes, these may directly or indirectly involve violence and heightens the importance of targeting effective interventions for them:

> There is strong evidence that predatory offenders who persistently and frequently use large amounts of multiple types of drugs commit crimes at significantly higher rates over longer periods than do less drug-involved offenders, and predatory offenders commit fewer crimes during periods in which they use no heroin [e.g. on methadone or in other treatment or simply quit]. (Chaiken and Chaiken 1990: 234–35)

Of course, the irony of current supply-side drug policies is that they direct drug-enforcement efforts to promoting scarcity and driving drug costs up; if successful, this has the likely effect of increasing crimes by addicts directed at income-generating activities and, possibly, concomitant violence. In addition, the destabilization of dealer networks through arrest and "street sweeps" may drive addicts further out of their territories, into less familiar sites for their crimes, again inflating the risks of violence occurring in more

volatile situations (Rasmussen and Benson 1999). Since the magnitude of violent crime found in the economic compulsive category is not that great, reforms aimed at improving drug access for addicts and decreasing their fear of arrest (e.g. methadone maintenance, heroin prescription, alternative measures) may have a modest but still significant impact, particularly in poor urban settings. Reducing property crime may indirectly also decrease the opportunities for violent encounters and enhance feelings of safety and security for citizens in their homes and on the streets.

Systemic violence

This third component of Goldstein's model refers to the violence that is inherent in the regular business of the illicit drug market. "The drug trade depends on violence for social control—of markets, of dealers and of customers"(Anderson, quoted in Short 1998: 23). While legally regulated markets, such as those in alcohol or pharmaceuticals, have recourse to legitimate authority to resolve disputes and set standards for fair competition, those involved in an illegal, high-profit market resort mainly to force. Goldstein notes that "the vast majority of victims of systemic violence are those who use drugs, sell drugs, or are otherwise engaged in some aspect of the drug business" (Goldstein 1989: 36), findings reflected also in Canadian research in the Toronto crack market (Erickson et al. 1996; Butters 1997).

Innocent bystanders may sometimes fall victim to shoot-outs between rival dealers. The visible presence of active drug transactions creates a pervasive and "constant sense of uncertainly" in a community (Anderson, in Short, 1998: 24), so that "even when the violence remains confined to participants in the industry, its sheer viciousness creates a general sense of lawlessness and brutality that is threatening to the community" (Drugs-Violence Task Force 1997: 71). Another aspect of systemic violence relates to the high potential for violence around drug enforcement itself, manifested during raids of suspected drug dealers' premises, street confrontations between officers and dealers, accidental targeting by police of innocent individuals as suspects, attacks on informants or undercover officers, intimidation of witnesses and threats to other criminal justice officials after charges are laid (Drugs-Violence Task Force 1997). It is hardly an exaggeration to state that the drug policy that defines an illegal market also creates an environment in which there is a very high risk of systemic violence.

A growing body of evidence supports this contention. Two studies of homicide in major American urban areas (Goldstein, Brownstein, Ryan, and Bellucci 1989; Kleck 1996) were consistent in finding that three-quarters of identified drug-related murders were attributable to systemic factors, although Goldstein's data showed this for 39 percent of all homicides in New York while Kleck found an overall proportion of only 16 percent in a larger sample of cities. While the rates of systemic violence have not been determined

with precision in other non-lethal violent crimes, any ethnography or in-depth look at the lives of those involved in the drug trade provides ample illustration of virtually omnipresent violence (Faupel 1991; Bourgeois 1995; Johnson et al. 1985; Maher and Daly 1996; Spunt et al. 1990). Some experts have also argued that violence among youth gangs has been increasingly related to their part in distributing drugs (Reuter and MacCoun 1992), although others have argued that gangs have a minor role overall in drug markets (Fagan 1989).

Other types of data are available from interviewing those in the drug market about their perceptions and experiences of violence. Recent studies of drug dealers have described a daily work environment in which the risk of death or serious injury is high: about 50 percent of adolescent drug sellers expect such a fate for themselves (Reuter, MacCoun, and Murphy 1990; Dembo et al. 1993). In a Canadian study, 63 percent of drug sellers on probation reported victimization and 56 percent admitted hurting others in the course of their activities (Butters 1997); similarly, in a American study, two-thirds of youthful crack sellers admitted hurting or killing someone due to their involvement in the drug trade (Dembo et al. 1993). Looking overall at rates of violence among those involved in drug dealing in Washington, DC, Reuter, MacCoun, and Murphy (1990) estimated that, for one year of regular dealing, the chance of serious injury was one in 14 and of death was one in 50. There is little dispute that systemic violence is the major component of drug-related violence.

Much ongoing work has been directed at identifying different types of systemic violence in drug markets (Drugs-Violence Task Force 1997: 76–78). Five categories have been identified in which violence is employed for different purposes: (1) competitive (retaliation or elimination of competitors); (2) non-competitive (secrecy and concealment of activities); (3) factionalism (attempts by subordinates to replace the leader); (4) discipline of employees (punishments for thefts, cheating, attempts to exit, or selling secrets); and (5) control of customers (punishment for failure to pay debts or for informing to police). For the most part, drug organizations recognize the superior weaponry of the police and tend to rely more on secrecy and corruption than on armed confrontation to deal with the threat of enforcement. In relation to other drug-selling competitors, however, organizations require a large capacity for violence in order to protect turf and supplies and to intimidate would-be competition.

