MINIMISATION OF HARM
A U-CURVE THEORY

U-curves have a long though questionable history in addiction studies. They were traditionally used to illustrate the decline and reform of alcoholics and drug addicts. Nicholas Dorn steals the U-curve and applies it in an entirely new way, reaching surprising conclusions about the relationship between harm-minimisation and types of drug use.

Nicholas Dorn

HARM-MINIMISATION[1] is not only on the agenda for policy-making and public debate in a way that would have seemed inconceivable even a year ago — it is actually at the heart of the debate. It is of course the threat of HIV (the AIDS virus) that highlighted these discussions. The recognition that perfectly legal sexual acts can lead to HIV infection has helped to legitimise harm-minimisation in relation to those acts; the recognition that drug injection can lead to infection in a quite similar manner (via transfer of body fluids) has provided a conduit for the idea of harm-minimisation to stretch from safe(r) sex to safe(r) drug use.

Yet there is fierce resistance to harm-minimisation (as documented in previous issues of ***Druglink***) and the discussion lacks depth. The pros and cons have been argued almost exclusively in relation to clean needles for injecting drug users: the wider potentials for minimisation of social, legal and personal harm/problems[2] are not being addressed and we lack a framework or theory that spells out when, where and how various types of harm-minimisation strategies may be effective. In these circumstances, the debate has tended to deteriorate to the level of assertion and counter-assertion.

The perspective put forward here relates (a) the potential for drug-related harm, and (b) the potential for countervailing harm-minimisation measures, to (c) the stage of people's involvement with drug use, forming a new kind of 'U-curve theory' (see figure).

THE FIRST-TIME USER. The first proposition of the theory is that there is considerable potential for harm — physical, social and legal — at the very beginning of involvement with any intoxicant (eg alcohol, solvents, illegal drugs). It is then that the user is most naive, least informed by any culture of use, and hence relatively prone to getting into serious trouble.

For example, first-time users may be confused about how much to take, where to take it, how to handle the effects, how to think about the experience in retrospect, how to deal with other people's real or imagined reactions, and so on. Looking back to the first few experiences of alcohol of oneself and one's friends, the reader may be able to identify these episodes as rather more open to accidents or unpleasant experiences than subsequent episodes — and that with a drug relatively well integrated into British culture. Initial use of solvents or of illegal drugs may be more hazardous (especially after drinking, or if aerosols or gases are used). The curious youngster who experiments with solvents alone and untutored is especially at risk. With illegal drugs, uncertainty over dose or how to 'handle' the effects is greatest at initial use.

So, harm-minimisation is particularly relevant in areas where the level or pattern of use is such that we can expect a proportion of current non-users will shortly use. Although some health educators say harm-minimisation measures should be restricted to *existing* users, such a restriction leaves unprotected a most vulnerable group — the *about-to-use*. It is surely irresponsible to withhold information that can save lives.[3]

CULTURES OF LOW-HARM USE. When we move on to those populations in which use of an intoxicant is already established on a reasonably stable and relatively undamaging basis (eg, not mixing one's sedatives, using modes of administration other than injection), then intervention is perhaps less urgent. The emergence of 'social' patterns of use, integrated into the rules and supports of cultures and subcultures and informed by some direct experience of drug use, provides its own harm-minimisation methods and channels for sharing information.

Of course, there are limitations to this. Just as 'social drinking' can provide a facilitating environment for the problem drinker, for binges and for public or private violence, so 'social drug use' can provide the context in which a proportion overdo it or otherwise get into trouble. But social networks do provide their own opportunities for norms and knowledge to develop and so for harm to be held down. So, while accurate knowledge about forms of harm and ways of avoiding them (eg, don't inject) should be made available to these social groups, there will often be less need to 'target' them than the novice or heavy abuser.

Indeed, we can probably learn from these groups, and perhaps pass on their experience to novices.

FLIRTING WITH DANGER. With the third group — the minority who become *heavily* or otherwise destructively involved on a continuous or episodic basis — then we are back in the realm of urgent action.

