HIGH TIME FOR HAR

For many youngsters, the 'just say no' campaign has come too late or failed: in some urban areas, heroin and other illicit drugs have become a 'normal' part of teenage experience. In areas like these, Russell Newcombe argues it's 'high time for harm-reduction'.

Russell Newcombe

THOUGH ILLICIT drug use has not yet become typical among most British youths, it has become 'normalised' in the sense that the majority of 15 to 20 year olds in urban areas such as London, Edinburgh and Merseyside are likely to have one or more friends who take drugs, and a substantial minority will be taking drugs such as cannabis and solvents on an experimental or recreational basis. A survey in Wirral in 1984-5 found that up to 1 in 10 unemployed male school leavers on some estates were known to be using heroin or similar drugs.[1]

Primary prevention (education which aims to deter youths from trying drugs) is too late for the present generation of drug users and has been found to be ineffective and sometimes counter-productive, findings now widely recognised.[2] However, one of the most carefully designed studies found that education *can* slow the development of more problematic forms of drug use, but may simultaneously increase the rate of 'safer' forms of drug use.[3]

Until research reveals an effective primary prevention programme, it would be prudent to direct some of our efforts toward minimising the harm that drug users might do to themselves or others ('secondary prevention', 'harm-reduction' or 'risk-minimisation'). The present generation of drug using youths should not be abandoned to inappropriate primary prevention programmes, nor to the many preventable problems (eg, overdose, infections, organic damage, accidents) that can occur because of lack of knowledge about safe use procedures.

This paper looks at the four main components of a harm-reduction strategy: the rationale, content, implementation and evaluation.

Rationale

Primary prevention approaches assume that the use of illicit drugs is morally wrong because it is illegal, and/or because it is unhealthy. Therefore, abstinence is the ultimate goal, and success is measured by a reduction in the incidence of drug use.

The rationale of secondary prevention rests on three different insights about the nature of drug use.

► Secondary prevention approaches recognise the frequently unmentioned (or disregarded) fact that most people like to get 'high' — to change their mental states and processes by chemical or other means — and that in this regard humankind is unlikely to change its ways. Rather than viewing drug use simply as a 'deviation' to be rectified, the secondary prevention approach concedes that there are many 'normal' motives underlying drug use, including curiosity, group membership, recreation, stimulation, relaxation, relief of boredom, and coping with depression or anxiety. In many cases, even 'dependent' drug use can be reconstrued as just another example of the basic human desire to repeat pleasurable activities.

► Harm-reduction is also based on evidence that most illicit psychoactive drugs — if used by scientifically determined or culturally prescribed methods — are probably far less harmful to health than many products to which people are licitly exposed, such as tobacco, alcohol, prescribed pharmaceuticals, processed and high-fat foods, polluted air, contaminated water, pesticides, radiation and nuclear waste. The message that drugs are unhealthy is likely to be regarded by many people in industrialised societies as akin to warning soldiers on the battlefield that chewing gum can cause indigestion.

► The necessity for a harm-reduction strategy stems from the growing realisation that unless society changes its repressive laws and policies toward drug users, most will remain 'underground', out of the reach of agencies which deal with problem drug use. A harm-reduction strategy would be based on a caring and non-judgemental approach, encouraging more teenagers experimenting with drugs to discuss their experiences with concerned adults.

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Content

Harm-reduction materials need to be based on scientific knowledge, meaning that their content needs to be constantly reassessed.

Programmes could include instruction on the psychological and physical effects of licit and illicit drugs; safest methods of administration and quantities of use; obtaining help for drug-related problems; and alternative (non-drug) methods of controlling mental states.

The focus would be on controlled use (rational choice, care and moderation) rather than abstinence ('just saying no'), the crucial assumption being that "abstinence is very much out of character with the reality of modern life".[4]

Anti-AIDS advice on the use of heroin and other injectable drugs provides a clear example of the logical 'flow-chart' structure of harm-reduction messages (see box). Rather than encouraging more harmful drug use, such an approach provides a series of 'safety nets' to catch various types of drug user, minimising potential harm to the user and the community.