One proposed taxonomy of urban street-drug markets based on the residential status of dealers and customers argues that the types differ in their potential for producing systemic violence (as well as economic gain or loss for the neighbourhood). Of the four types, Local, Export, Import, and Public markets, Reuter and MacCoun (1992) predict the greatest capacity for violence in the latter two, where informal social controls are minimized.[5]

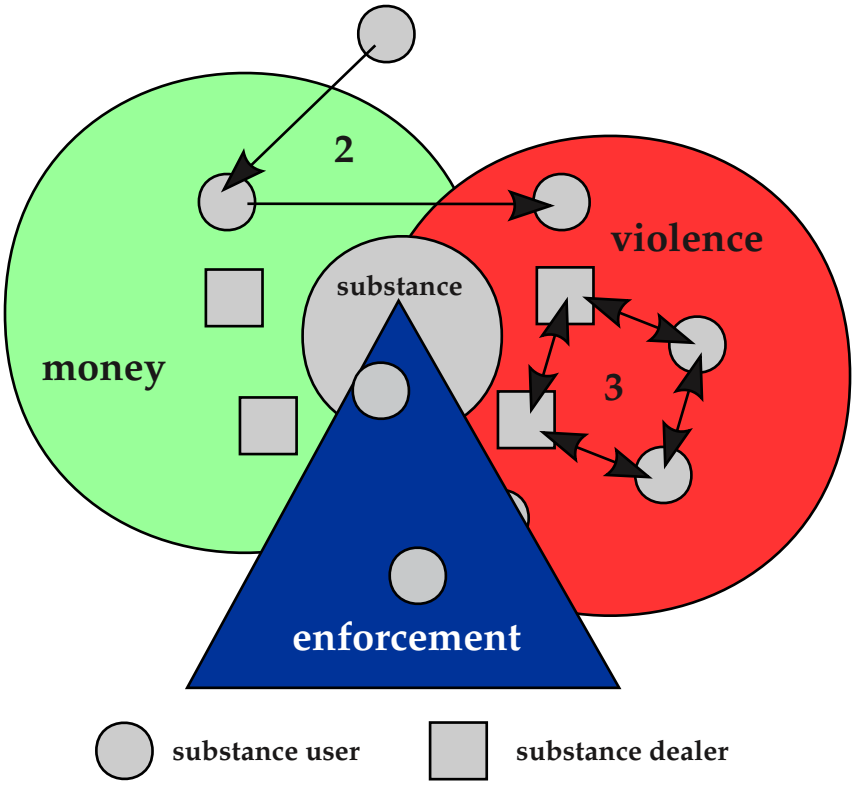
The social cultural context may also affect the levels of violence in drug markets, as was illustrated in a Toronto study of a crack market that displayed considerably less lethal and serious violence than its American counterparts (Erickson et al. 1996). Some research has indicated that the type of drug also plays a part in the level of systemic violence: cannabis generates the least violence (mainly in the cultivation areas), heroin is next, due to the relatively well-structured and stable distribution systems that have evolved, while powder cocaine and, especially, crack cocaine generate the most violence because of the introduction of many new, short-term players, the multiple transactions engaged in by users, and the high levels of competition (Fagin and Chin 1989). Finally, leaving aside variations in market structure, Goldstein asks how much of the violence can be understood at the individual level of participants, noting that "what is not clear is the extent to which the drug business itself makes people violent or whether violence-prone individuals may self-select themselves for violent roles in the drug business" (Goldstein 1989: 35).

While some of these studies consider policy implications for reducing violence through particular enforcement strategies, this does not address the central truth that illegal drug markets are high-risk settings that promote violent interactions far beyond what occurs in legal drug markets. In sum, it is the fundamental policy of prohibition, practiced in its most repressive forms in "drug wars," that creates much of the violence that is so decried. The opportunities for profits are attractive even for those who do not use drugs, as the well-documented attractions of the crack market for youth in economically deprived areas illustrate. As one young black man in Philadelphia said to the ethnographer, Eli Anderson (1996): "Why is it so hard for me to get a job and so easy for me to sell drugs?" The violence and fear of violence affects innocent bystanders, the public at large, and the whole urban community. If the response is to increase levels of enforcement and incarceration, the lure of profits and the need of users will guarantee a never-ending supply of usually young, often poor, undereducated and unskilled recruits for the drug market, who will be the principal agents as well as the targets of violence in deprived urban areas.

How does the harm reduction approach differ from the criminal justice approach?

