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Les Kay challenges drugs and preventi
school-based attempts to stop drug us
to reducing drug harm — a

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"Since the *Prevention* report[1] of the Advisory Council on the Misuse of Drugs (ACMD) in 1984, increasing resources have been devoted to preventing drug problems. The ACMD said prevention initiatives should *either* reduce the chance of someone using drugs *or* reduce harm from this use.

To date, most efforts have targeted the first option, and the most significant have been aimed at secondary school children through personal and social education. There has also been the publicity campaign launched by government through press and television.

Failure of these approaches means effort is now being directed to alternative approaches which focus on the community rather than the school. There has also been a shift from primary (reduction of use) to secondary (harm-reduction) strategies.

In what follows I explore some issues raised by these developments, first by presenting a six-point 'Prevention Charter' which might form the basis for our work in this area, then by listing some of the new prevention options suggested by this framework.

1 Admit we don't know how to prevent drug use

There is no evidence to demonstrate *any* behavioural change as a consequence of *any* educational strategy for reducing drug use or drug problems.

After reviewing approaches to education about drugs for adolescents, ISDD concluded: "none of these approaches have been shown to reduce either; 1) drug/alcohol experimentation, or 2) any type of harm that may be associated with experimentation, or 3) the chances of experimentation developing into heavy use, in the British situation."[2]

In the USA, the message is the same.[3]

The clear, unpalatable truth, is that *we don't know how to prevent drug use*. We should stop colluding in the fiction that better prevention strategies could solve the drug problem. Better to be honest and say we don't yet know how to do it.

We may also have to concede that it is just not possible. At the moment we are acting as if the prevention of drug problems *must* be possible. Prevention activities should be the product of scientific enquiry, not an act of faith.

2 Don't repeat mistakes

Many educational approaches have stumbled on the simplistic assumption that providing the right sort of knowledge will help restructure attitude, which in itself determines behaviour.

Behaviour is a much more complicated product of a range of factors than this model allows for. For example, it may be that behaviour can restructure attitudes, rather than the reverse.

Most smokers are aware of the harm being done to them. Probably most feel they should stop. But these views do not necessarily carry through to behaviour. Many go to an 'early' grave still holding those views *and the cigarettes*.

What is true for education in schools also holds for public education. The current advertising campaign emphasises the nastiness rather than the horror of drugs, an approach described in government circles as the 'chill factor'.

Once more psychological research has clearly demonstrated the pointlessness of these approaches based on manipulation of fear.[4] The government's own Advisory Council on the Misuse of Drugs has argued against a national campaign targeting one drug or any form of drug education that aims to scare.[5] Despite this advice, backed up by solid research, we plough on with the same old approach.

3 Controlled experiments only

Given the above, future attempts at preventing drug use can only be justified as innovative and carefully evaluated experiments. The main lessons we have learnt from previous evaluations have been methodological.

We realise the importance of measuring the impact of a specific programme at a number of points in time rather than just at the end. From work on smoking, we also understand the importance of the differing impact of prevention messages on different groups. Results from blanket programmes may hide what could be significant variations in their impact on these groups.

Our evaluation methods should also learn from the past and be sufficiently rigorous to produce reliable results.

4 Unshackle PSE from prevention

'Prevention' has itself been mystified. For example, we assume prevention and education are allied and supporting concepts. Prevention and education may instead be mutually exclusive, antagonistic concepts.

Current approaches to personal and social education (PSE) aim to enhance the power of young people to make their *own* decisions about important life events. Prevention assumes that we can set off with a set of objectives, which we can transfer to young people who will then adopt them as their own. But autonomous decision-making implies they will be able to resist not just peer group pressure, but *our* influences too.

We cannot logically demand that young people become more autonomous, *and* do what we want them to do.

Education should be about positive outcomes such as healthy lifestyles rather than narrow, negative, 'don't do it' messages. If we can unshackle PSE from prevention, teachers can get on with what they are good at, while we try to find other ways of preventing drug harm.

5 Expose hypocrisy

Among professionals, issues of relative harm from different forms of drug use have been adequately dealt with. Most will quickly recognise that problem drug use can embrace a wide range of substances, including legal drugs. But we are failing to translate these insights into the public arena.