Another important example is instructing potential sniffers about the risks of experimenting with solvents.[5] Over 40 per cent of solvent-related deaths reported in 1971-81 were due to indirect causes, such as accidents and injuries due to sniffing in dangerous situations, or suffocation from over-large plastic bags.[6] Also, some inhalants are inherently more dangerous than others. Giving instruction about these avoidable hazards to current and potential solvent users, while taking great care not to encourage the practice, could do much to reduce injury and death.

Harm-reduction programmes might also reduce the relatively high incidence of accidental overdosing by drug users recorded at some urban hospitals. For instance, many accidents and deaths might be avoided if polydrug users were given early instruction never to use alcohol with other depressant drugs such as sedatives or opiates — it is reported that one-third of all illicit drug overdoses in the UK in 1985 occurred in combination with alcohol.

Implementation

Implementation of harm-reduction programmes also needs to be based on scientific knowledge, this time of how to maximise the probability of success — but there are some formidable practical problems to be overcome.

Research suggests the majority of young people have neither tried nor plan to try illicit drugs. Some believe this makes it unwise to risk stimulating their interest by giving information about the effects and

Structure of anti-AIDS advice on heroin

HEROIN can cause many problems, so it is best to avoid this way of getting high;

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BUT if you are going to use heroin, then smoke (or sniff) rather than inject;

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BUT if you have decided to inject, do not share your needles or other injection equipment;

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BUT if you are going to share needles and syringes, make sure you follow the correct procedure for cleaning injection equipment;

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ALSO if you are injecting heroin, make sure you regularly obtain fresh supplies of needles, syringes and condoms.

M REDUCTION

methods of using drugs. Others argue that, given certain conditions (eg, unemployment, hedonistic values), virtually all young people are susceptible to experimentation with drugs, so harm-reduction programmes should be given to everyone approaching the age of first drug use.[7]

There is no doubt that it would be advisable to learn from past mistakes by treading cautiously in the first stages of implementing a harm-reduction programme. One solution is to initially give harm-reduction education only to young people already using drugs or most likely to use drugs in the future.

The missing link has been how to identify the young people most at risk of using drugs, before they actually start. However, in recent research early, frequent and heavy use of alcohol and tobacco, planning to try drugs or having pro-drug attitudes, and having large numbers of friends who smoke or drink, have been found to be strong indicators of later illicit drug use.[8]

Accordingly, groups of young people found to be smoking or drinking earlier or more heavily than others could be targeted (along with current users) for a harm-reduction programme. Regular surveys of the drinking and smoking habits of young people from the age of about 9 or 10 years would be needed.

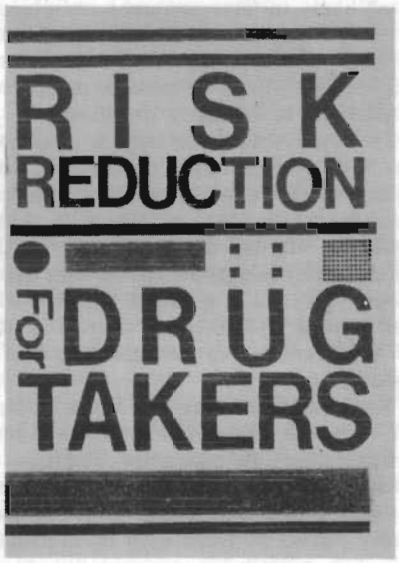
However, there may be problems in conducting programmes with different objectives within the same school or group of youths. Youngsters are likely to talk to each other about any 'special classes', spreading harm-reduction information to the low-risk group. If targeted youths become aware they are thought to be potential drug users, this may have the effect of a 'self-fulfilling prophecy'. Some teachers and parents may regard targeting as unethical. Lastly, identifying the majority of at-risk youths may turn out to be difficult in practice.

One way of overcoming some of these difficulties would be to target larger groups, rather than specific individuals. Since illicit drug use appears to be more widespread among young people in areas of social deprivation, all the young people in some schools and townships might usefully be regarded as 'at risk' of drug use.

It may be advisable to transfer responsibility for harm-reduction programmes from teachers to specialist instructors with some basic training in the medical and social sciences. Alternatively, teachers with appropriate experience could be trained on courses of about six months' to a year's duration. Harm-reduction programmes may be better separated from (rather than integrated into) the secondary school curriculum, a change in approach in conflict with the view of most contemporary health educationists.