While the generals who remain committed to fighting the war on drugs with the tools of the criminal law and criminal-justice system declare, in the words of Nils Christie (1998), a state of "victorious retreat," (i.e. without their tactics the situation would be even worse), others have been considering drug-related violence from a different perspective, that of public health. The term "public health" implies government action on behalf of the community to "avoid disease and threats to the health and welfare of individuals and the community at large" (Duffy 1993: 200). Traditionally concerned with the control of sanitation and the prevention of contagious diseases, public health has expanded with

Figure 2 The criminal justice model illustrating the expansion of enforcement against user and dealers and also encompassing police, violence, and corruption



new objectives of prevention, protection, and health promotion, searching for means to provide optimal health to the individual and community (Ashton and Seymour 1988). The embracing of violence as an issue of public health is more recent, prompted in part by the increasing recognition that the reactive nature of the criminal justice system has been limited in preventing death and intentional injuries among particularly vulnerable members of the population (e.g. children, youth, women, minorities). While the criminal law is meant also to prevent crime through the mechanisms of general and specific deterrence, its effectiveness in relation to drug use and to drug-related violent crime has been unproven and is thought by many to be insufficient to deal with the current problem (Erickson 1980; Blumstein 1993). When considering violence in communities, public-health specialists apply analytic tools to determine the relative contribution of victim, perpetrator, and the social environment, and seek ways to prevent or reduce the toll of death and serious injury (Moore et al. 1994). The approach to drug problems that has evolved from this expanded notion of public health over the past decade has become known as "harm reduction." The basic features of this approach will be outlined and the remainder of the chapter will consider whether it might be applied to drug-related violence in order to prevent and reduce harm.

Harm reduction is rooted in the public health perspective and takes particular form and expression in response to the modern urban drug crisis in HIV transmission, violence, rising economic costs of enforcement, and consideration of the human rights of drug users (Erickson, Riley, Cheung, and O'Hare 1997). The principles of harm reduction (HR) differentiate it from the dominant policy of criminalization in several ways (Erickson and Ottaway 1994). First, HR asks the basic question, what is the immediate harm and how can it be mitigated now or prevented in the immediate future? HR is versatile, offering a wide range of strategies; nor does HR pass judgement on the deviant or otherwise questionable nature of the conduct of concern. Voluntary participation of those involved is encouraged in decision-making and coercion (though not absent from the public health model) is seen as a last resort. In contrast, the criminal justice model is reactive, concerned with moral standards of right and wrong, geared to assign blame, seeks to publically stigmatize wrong-doers, offers punishment as its primary strategy, and imposes a decision without reference to the consent of the individual offender. The central difference is highlighted in the question posed by Nils Christie: "When are doctors not allowed to behave like doctors?" The answer: "When the life threatening conditions are believed to be 'caused' by drugs" (Christie 1998). Instead of doctors, educators, and other health professionals, the agents of criminalization policies are police, probation officers, judges, and prison guards. If, as presented in the earlier review of the literature on drugs and violence, society (in the form of individual drug users and and sellers, police officers, and the community as a whole) is indeed facing "life-threatening conditions" on the streets, how could harm reduction contribute to a solution?

Two contrasting scenarios—stepped enforcement and stepped care

Specifically, what kinds of strategies does HR offer to reduce the harms of urban drug-related violence, how might this approach work, and what would the likely impacts be? This must be speculative on my part, as there are few tested options with illicit drug policy and, at this point, HR provides a framework in which to consider alternatives, not a "quick fix" for these complex issues. Public health also requires that innovative approaches be tested and provide proof of efficacy before they are widely implemented—the progress of HR will be built on evidence-based policies and programs. A useful contrast is provided by comparing the "stepped-care" continuum, widely used and applied in health-care settings (Kaplan 1998), with what might be called the "stepped-enforcement" continuum that characterizes the criminalization approach. Since the earlier review of drug-related violence targets two key elements, addicted users and those involved in the illicit street-drug market, these will be emphasized in the comparison.[6]

Any consideration of solutions to the urban drug problem must face directly the fact of addicted consumers. They are the source of most drug profits, whether the substance is

legal or illegal (Jonas, 1990; Everingham, Rydell, and Caulkins 1995). There would be no large profits for industries or the *narcotrafficantes* if everyone was a social drinker, occasional tobacco smoker, or weekend cocaine snorter. Moreover, while addicted consumers (and the health and social burden that they impose on themselves and society) are found in all social classes, the problem of urban violence is fundamentally related to the poor, marginalized addict, a segment of whom derive their money for drugs from crime that sometimes includes violence and most of whom are active participants in the street-drug markets where violence is endemic.

Stepped enforcement

Stepped enforcement includes the whole range of social control practices against illicit drug use predicated on the criminal law. This approach dictates that such individuals are despised and condemned in the larger society where the general prevention message is one of moral and legal threat. Clearly, addicts reflect failures of both general and specific deterrence, since the message that "drugs are wrong and if you use them you are a bad person and will be punished" has not been effective, and most have criminal records and have spent time incarcerated. The police know them, observe them, sometimes hassle them, and may attempt to recruit them as informants (Stoddart 1988). Their life on the streets is organized around obtaining drugs of unknown purity and potency, using them in unsafe and unsanitary conditions, perhaps "crashing" in alleys or substandard housing, then seeking more drugs and money for drugs, leaving little resources for other basic necessities such as food, shelter, and clothing. If arrested, they will spend time in police stations and jail, perhaps undergoing forced withdrawal, face a court appearance and public labelling as a drug offender, begin or add to a permanent criminal record, and be subjected to a loss of liberty through probation or incarceration. This criminalizing response to detected breaking of drug laws occurs regardless of whether the person is a novice or experienced drug user, whether drugs are consumed in public or private, or what form of health or other problems are linked with the use. The amount of drugs being consumed is irrelevant to the enforcement response, though the amount detected may lead the addict to be charged with trafficking and face longer incarceration. The powers of doctors to prescribe narcotics are limited and "abuses" are also subject to criminal penalties. Even if the addict has "reformed," undergone treatment, or stabilized on methadone, few legitimate jobs or stable life-conditions await. He or she exists in a state of permanent criminality, where "good" behaviour goes unrewarded but any slip back to addiction may be immediately detected and punished. If the addict and petty trafficker has the misfortune to live in China, Iran, or Malaysia, the finality of execution may end the cycle. In western democracies, death on the street from violence or overdose or an HIV related illness, is also a possible endpoint. This is the scenario that generates the problem of urban street drugs and violence.