For many people 'killer heroin' has assumed a demonic status. Yet harm from heroin use is miniscule compared to harm from 'killer alcohol' or 'killer tobacco'.

Rough estimates for the UK would suggest less than 150 deaths from heroin, up to 10,000 from alcohol, and about 100,000 from tobacco. Many more people drink or smoke than use heroin, but the assumption that we have 'killer heroin' and, by implication, 'safe alcohol and tobacco', bears no relation to the truth.

There are reasons why we have been hesitant to expose this hypocrisy. Most of our agencies are funded by a government which has put a relatively large amount of money into the field because of its concern about 'killer heroin'. Establishing in public that alcohol and tobacco are also major drug problems can be a risky business, threatening our continued professional survival.

Our understandable failure to confront these issues may well have become part of the problem. Turning the situation around will require consistent attention from us and a determination not to duck out of sight when the flak starts to fly.

6 Promote community harm-reduction

This is the element which opens up a whole new range of work. To date, we have done little to address the second of the two main objectives identified by the Advisory Council — preventing drug harm. I would argue this is because we have been bogged down pursuing the chimera of primary prevention, or prevention of the *use* of drugs. There is a vast, practically unexplored range of secondary prevention options designed to reduce *harm* from drug use.

In what follows eight such options are identified. Some of the issues and questions raised by each option are explored. One thread running throughout is the need for more useful local information on drug use,

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1. Advisory Council on the Misuse of Drugs. *Prevention*. London: HMSO, 1984. Available from ISDD, £4.25 inc. p&p.
2. ISDD Research and Development Unit. *Drugs in health education: trends and issues*. London: ISDD, 1984. Available from ISDD, £0.40 inc. p&p.
3. See for example: Moskowitz J. M. Preventing adolescent substance abuse through drug education. In: National Institute on Drug Abuse. *Preventing adolescent drug abuse: intervention strategies*. Rockville, Md: NIDA, 1983.
4. Leventhal H. Findings and theory in the study of fear communications. In: Berkowitz L. *ed. Advances in*

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drug problems and the community's needs. Much of the work conducted so far has been based on some very questionable assumptions.

Public education/information

The tendency in the past has been to target youth as the main problem. But the assumption that more parents are damaged by their youngsters' illicit drug use, than there are youngsters damaged by their parents' licit use, may be completely wrong-headed. We simply do not know which is the more important problem.

This is clearly an important issue to resolve if we are to work out what we should be saying to whom about drug problems. We will need to learn, from our colleagues in youth and community work, the methods and issues involved in community consultation.

We also need to identify and key into local information systems. This will entail a much more systematic approach to work with organisations as diverse as community pharmacists, local libraries, tenants groups, advice centres, trade unions, service organisations, etc.

Diversion options

Once more there is a need to start from a survey of the whole range of drug-related problems in different groups and from people's expressed needs, rather than from our beliefs about what they might need. It would be easy to dream up what seem to us exciting and fulfilling activities to act as a diversion to bored young drug users. We may well miss the target completely.

We should also think about ways to allow the community to become more involved in decisions about services. There is a useful body of experience of neighbourhood consultations in programmes of local crime prevention conducted by NACRO.[6]

Our interests in prevention here dovetail with those of local authorities currently shifting the emphasis toward neighbourhood services.

experimental social psychology, volume 5. Academic Press, 1970.

5. Advisory Council, *op cit.*

6. NACRO Crime Prevention Unit. *Neighbourhood consultations: a practical guide.* London: NACRO, 1982. Available from NACRO at 169 Clapham Road, London SW9 0PU.

7. Thus Liverpool Health Authority's employment policy on *Procedure in relation to problem drinkers* (sic) starts with the assertion that: "The authority recognises alcoholism as an illness and will make every reasonable effort to ensure that employees suffering from this illness are supported."

Social action

Treatment agencies indicate that many of their clients are in acute housing need, unemployed and suffer chronic financial problems. To reduce drug-related harm we could look towards housing, unemployment and welfare rights options as an alternative or supplement to individual treatment, taking care not to pathologise social deprivation itself as a treatable condition.