The situation is however rather complicated, because heavy use may be shaped by deliberate flirtations with danger and ironic playing out of stereotyped 'addict' roles,[4] as well as by involvement with intoxication *per se*. Hence it cannot be assumed that direct risk-reduction messages will be heeded. Also, the poor material circumstances of at least some heavy abusers[5] do not lend themselves to harm-minimisation: eg, no money for the bus to get a clean needle; no warm coat to make the walk bearable; no tranquillity in which to consider the pros and cons of making an effort.

Here, didactic education methods — 'Why not smoke your smack [heroin] instead of injecting it?' — may be quite useless with people who are not well motivated to give up a self-image as a

SOME PRELIMINARY IMPLICATIONS OF U-CURVE THEORY

- With novice users and those who may soon become users, harm-minimisation is a prerequisite to any rounded prevention strategy. Implications of this are currently being dodged by purveyors of mass media and schools programmes.
- With populations in which patterns of drug use are established in relatively stable and controlled forms, the relationship between the population and the educator must be rather more two-way: the educator may learn about harm-minimisation from the users.
- With populations whose involvements with intoxicants are extreme (whether on a continuous or episodic basis) then harm-minimisation is again a priority. But economic, social and health service interventions — changing conditions for users and those around them — will be more efficacious than conventional types of public health information.

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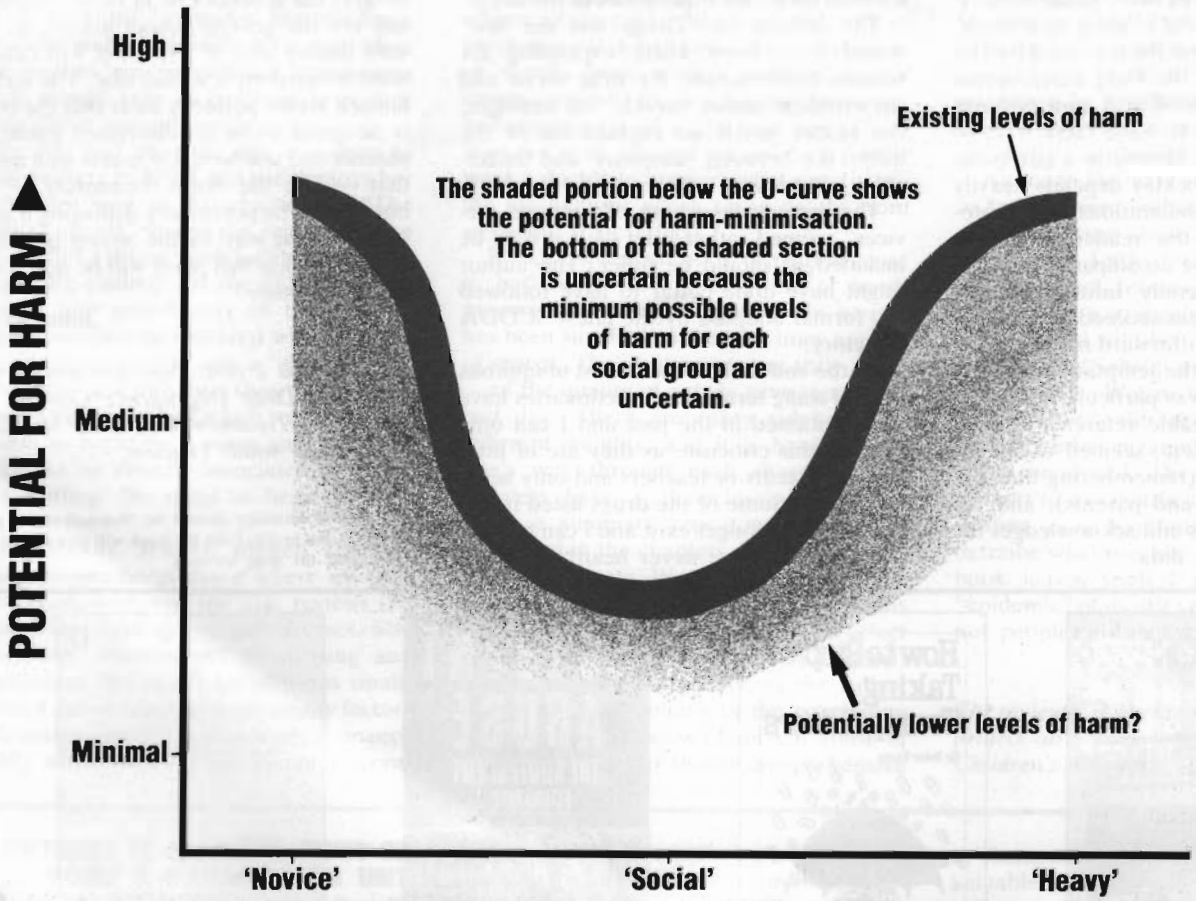
HOW THE POTENTIAL FOR MINIMISING HARM MAY VARY WITH LEVEL OF INVOLVEMENT IN DRUG USE



