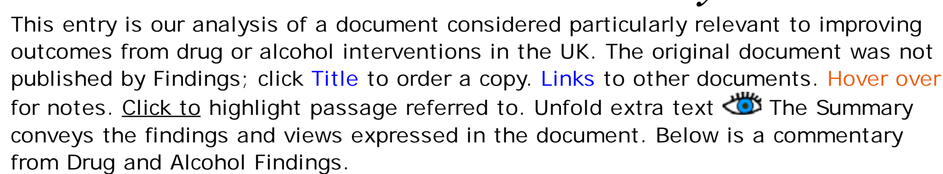

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▶ High time for harm reduction.

Newcombe R.

Druglink: January/February 1987, 2(1), p.10-11.

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Impelled by the injecting-related AIDS crisis, Merseyside was where harm reduction in the UK first took root. From there in 1987 came this groundbreaking call for a turn away from what was seen as a failed attempt to prevent use to mitigating the harm. Expressed modestly as a "prudent" suggestion, with Russell Newcombe's essay, "harm reduction" had come of age.

SUMMARY *Below is the author's manuscript published in edited form in 1987. Copyright remains with the original copyright holders. This article has been reproduced as part of the Effectiveness Bank's contribution to International Harm Reduction Day on 7 May 2019.*

Research in the 1980s has found relatively high rates of illicit drug experiences among secondary schoolchildren and school-leavers, involving particularly cannabis, solvents and 'magic mushrooms', with amphetamine not far behind. Other studies have found that more heroin users are becoming known to official agencies and in some cities most started using heroin between 15 to 20 years of age.

For instance, a survey in Wirral (Merseyside) during 1984–85 found over 1800 problem drug users known to 10 agencies, typically men aged 18 to 22 years with a heroin habit of about three years' duration.[1] Unemployed male school-leavers were the most 'at-risk' group: 1 in 20 were known opiate[2] users, up to 1 in 10 on the hardest hit estates. In Wirral there are probably at least as many unknown heroin users – and perhaps up to five times as many.

Though illicit drug use has not yet become typical among most British youths, it has become 'normalised' in the sense that the majority of 15–20-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 have tried drugs such as cannabis and solvents. There would seem to be a clear need for education about drugs through the secondary school curriculum and youth agencies.

Primary prevention (education which aims to deter youths from trying drugs) is too late for the present generation of drug users. Also, several reviews have

concluded that drug education has generally been ineffective and sometimes counter-productive, findings now widely recognised.[3]

Russell Newcombe in 2017, 30 years after his groundbreaking article. In 1987 he was at the Misuse of Drugs Research Project, University of Liverpool. Now he is an independent researcher, trainer and consultant on drug use, problems and services, and co-director of 3D Research, which offers research, training and consultancy on drug use, drinking and deviancy.

However, one of the most carefully designed studies found that education *can* reduce the rate of more problematic forms of drug use, but may simultaneously increase the rate of 'safer' forms of drug use.[4]

A large minority of 15–20-year-olds are now trying illicit drugs on an experimental or recreational basis. Primary prevention instruction is inappropriate for these youths, so 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: 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 that it is unhealthy. Therefore, abstinence is the ultimate goal, and success is measured by a reduction in the incidence of drug use. The rationale for 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 in this regard, humankind is unlikely to change its ways.

This key starting point allows the development of an approach which takes into account the multiple causes of and reasons for the various patterns of drug use found in Western society. 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 re-construed 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 – 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 health educationalist's 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 among many concerned professionals 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. Drug users should be encouraged to come forward so they can be advised how to avoid potential pitfalls, and so that the main social costs of drug use – crime, disease and family stress – can be reduced. A harm reduction strategy would be based on a caring and non-judgmental approach to illicit drug users, encouraging more teenagers experimenting with drugs to discuss their experiences with concerned adults.

For these and other reasons, the harm reduction approach is now regarded as a viable alternative or complementary approach to primary prevention programmes by drug organisations such as the Standing Conference on Drug Abuse, the Institute for the Study of Drug Dependence, and the Advisory Council on the Misuse of Drugs. The 1984 report on prevention by the Advisory Council begins by stating[5] that: "the increasing incidence of drug misuse casts doubt on the adequacy of existing preventive measures, making it

more important than ever to examine their effectiveness and consider ways to improve them or develop better ones". The report recommends that future preventive measures should focus on two objectives:
– "reducing the risk of an individual engaging in drug misuse";
– "reducing the harm associated with drug misuse".

The realistic and practical aims of a harm reduction strategy are also being increasingly recognised by youth workers, teachers, counsellors and others with first-hand experience of drug users. This trend is particularly evident in areas such as Merseyside, where illicit drug use has become so widespread that it is now commonplace in some localities to see teenagers openly smoking cannabis in public. In response, the Mersey Regional Health Authority has presented a strategy for dealing with drug use which includes harm reduction programmes, raising the crucial question of the content of such programmes.