Stepped care

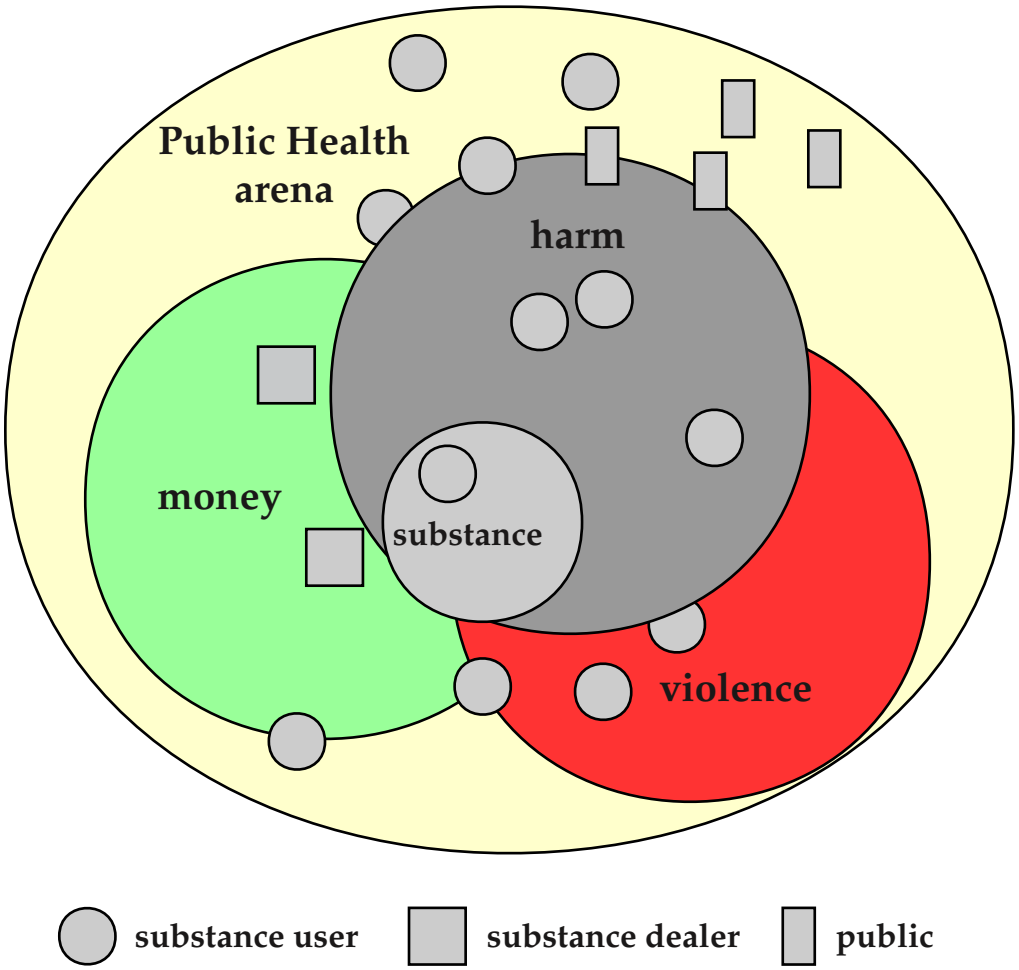
Guided by the principles of harm reduction, what would be an alternative response? For example, how would such individuals be treated in a "stepped-care" approach? (Kaplan 1998). It is characterized by the reinforcement of "good" behaviour, combined with the least intrusive response, geared to the particular manifestation of the underlying problem. The most intense intervention is reserved for the most severe presentations of the addictive condition. As a basis, the state of addiction, viewed as a chronic, relapsing health problem, would be subject to pity and concern, perhaps tempered with some of the disapproval that accrues to bad habits. Drug users who became concerned about their drug use could seek early help and advice from a physician or other health-care professional. A decision to quit would be supported by appropriate encouragement, therapies, or alternative medications as discussed with, and agreed upon by, the addict-patient. A decision to keep using would be accompanied by a plan, with the patient's consent, for a more controlled and less harmful pattern of drug use, perhaps with drug substitution. If, after a period of follow up, on an out-patient basis, progress was not satisfactory from either the patient's or the doctor's perspective, a more intensive form of intervention would be considered. This might involve further assessment and in-patient care with long-range follow-up. All records of treatment would be confidential and would not be a basis for denying employment, disability payments, or other forms of social assistance. While a "cure" in the form of eventual abstinence might be realized, adaptation to a chronic condition is an equally valid objective, requiring on-going support from the health care system.

This "stepped-care" scenario is only one variation of many that could be generated in a HR approach. Another might be to offer "one-stop shopping" for addicts, similar to the holistic approach being developed for chronic diabetic individuals, where a variety of health and social needs are met by practitioners within one specialized facility. Another option might be to encourage far more utilization of primary care physicians to treat addicts as part of their regular practice. The public health model encourages multi-modal strategies and many different programs could be tested, geared to different types of addicts and social contingencies. Suitably evaluated, they would provide a basis to proceed.

