2 INTRODUCTION TO HARM

Conventional approaches to working with young people who use drugs in a harmful or hazardous way or who are dependent upon drugs are based on the principle that complete abstinence is the only acceptable goal: if a young person is injecting heroin, they should 'kick the habit'; a youth experiencing problems with alcohol should stop drinking; and the young mother at home, on sedatives, should stop taking the pills. The only desirable outcome is considered to be a complete halt to the usage of the substance in question.

Such an approach, however desirable it may appear on paper, ignores much of the reality of drug use, misuse and dependence. As such, as a premise for working in the area of drugs, it may not be a helpful starting point, and in some situations it could even compound the use of harmful drugs.

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In many cases it is not the chemical property of the drug which causes the harm, but the situation where usage takes place or the way in which the drug is used: a drunk driver behind the wheel of a car is more dangerous than a hangover; and the workmate in a factory who uses marijuana on site is more dangerous there than in his or her front room. This situation even applies to the intravenous use of heroin. AIDS, commonly acquired by the use of shared, contaminated needles, is a more certain killer than heroin itself will ever be. Anyone working with young people using drugs cannot afford to ignore this perspective.

Ceasing to use drugs is an extremely difficult process for any drug-dependent individual. This is the case irrespective of whether the addictive process is chemical, with the body and mind coming to rely on the introduction of an outside agent in order for it to operate, psychological, with the person believing that they need to consume drugs in order to live, or a combination of the two. From the user's point of view, it is of little importance what the addictive process is; the fact is that he or she knows it will be a struggle to give it up. The very nature of addiction makes it so.

Anti-drugs programmes which attempt to get people to go the whole course immediately may simply be establishing a goal which is

too difficult for most people to attain. The mountain may be too high for the novice climber. Indeed, the difficulty of that goal may actually act as a deterrent to trying. The user could come to see the achievement of such a goal as impossible and, therefore, not worth struggling towards.

A step-by-step approach that recognises these difficulties may be more effective than one that expects people to go the whole distance immediately. A climbable hill may be a better starting point. In the end, despite any programme, be it compulsory or voluntary, rugged or 'soft', the only person who can make the decision to stop using drugs is the drug user. Though some people never make that decision, the vast majority do.

"for many individuals, the immediate goal of a drug-free life may be unrealistic"

There appears to be evidence, albeit often subjective and anecdotal, that illicit drug usage follows a similar pattern to crime. The majority of people convicted of criminal offences are young people. The incidence of convictions peaks in the late teens and early twenties age group, and then falls off until the late twenties and early thirties when a hard core of 'professional' criminals remain. Experience indicates that many young people, even those supposedly addicted to heroin and cocaine, make their own decision to stop using drugs after an approximate four year period. Only a hard core of drug addicts remain.

If this is the case, then an important role for a drugs concern agency or programme should be to assist the user to get through that period in a comparatively healthy state. When they then show signs of wishing to give up, assistance can be provided to support and encourage them. Should they decide to continue to use equal support should be provided. For many people drug use remains a part of their lives and if they are not dependent on it controlled use may be an acceptable goal.

The underlying premise presented in this paper is that, for many individuals, the immediate goal of a drug-free life may be unrealistic. To expect people to move rapidly from addiction or heavy usage of drugs to complete abstinence, flies in the face of much of what is known about human nature, drug usage patterns and the difficulties of stopping. To ignore these factors may be to compound drug usage and to expose drug users to the associated, and often more harmful, impacts of their behaviour as a user. Such harm is not restricted just to themselves.

The consequences of drug use have a wide impact. They can include mental anguish for the person's family, physical danger to work colleagues or other road users, and the harm, often called 'Burn Out', suffered by drugs workers. Society as a whole may suffer a loss

of income and wealth, have to contend with increasing crime, and will certainly have to bear opportunity costs as scarce resources go into drugs programmes rather than other necessary services such as health or education.

Harm minimisation strategies can have relevance to all of these areas. The remainder of the paper examines such strategies in some detail and specifically focuses on:

- the minimisation of harm to the individual drug user;
- the minimisation of harm to the user's family;
- the minimisation of harm to the community;
- the minimisation of harm in the work place; and
- the minimisation of harm to the drugs worker.

"...all mood and mind altering substances must be considered, and particular emphasis should be given to those drugs which cause the greatest morbidity and mortality"

Before examining individual strategies, it is necessary to point out that for any country to have an effective drugs strategy all mood and mind altering substances must be considered, and particular emphasis should be given to those drugs which cause the greatest morbidity and mortality.

By way of example, of the 22,000 drug-related deaths that occurred in one Commonwealth country in 1985: (Statistics on Drug Abuse in Australia, 1987, Commonwealth Department of Community Services and Health).

- 81% were caused by tobacco;
- 16% were caused by alcohol;
- 1% were caused by heroin and other opiates; and
- 2% were caused by other drugs.

Obviously then, alcohol and tobacco have to be high on the agenda.

Many people reading the suggestions that follow may be appalled or, at best, suffer a gut reaction against them. This is understandable. Many of the suggestions appear, at face value, to condone drug use. They do not. They simply recognise the realities of the situation and attempt to do something positive to shift those realities - to bring

people closer to giving up drugs or controlling their use without doing themselves, or the people around them, any harm in the meantime. Abstinence may not be the only goal. The realisable goals of the individual drug user need to be considered.