heavy and/or chaotic user (while such methods might work better with novices). Social and health care interventions are more likely to be helpful — eg, supplying clean needles on a local basis; attempts to find positive aspects in the subculture to which prevention can be allied; economic reforms and community programmes yielding job and other opportunities to provide some stability. There are also opportunities to work with parents, spouses and friends in ways that help them to moderate the harm suffered by heavy users, and to reduce their own distress.

SOME IMPORTANT DISTINCTIONS. No framework or theory can be applied rigidly to every individual case, since there will be variations in types and levels of risks faced *within* each social group or population. Nevertheless, some overall framework is always needed as a guide at the macro level, ie, when planning prevention strategies in relation to *groups*.

Some groups are more open to drug-related harm than others. With this in mind, we can make a distinction between the degree of harm faced by each group, and the potential for minimising it. Whatever the level of harm within a social group, the potential for reducing harm will always be less than that level, because it is impossible to get rid of all drug-related harm except by absolutely preventing drug use (and nobody knows how to do that). We can strive to minimise harm, but have to accept that there will always be a residue.

With limited resources and imperfect methods, each of us has to decide where to put our energies —which group to focus on (novices, users, heavy users, etc) and what methods to adopt with that group. Such decisions can be difficult to take, but there seems little justification for ignoring the issue.

AS WITH ANY attempt to bring together disparate experiences, this account of the prospects for harm-minimisation with social groups would benefit from challenges, revision, and subsequent elaboration.

One clear shortcoming of this account is that it understates the differences in types (as distinct from levels) of harm likely to befall different social groups. Another possible difficulty, epitomised by the U-curve diagram, is that the shape of the curve is arguable. Should it be re-drawn so that novices are shown as being more open to harm than heavy users? — or vice versa? Should the curve be flatter, more accentuated, or a rather different shape? Given any particular social group, how great is the potential for reducing each of the various aspects of harm (social, legal, physical, etc) and by what means can these various aspects be addressed? Answers to these questions are still elusive.

The purpose of putting forward this preliminary note is to offer U-curve theory as an alternative to the 'for-or-against' debates on harm-minimisation up to now, and as a stimulus to something better. □

1. The term harm-minimisation is used in preference to the alternative, harm-reduction, since the aim is to explore the possibilities for reducing drug-related harm to a minimum rather than merely reducing it. The term harm-reduction betrays a certain ambivalence in the stance of those who use it.
2. See: Advisory Council on the Misuse of Drugs. *Treatment and rehabilitation*. HMSO, 1982.
Advisory Council on the Misuse of Drugs. *Prevention*. HMSO, 1984.
3. This would be an arguable point if drug education were effective in relation to the goal of preventing experimentation, but — since it is not even partially so — the only course of preventive action open to a *health* educator (or indeed any rational person concerned about reducing human suffering) remains harm-minimisation. If one likes to add in a little inert 'use-prevention' for appearance's sake, then so be it.
4. Ives R. The rise and fall of the solvent panic. *Druglink*: 1986, *1*(4), p.10-12.
5. Pearson G. Social deprivation, unemployment and patterns of heroin use. *In*: Dorn N. and South N., eds. *A land fit for heroin?*. London: Macmillan (*in press*).