The potential impact of applying the harm reduction approach to drug-related violence

One research issue to be considered would be the effect of such health-directed programs on drug-related violence. Until evidence is accrued, these hypotheses can be offered. First, the psycho-pharmacological link to violence, already a very small component, is least likely to be affected, although there are some possibilities. In those

Figure 3 The harm-reduction model, showing drugs, money, violence and other harms, including those in the community, within the broad public-health arena



individuals with strong, pre-existing violent tendencies, frustration might be lowered along with its active expression; moreover, enhancing the ability of addicts to avoid withdrawal symptoms through regular prescription maintenance would tend to reduce violence, as would their seeking earlier treatment before problems become more acute.

Second, the economic compulsive aspect of violent crime would be reduced if addicts were less likely to steal to get money to obtain drugs. Greater social stability would also reduce crime and, hence, violence: they would become more able to hold jobs, retain other means of legitimate income, and direct available resources to improving their situation. Whereas all crime by addicts, even those who have "recovered," would not cease if harm reduction strategies are implemented (many in this group were involved in crime before addiction and may remain committed to crime as a way of life), it

would be possible to identify the types of addicts who could benefit most, along with society, from such programs. Levels of urban violence seem likely to be reduced with fewer truly desperate addicts on the street. When addicts are re-integrated into the community—"normalizing" their lives by eliminating exclusion and stigmatization—and are not treated as outsiders, they are less likely to commit predations on their fellow citizens and each other.

The greatest portion of drug-related violence is of the third variety, the systemic, which is inherent in the dynamic of the illegal market. To find even a partial solution poses a challenge for harm reduction. HR can and does operate in the context of various legal and national policies but directs consideration to the intended and unintended consequences of these policies in reducing levels of particular harms (Erickson et al. 1997). Therefore, it is necessary to consider the possible impact of harm reduction strategies under two legal substance control models, prohibition and regulation.

First, under prohibition, most of the factors that generate violence in the drug market would remain in play. The stepped-care approach and other user-directed programs above could operate with the continuation of criminal prohibition of supply, making drugs available by prescription through medical gate-keepers. While this would likely lead to a decrease in addicts obtaining supplies illicitly and fewer poor addicts overall to fuel illicit demand, the increased competition on the streets might, at least for a period, increase drug market violence as dealers compete for fewer customers. There is also the possibility that those who have been able to make money through drug selling, such as adolescent non-users involved in crack sales, would be inclined to turn to other forms of crime if their customers disappeared. Also, the question of the social class of addicts becomes important: would well-off addicts be willing to go to physicians for supplies, perhaps even be "registered" in order to qualify, or would their habits continue in secret to fund illicit suppliers? A less aggressively enforced prohibition policy or some form of decriminalization of possession, might reduce the overall "drug war" mentality and contribute to more peaceable communities. This resembles the situation in the Netherlands and some parts of Europe, where levels of street violence associated with drug trafficking appear to be much lower than in the United States or Canada. The social cultural context of violence and obvious differences such as the availability of guns are other factors. Still, measures focused on the addicts are not likely to eliminate systemic violence between rival dealers and organizations, unless lack of demand drives them out of business. The effects of harm reduction measures on systemic violence within the framework of prohibition are not known. We can hypothesize that the de-escalation of prohibition against users would lead to less police violence against users and some reduction of violence among users and between users and sellers in the street-level drug market. Higher level organizational conflicts and disputes among traffickers would remain a major component of drug-related violence, but less likely to be part of the street scene.

Assuming continuity of demand, to lower a significant portion of systemic violence in the drug market would require legal regulation of the market, providing legitimate authorities to resolve conflicts. The removal of profits from the organized criminals who control the higher echelons of the international and national drug trade would also remove the centrality of violence as social control, one that would filter down to the street. (Of course, as Canadians know from the short lived attempt to increase tobacco prices, an illicit market can burgeon even for a legally available product.) A legal market implies that adult members of the public can obtain drugs from authorized outlets without fear of criminal sanction. The type of distribution system could vary enormously, from a free market to heavily restrictive state monopolies. Within the public health framework, the lessons of alcohol and tobacco would direct fairly strict controls over availability (e.g. ages, locations, perhaps quotas, and monitoring of distribution) in order to minimize harm to the individual and the community. Public health would also propose different models for different drugs, considering their likely impact upon health and society and their patterns of use.

The harm-reduction approach seeks a balance of harms to be reduced and benefits to be gained, but not at the expense of generating other, more serious damage. It is a cautious approach, more likely to start with small-scale experiments such as seeking evidence about the effects of making heroin and cocaine available in controlled trials to addicted users, than to advocate general access to the public. This, of course, leaves the controlled, recreational user to resort to illicit channels, and suppliers open to prosecution. Opinions among experts, including addicts themselves, vary, some voicing their opposition to a fully legal market and preferring a more medicalized approach that removes criminal punishments and provides treatment and other basic health and social services. Others argue that freer availability would lead to fewer, not more, problems as users would learn to monitor and control use more effectively from informal, rather than formal, social control. At present, harm reduction occupies a middle ground, as perhaps best illustrated in the Netherlands, which retains the symbolic value of prohibition, has priorities for enforcement, mainly against very large-scale drug suppliers, and treats users and addicts in a humane and supportive way (Leuw and Marshall 1994). The dilemma of global and national drug policy is complex but harm reduction offers ways to deal with the most immediate harms to the users and the community, and shows promise for reducing drug-related violence.