Content

Harm reduction materials need to be based on scientific knowledge about drug effects and about the social role of drug use in subcultures and among the population at large, meaning that their content needs to be constantly reassessed.

Harm reduction 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. Traditional components of drug education programmes, such as training in social skills, making decisions, and coping with stress, can also be included.

In short, harm reduction programmes would focus 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".[6]

Developing such a programme is a formidable task, involving careful planning to avoid legal problems, and the eradication of deeply rooted myths derived from the media and elsewhere. Despite the difficulties, some components of harm reduction education have already been implemented.[7] However, most of the scattered harm reduction messages to date have been concerned with responsible drinking. The only other major example concerns tobacco, including the message in some cigarette packets advising smokers to "leave a long stub, remove from mouth between puffs, inhale less, and take fewer puffs".

Harm reduction messages concerning illicit drugs did not become official policy for any government department or local authority until very recently, when strategies aimed at encouraging young people to engage in safer drug use methods (and sexual practices) were introduced in response to the serious threat to public health presented by the spread of the AIDS virus among needle-sharing drug injectors and their associates.

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 ▸ panel. 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. Similarly, prescribing maintenance doses of opiates to heroin users who have turned to crime to finance their habits could be regarded as an active form of harm reduction which goes beyond formal instruction.

Another important example of harm reduction is instructing at-risk youths about the risks of experimenting with solvents.[8] Solvent sniffing is the only form of drug use distinguishable as typically a short-term adolescent phase. Since no effective strategies for preventing solvent misuse have been identified, it may be productive to attempt to reduce the many avoidable problems that at-risk youths could

Structure of anti-AIDS advice on heroin

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

▼

But if you are going to use

encounter during this period. Of 140 deaths associated with solvent use in the decade up to 1981, fewer than half were attributed to the direct toxic effects, and just over 40% were due to indirect causes – for example, accidents and injuries related to sniffing in dangerous situations or suffocation from the use of over-large plastic bags.[9] 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 the incidence of injury and death.

heroin, then smoke (or sniff) rather than inject;

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

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

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

Harm reduction programmes are also a suitable vehicle for attempting to 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 in combination 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.

One other important candidate for harm reduction programmes is instruction about 'magic mushrooms' (hallucinogenic fungi). The seasonal picking and eating of *psilocybe semilanceata* (Liberty Cap), the most popular variety, has become increasingly widespread and is legal as long as the mushroom is not prepared in any way [this is no longer the case]. There is no evidence of lasting medical harm from *psilocybe* use, but there is a risk of eating poisonous mushrooms by mistake. 'Magic mushrooms' are probably second only to cannabis in popularity among school-age youths, so much avoidable harm could be prevented by instructing current and potential users about how to identify the harmless, psychedelic types, and about safe quantities and methods of consumption – in this case, without the added complication of the activity being illegal.

Implementation

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

Recent research has highlighted the importance of the characteristics of the target audience, particularly their previous drug experience. Research also suggests the majority of young people in Britain 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 methods of using drugs.[10] 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. Indeed, alcohol is used regularly or occasionally by the vast majority of young people from the age of about 10 or 11 years, and tobacco is regularly used by up to a third of all 15–20-year-olds.

There is no doubt that it would be advisable to learn from past mistakes by treading cautiously in the initial stages of implementing a harm reduction programme. One solution is to initially target only young people already using drugs or most likely to use drugs in the future, as the group most at risk of drug problems. Rather than the usual 'blanket' approach, these

youngsters would be given the harm reduction programme, while young people identified as unlikely to use drugs could be given no drug education, or else a form of primary-prevention drug education found to have had no counter-productive effects.

The missing link has been how to identify the young people most at risk of using drugs, before they actually start. However, recent research suggests a relatively inexpensive and uncomplicated way of identifying, at an early age, the group of young people from whom future drug users are most likely to be drawn.[11] 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 illicit drug use during later adolescence.

Accordingly, groups of young people found to be smoking or drinking 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. This would be more difficult among school-leavers than among schoolchildren, but access to at-risk young adults could be established through youth services and occupational training schemes.

Such surveys would most practicably be carried out by teachers within the school or youth workers within the community, although obtaining valid responses would require that the policies of schools and other youth institutions toward drug use become less disciplinary and more treatment-oriented in approach. Alternatively, independent researchers (perhaps teachers with relevant experience) could be commissioned to carry out the surveys on an annual basis, and use computer-based analyses to identify the at-risk group.

A more expensive, but potentially more accurate, method of identifying young potential drug users would be to add a set of psychometric tests providing measures of various attitudes and dispositions known to be associated with drug use (eg, risk-taking, dislike of school, truancy, extraversion, vulnerability to peer pressure).

However, many teachers and other professionals in the field of drug education foresee problems in conducting programmes with different objectives within the same school or group of youths. Young people within the same school or locality 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, since the feasibility of such a procedure is so far based only on preliminary research.