This raises questions about whether our responses should be specialist or generic. For example, should we be arguing for special employment projects for drug users, or trying to open up existing employment provision?

Campaigning

Targeted campaigns could be launched at district level. For example, reducing the prescription of tranquillisers could involve work with GPs and the public, and with the media. Self-help groups for tranquilliser users would need to be set up or supported, taking us into liaison work with clinical psychologists, local voluntary agencies, tranquilliser users themselves and staff from primary health care teams.

Local campaigns could also work directly on the hypocrisy of tobacco and alcohol advertising. In many cases government *Heroin Screws You Up* posters have been sandwiched between adverts promoting alcohol and tobacco. Many local authorities supporting the new drug initiatives receive financial support from alcohol and tobacco interests.

Here we should be working much more closely with colleagues in tobacco and alcohol campaigning agencies.

Casualty-reduction

There are still many myths believed by drug users about, for example, overdose, how to treat a coma, AIDS, and other infectious diseases. Should every drug user we come across be given a package of first aid advice? What should it be? What sort of literature do we need and is there a need for further training? At whom should a casualty-reduction message be aimed? What should be its content?

Experience suggests these initiatives may attract opposition from those who interpret casualty-reduction efforts as encouraging drug use. This should not deter us, but should inform the wording and targeting of our efforts.

Early intervention

The major obstacle to greater *community* involvement in early intervention is the mystification of certain forms of drug use.

Most people have been led to switch off their common sense understanding of life's difficulties when confronted by drug problems. Parents who take in their stride the teenager coming home drunk on cider, recoil in horror when they come home intoxicated from glue. Reactions if heroin is involved vary from a door slammed in the face to cardiac arrest.

A major objective of our community education/awareness activities should be to dispel this mystique. We should help people to recognise and value the understanding and skills they have from their own use of drugs. There is a great deal for many people to learn from their struggles to get by in an increasingly brutal and uncaring world.

Changing the climate

To turn round public debate from hysteria to rational discussion, we will need to address the media and local opinion leaders who shape public discussion.

We have been reactive, often rightly criticising press articles emphasising the horror, depravity and hopelessness of drug problems, but ourselves failing to provide a positive alternative. To change the climate we will need to take a more pro-active approach, identifying and cultivating key journalists to whom we can promote positive messages of success and progress by individuals and organisations.

This implies developing expertise in media relations. Working parties might be set up at national (SCODA has already done this), regional and district level, perhaps involving journalists and editors.

Some of the most powerful local opinion leaders are local politicians, business and trade union leaders, church people and members of local service and community organisations. Such people can be reached through developing a more community-oriented training programme at district level.

Workplace policies

In the workplace we have to start with the sometimes unhelpful legacy of alcohol policies. It has often been assumed, in my view mistakenly, that it is necessary to revert from the 'problem drinker' model to a disease model,[7] in order to persuade managements to deal with the issue compassionately.

The result is that workplace alcohol policies have often concentrated on the *consequences* of use rather than the *causes*. With both alcohol and drugs there is a wide range of issues which can lead to problem drinking/drug taking, including conditions of work such as isolation, lack of job security, overwork, boredom, etc.

These are all bread and butter issues for trade unionists and managers. Those concerned with alcohol policies have been led away from addressing these issues by the re-introduction of the disease model. In developing new drug policies we will have to break out of this blind alley.

IN THE OPTIONS above I have done little more than identify some of the questions. The range of issues yet to be adequately discussed is so large because we have yet to engage seriously in these discussions.

It *is* sensible to proceed with care to avoid repeating previous blunders. However, as Groucho Marx once said: "If you don't stand for something, you'll fall for everything." Many of us have been reluctant to stand up clearly for anything and are now in danger of ending up immobilised by fear of making further mistakes.

Planning is needed, but we also need to address some key areas immediately. In the North West a start has been made in exploring, demonstrating and evaluating new prevention options in small-scale experimental programmes. These might provide a model for others to develop.

There is clearly a need for much more discussion and debate about the relative merits of various approaches. Hopefully these notes will stimulate a response which furthers such a discussion.