Conclusion

It may not be easy to change laws but it is possible to de-escalate the most destructive and punitive practices of prohibition. It is not easy to give up deeply held "fact beliefs" that certain things are so, even in the face of evidence to the contrary. However, we have learned that medical practices and potions of the 1920s are better replaced by modern standards of clinical care and drugs that have passed clinical trials of safety

and efficacy. We have a much more sophisticated understanding of the behaviour of drug users than 30 years ago. In my view, it is time to start taking some small steps to undo damage, to try and assess new initiatives, and discover what leads to a better result than current practices. HR would replace the criminal-justice measures of "success," that is, arrests, imprisonment, seizures, with health and community-safety measures. These public health indicators include lower HIV rates, less crime and violence, more employed and socially stable addicts. The harm reduction approach, with its emphasis on ameliorating the consequences of illicit drug use, being pragmatic, gaining the cooperation of users, re-integrating rather than excluding, is a sensible direction if not a total solution to these complex issues. Harm reduction is not a panacea for urban drug-related violence but it is a place to start.

Notes

1 Other important sources are the report for the National Research Council by Reiss and Roth (1993), Understanding and Preventing Violence, and the American Sociological Association's overview, Social Causes of Violence: Crafting a Science Agenda, by Levine & Rosich (1996).

2 Other indirect relationships that may escalate violence (proposed but not yet validated) are the climate of fear in the community that leads to self-protective measures (e.g. carrying weapons), the forced early release from prison of violent inmates to make room for non-violent drug offenders, and the removal of adult role models from the community and the consequent weakening of informal social controls over youth (Drugs-Violence Task Force 1997: 23).

3 In the United States, neither the Attorney General's Task Force on Violent Crime (1981: 28) nor President Bush's Commission on Model State Drug Laws (1993: 1) cite any research in support of their conclusions that "addiction is *directly related* to a staggering amount of crime" and "most violent and property crimes are committed by persons under the influence of alcohol and other drugs (cited in Drugs-Violence Task Force 1997: 29; emphases added).

4 Evidence that cannabis is implicated in economically motivated violence is absent, although delinquents and street youth may spend proceeds of crime on it and other drugs.

5 Drug Market Typology (Reuter & MacCoun, 1992)

	Residential Status of Dealer	**Residential Status of Customer**
	Insider	**Outsider**
Insider	Local	Export
Outsider	Import	Public

6 While the prevalence of illicit drug use is as high among the middle classes, there are fewer violence-related issues among social recreational and more compulsive users and those who supply this market (Waldorf, Murphy & Lauderback, 1994). Such users who drive into Export or Public street markets for their drugs do place themselves at risk of being cheated or assaulted.

References

Anderson, E. (1996). Presentation to the Drugs-Violence Task Force. Appendix B.

Ashton, J., and H. Seymour (1988). *The New Public Health*. Bristol: Open University Press.

Beck, S., D. Gilliard, L. Greenfield, C. Harlow, T. Hester, L. Jankowski, T. Snell, J. Stephan, and D. Morton (1993). *Survey of State Prison Inmates, 1991* (NCJ-136949). Washington, DC: Bureau of Justice Statistics.

Benson, B., I. Kim, D. Rasmussen, and T. Zuehlke (1992). Is Property Crime Caused by Drug Use or Drug Enforcement Policy? *Applied Economics* 24 (July): 679–92.

Blum, R. (1969). Drugs and violence. In D. Mulvihill et al. (Eds.), *Causes of Violence, Vol. 13, A Staff Report to the National Commission on the Causes and Prevention of Violence*. Washington, DC: US Government Printing Office.

Blumstein, A. (1993). Making Rationality Relevant. *Criminology* 31, 1: 1–16.

Bourgeois, P. (1995). *In Search of Respect: Selling Crack in El Barrio*. New York: Cambridge University Press.

Boyd, N., L. Elliott, and B. Gaucher (1991). Drug Use and Violence: Rethinking the Connections. *Journal of Human Justice* 3: 67–83.

Brochu, S. (1997). Draft Report: Estimating the Costs of Drug-Related Crime. Ottawa: Canadian Centre on Substance Abuse.

Buka, S., and F. Earls (1993). Early Determinants of Delinquency and Violence. *Health Affairs* 12, 4: 46–64.

Butters, J. (1997). Drug Market Violence and Criminality among Two Groups of Drug Dealers. Paper presented at the American Society of Criminology annual meeting, San Diego.

Cain, V. (1994). *Illicit Narcotic Overdose Deaths in British Columbia*. Task Force Report. Office of the Chief Coroner, Ministry of the Attorney General of British Columbia.

Chaiken, J., and M. Chaiken (1990). Drugs and Predatory Crime. In M. Tonry and J. Wilson (Eds.), *Drugs and Crime*. Chicago: University of Chicago Press.

Christie, N. (1998). Foreword. In E. Jensen and J. Gerber (Eds.), *The New War on Drugs: Symbolic Justice and Criminal Justice Policy*. Chicago: Anderson, Academy of Criminal Justice Sciences.