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.

Secondary prevention programmes will contain far more scientific and technical information than current primary prevention programmes, and the presentation of such material must be very carefully controlled and monitored if previous problems are to be avoided. It may be advisable to transfer responsibility for such 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 views of most contemporary health educationalists.

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 programmes for young people should be conducted in tandem with programmes for adults, allowing adults involved with young people to make more informed judgments about the approach.

Acknowledging the likely antipathy of some groups to harm reduction education, initially it would probably be more feasible to steer a course between research-based recommendations and the existing beliefs and practices of concerned adults. One possible compromise between targeting high-risk young people for harm reduction programmes and the objections to such programmes, would be to split the project into two phases. First, confidential surveys of young people throughout the school would identify actual and potential users, but no general response would be made. Only on leaving school would those identified as at risk of drug use 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 by the time they leave school, and many of those most at risk (particularly the unemployed) will be hard to contact through youth work agencies. These and other practical issues need to be considered and debated before the introduction of a secondary prevention programme.

Evaluation

As is true of all drug education programmes, a targeted harm reduction programme is 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.

Most traditional drug education evaluation studies measure effectiveness by changes in drug knowledge, drug attitudes, and the incidence or prevalence of drug use. Harm reduction 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 – an effective harm reduction programme would 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 (eg, tobacco) or social (eg, heroin) problems; and
• increase people's 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 are less punishment-oriented, policies which create an atmosphere in which young people can talk truthfully about their use of drugs.

Reduction in the harm drug use causes to the community could

be monitored through:
• the number of acquisitive offences committed by drug users (eg, burglaries, theft);
• the incidence of drug-related diseases in the local community (eg, hepatitis B, AIDS, lung cancer); and
• 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 decrease the incidence of illicit drug use while not promoting safer forms of drug use, or would it be more realistic to prioritise 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. and Newcombe R.D. *Drug misuse in Wirral: a study of 1800 problem drug users known to official agencies*. Liverpool: the University, 1986.

2 In this article the term 'opiate' refers to drugs derived from the opium poppy (morphine, heroin, etc) and synthetic drugs with similar effects (dipipanone, methadone, etc).

3 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. In Britain, there have been few scientific evaluations of the efficacy of contemporary preventive programmes. Given that some of these are currently being introduced into British schools, it seems reasonable to continue with them *as long* as their effects are scientifically evaluated.

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

5 Advisory Council on the Misuse of Drugs, *op cit*, pages 2 and 4.

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

7 See materials produced by TACADE and ISDD.

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

9 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), p. 207–221.

10 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, instead serving to counteract the many dangerous drug myths that often derive from the various mass media and other social organisations. If this is the case, then the targeting strategy discussed later may be unnecessary.

11 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, p. 1–11.
Kandel D.B. "Epidemiological and psychosocial perspectives on adolescent drug use." *Journal of the American Academy of Child Psychiatry*: 1982, 21(4), p. 328–347.
Parker H., Newcombe R.D. & Bakx K. *Alcohol, tobacco and illicit drug use among young people in Wirral*. Liverpool: The University, 1986.

COMMENTARY Russell Newcombe's essay

raised issues which remain live and controversial today, but in its time it was revolutionary, catching the until then unnamed tide of harm reduction emerging in the Merseyside area of north-west England, centred on the city of Liverpool, where Dr Newcombe worked and the region he researched. The year before the city had seen the opening of the UK's first needle exchange, and the region hosted an addiction treatment clinic which promoted and practised (1 2) the prescribing of heroin as an important harm reduction tactic, especially for the reduction of crime and of injecting-related ill health, even as the bulk of British treatment practice turned away from this approach in favour of more cure-oriented treatment.

Faced with the AIDS epidemic and threat of its flooding into the general population, even conservative governments were willing to take radical action in relation to drug injectors – most evident when a few months after publication of Dr Newcombe's article the UK government set up an evaluation of 15 pilot needle exchange schemes. But Dr Newcombe went further than even 30 years later many would wish to go in calling for a harm reduction approach not just when prevention has failed and the drug user is risking their own and other's lives, but as a widely implemented educational approach intended to forestall the development of damaging forms of substance use, rooted in the fact that substance use itself is widespread and normal rather than necessarily deviant and abnormal.

In large part his essay could have been written today. Evaluations of harm reduction education have been promising, but as 30 years ago, have focused on drinking. Dr Newcombe's careful consideration of segmenting young people into groups appropriate for drug education with different aims shows that thinking has not moved much further. This remains a possibility attracting interest, but also one fraught with the difficulties and risks Dr Newcombe identified. His "Structure of anti-AIDS advice on heroin" has been validated and in varied forms replicated in advice to drug users across the world.

An Effectiveness Bank hot topic places this article in the context of the development of harm reduction and discusses later policy.

Mike Ashton of Drug and Alcohol Findings was at the time the editor of the journal in which the featured article was published.

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