Introduction of harm-reduction programmes may meet with strong opposition from many parents, teachers, youth workers and community groups. It would therefore be prudent to conduct a series of meetings and discussions with representatives of these groups, whose cooperation and good will is essential to the effectiveness of any drug education programme. Ideally, secondary prevention programmes for young people should be conducted in tandem with programmes for adults, allowing adults to make more informed judgments about the approach.

One possible compromise between targeting high-risk young people for harm-reduction programmes and the objections



An experimental harm-reduction leaflet being evaluated in the Salford area.

to such programmes, would be to split the project into two phases. Confidential surveys of young people throughout the school could identify actual and potential users, but only on leaving school would those identified be given harm-reduction instruction.

Though such an approach may be more acceptable to some groups of parents and teachers, the obvious shortcomings are that large numbers of youths will already have been using various drugs for several years while at school, and, after they leave, many of those most at risk will be hard to contact through youth work agencies.

Evaluation

Harm-reduction programmes are only worthwhile if the effects on young people are evaluated by carefully designed 'before and after' studies and by long-term follow-up studies using control groups.

Such programmes are, by definition, evaluated by the type and number of potential or actual problems drug users (1) experience themselves; or (2) cause others to experience.

For instance, in the first case — problems experienced by the user — programmes might be expected to:

— reduce the prevalence of unsafe frequencies and methods of use;

— reduce the rate of heavy or dependent consumption;

— reduce experimentation with drugs most likely to cause medical problems (eg, tobacco) or social problems (eg, heroin);

— improve abilities to recognise and respond to drug-related problems.

Examination of any of these variables requires that schools and other youth agencies develop drug policies which create an atmosphere in which young people can talk truthfully about their use of drugs.

Reduction in harm caused to the community could be monitored through:

— the number of acquisitive offences committed by drug users;

— the local incidence of drug-related diseases (eg, AIDS, lung cancer);

— the number of overdoses and accidents involving drugs recorded by local accident and emergency departments and coroners.

DRUG EDUCATION policy-makers and practitioners should be giving serious consideration to how the reality of drug use in the '80s is best tackled. The question they should ask themselves is: would it be preferable to reduce the incidence of illicit drug use while not promoting safer forms of drug use, or would it be more realistic to give greater priority to the reduction of harm from drug use? The emerging AIDS epidemic has rapidly brought this question to the forefront of the debate. It is my view, and increasingly the view of others who work with drug users or young people, that it is high time for harm-reduction. □

1. Parker H., Bakx K. & Newcombe R.D. *Drug misuse in Wirral: a study of eighteen hundred problem drug users known to official agencies*. Liverpool: the University, 1986.

2. See for example: Advisory Council on the Misuse of Drugs. *Prevention*. London: HMSO, 1984. But it is important to remember that most methodologically sound research supporting this verdict is concerned with North American drug education programmes, and that countless programmes have never been properly evaluated.

3. Blum R.H. *Drug education: results and recommendations*. Lexington, Mass.: Lexington, 1976.

4. Carroll R.J. *Shifting gears: making secondary prevention strategies 'primary' in the substance abuse field*. Pennsylvania, USA: Eagleville Hospital, 1985.

5. See ISDD Research and Development Unit. *Teaching about a volatile situation*. London: ISDD, 1981.

6. Anderson H.R., Dick B., MacNair R.S., *et al*. An investigation of 140 deaths associated with volatile substance abuse in the United Kingdom (1971-1981). *Human Toxicology*: 1982, *1* (3), p207-221.

7. Many teachers and youth workers believe that young people are now far more knowledgeable about drugs than older generations — not surprising given increasing press coverage and the high-profile media prevention campaigns aimed at youths. Formal instruction about drugs from trained teachers could not therefore be expected to arouse an already primed curiosity. If this is the case, then the targeting strategy discussed later may be unnecessary.

8. See: Pritchard C., Fielding M., Choudry N., *et al*. Incidence of drug and solvent abuse in 'normal' fourth and fifth year comprehensive school children — some socio-behavioural characteristics. *British Journal of Social Work*: 1986, *16*, p1-11

Kandel D.B. Epidemiological and psychosocial perspectives on adolescent drug use. *Journal of the American Academy of Child Psychiatry*: 1982, *21* (4), p328-47.

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