Dembo, R., P. Hughes, L. Jackson, and T. Mieczkowski (1993). Crack Cocaine Dealing by Adolescents in Two Public Housing Projects. *Human Organization* 52: 89–96.

Drugs-Violence Task Force (1997). *Exploring the Drugs and Violence Relationship*. Draft Report. US Sentencing Commission and Florida State University (Tallahassee) School of Criminal Justice, 1997.

Duffy, J. (1993). History of Public Health and Sanitation in the West since 1700. In K. Kiple (Ed.), *The Cambridge World History of Human Disease*. New York: Cambridge University Press.

Erickson, P. G. (1980). *Cannabis Criminals*. Toronto: ARF Books.

Erickson, P. G., and C.A. Ottaway (1994). Policy—Alcohol and Other Drugs. In P. Nathan et al. (Eds.), *Annual Review of Addiction Research and Treatment, Vol. 3.* New York: Elsvier.

Erickson, P .G., E. Adlaf, R. Smart, and G. Murray (1994). *The Steel Drug: Cocaine and Crack in Perspective.* 2nd ed. New York: Lexington.

Erickson. P. G., J. Cohen, and B. Allen (1996). *Alcohol and Other Drugs in the Criminal Justice System: Final Report*. ARF Internal Document, No. 123. Toronto: Addiction Research Foundation.

Erickson, P. G., J. Butters, B. Fischer, E. Fehrman, D. Haans, and B. Poland (1996). Exploring Drug Market Violence in a More Peaceable Society. Presented to the Drugs-Violence Task Force. Appendix G.

Erickson, P. G., D. Riley, W. Cheung, and P. O'Hare (Eds.) (1997). *Harm Reduction: A New Direction for Drug Policies and Programs*. Toronto: University of Toronto Press.

Erickson, P. G., and T. Weber (1994). Cocaine Careers, Control and Consequences: Results from a Canadian study. *Addiction Research* 2, 1: 37–50.

Everingham, S., P. Rydell, and J. Caulkins (1995). Cocaine Consumption in the US: Estimating Past Trends and Future Scenarios. *Socio-Economic Planning Sciences* 29, 4: 305–14.

Fagan, J. (1989). The Social Organization of Drug Use and Drug Dealing among Urban Gangs. *Criminology* 27, 4 : 633–69.

Fagan, J. (1990). Intoxication and Aggression. In M. Tonry and J. Wilson (Eds.), *Drugs and Crime*. Chicago: University of Chicago Press.

Fagan, J., and K. Chin (1989). Initiation into Crack and Cocaine. *Contemporary Drug Problems* 27, 4: 579–617.

Faupel, C. (1991). *Shooting Dope: Career Patterns of Hard-Core Heroin Users*. Gainesville, FL: University Press of Florida.

Giffen, P., S. Endicott, and S. Lambert (1991). *Panic and Indifference: The Politics of Canada's Drug Laws*. Ottawa: Canadian Centre on Substance Abuse.

Goldstein, P. (1985). The Drugs/Violence Nexus: A Tripartite Conceptual Framework. *Journal of Drug Issues* 21, 2: 345–67.

Goldstein, P. (1989). Drugs and Violent Crime. In N. Weiner and M. Wolfgang (Eds.), *Pathways to Criminal Violence*. Beverly Hills: Sage.

Goldstein, P., H. Brownstein, P. Ryan, and P. Bellucci (1989). Crack and Homicide in New York: A Conceptually Based Event Analysis. *Contemporary Drug Problems* 16, 4: 651–87.

Gottfredson, M., and T. Hirschi (1990). *A General Theory of Crime*. Stanford: Stanford University Press.

Graham, K., G. Schmidt, and K. Gillis (1996). Circumstances When Drinking Leads to Aggression: An Overview of Research Findings. *Contemporary Drug Problems* 23: 493–557.

Grund, J.-P., L. Synn Stern, G. Kaplan, N. Adriaans, and E. Drucker (1992). Drug Use Contexts and HIV Consequences: The Effect of Drug Policy on Patterns of Everyday Drug Use in Rotterdam and the Bronx. *Addiction* 87: 381–92.

Hagan, J., and B. McCarthy (1997). *Mean Streets: Youth, Crime and Homelessness*. New York: Cambridge University Press.

Harlow, C. (1991). *Drugs and Jail Inmates, 1989* (NCJ-130836). Washington, DC: Bureau of Justice Statistics.

Health Canada (1997). *HIV, AIDS and Injection Drug Use: A National Action Plan*. Ottawa.

Inciardi, J. (1992). *The War on Drugs II*. 2nd ed. Mountain View, CA: Mayfield.

Inciardi, J., and A. Potteiger (1991). Kids, Crack and Crime. *Journal of Drug Issues* 21, 1: 257–70.

Johnson, B., P. Goldstein, E. Preble, J. Schneidler, D. Lipton, B. Spunt, and T. Miller (1985). *Taking Care of Business: The Economics of Crime by Heroin Abusers*. Lexington, KY: Lexington Books.

Jonas, S. (1990). Solving the Drug Problem: A Public Health Approach to the Reduction of the Use and Abuse of Both Legal and Illegal Recreational Drugs. *Hofstra Law Review* 18, 3: 751–94.

Kaplan, A. (1998). The Toronto Hospital Treatment Program for Eating Disorders: An Integrated Comprehensive Stepped Care Model. Presentation at ARF Clinical and Research seminar series, Toronto (January 16).

Kleck, G. (1996). Presentation to the Drugs-Violence Task Force. Appendix I.

Leuw, E., and H. Marshall (Eds.) (1994). *Between Prohibition and Legalization: The Dutch Experiment in Drug Policy*. New York: Kugler.

Levine, F.J., and K.J. Rosich (1996). *Social Causes of Violence: Crafting a Science Agenda*. Washington, DC: American Sociological Association.

Maher, L., and K. Daly (1996). Women in the Street-Level Drug Economy: Continuity or Change? Criminology 34, 4: 465–92.

Miczek, K., A. Mirsky, G.Carey, J. DeBold, and A. Raine (1994). In A. Reiss and J. Roth (Eds.), *Understanding and Preventing Violence, Vol. 2: Biobehavioral Influences.* Washington, DC: National Academy Press.

Miller, J. (1998). Up It Up: Gender and the Accomplishment of Street Robbery. *Criminology* 36, 1: 37–66.

Moore, M., D. Prothrow-Stith, B. guyer, and H. Spivak (1994). Violence and Intentional Injuries: Public Health Perspectives on an Urgent National Problem. In A. Reiss and J. Roth (Eds.), *Understanding and Preventing Violence, Vol. 4: Consequences and Control*. Washington, DC: National Academy Press.

Nurco, D., T. Hanlon, T. Kinlock, and K. Duszynski (1988). Differential Criminal Patterns of Narcotic Addicts over an Addiction Career. *Criminology* 26, 3: 407–23.

Rasmussen, D.W., and B.L. Benson (1999). Reducing the Harms of Drug Policy: An Economic Perspective. *Substance Use and Misuse* 34,1: 49–68.

Reiss, A., and J. Roth , Eds. (1993). *Understanding and Preventing Violence*. Washington, DC: National Academy Press.

Reuter, P., and R. MacCoun (1992). Street Drug Markets in Inner-City Neighborhoods. In J. Steinberg et al. (Eds.), *Urban America: Policy Choices*. Santa Monica, CA: RAND.

Reuter, P., R. MacCoun, and P. Murphy (1990). *Money from Crime*. Santa Monica, CA: RAND

Short, J. (1998). The Level of Explanation Problem Revisited. *Criminology* 36, 1: 3–36.

Siegel, R. K. (1996). Presentation to the Drugs-Violence Task Force. Appendix A.

Spunt, B., P. Goldstein, P. Belluci, and T. Miller (1990). Drug Relationships in Violence among Methadone Maintenance Treatment Clients. *Advances in Alcohol and Substance Abuse* 9, 3/4: 81–99.

Stoddart, K. (1988). The Enforcement of Narcotics Violations in a Canadian City. In P. Erickson and J. Blackwell (Eds.), *Illicit Drugs in Canada: A Risky Business*. Scarborough, ON: Nelson Canada.

United States Department of Justice (1992). *Drugs, Crime and the Criminal Justice System* (NCJ-133652). Washington, DC: Bureau of Justice Statistics.

Waldorf, D., S. Murphy, and D. Lauderback (1994). Middle Class Cocaine Sellers: Self Reported Reasons for Stopping Sales. *Addiciton Research* 2, 1:109–26.

Waldorf, D., C. Reinarman, and S. Murphy (1991). *Cocaine Changes: The Experience of Using and Quitting*. Philadelphia: Temple University Press.

Wild, C. (1999). Compulsory Substance Abuse Treatment and Harm Reduction: A Critical Analysis. *Substance Use and Misuse* 34, 1: 83–102.

About The Fraser Institute

The Fraser Institute is an independent Canadian economic and social research and educational organization. It has as its objective the redirection of public attention to the role of competitive markets in providing for the well-being of Canadians. Where markets work, the Institute's interest lies in trying to discover prospects for improvement. Where markets do not work, its interest lies in finding the reasons. Where competitive markets have been replaced by government control, the interest of the Institute lies in documenting objectively the nature of the improvement or deterioration resulting from government intervention. The work of the Institute is assisted by an Editorial Advisory Board of internationally renowned economists. The Fraser Institute is a national, federally chartered, non-profit organization financed by the sale of its publications and the tax-deductible contributions from its members, from foundations, and from other supporters; it receives no government funding.

Membership

For information about becoming a member of The Fraser Institute, please contact the Development Department via e-mail: membership@fraserinstitute.ca; via telephone: 604.688.0221 ext. 586; via fax: 604.688.8539. In Calgary, please contact us via e-mail: paulineh@fraserinstitute.ca; via telephone: 403.216.7175; via fax: 403.234.9010. From Toronto, please telephone 416.363.6575 or fax 416.601.7322.

Media

For media enquiries, please contact Suzanne Walters, Director of Communications, via e-mail: suzannew@fraserinstitute.ca; via telephone: 604.714.4582 or, from Toronto, 416.363.6575 ext. 582.

Ordering publications

For information about ordering the printed publications of the Fraser Instiute, please contact the book sales coordinator via e-mail: sales@fraserinstitute.ca; via telephone: 604.688.0221 ext. 580 or, toll free, 1.800.665.3558 ext. 580; via fax: 604.688.8539.

Editing, design and production

Lindsey Thomas Martin