APPROACHING DRUGS (HARM MINIMISATION)

CROSS-REFERENCE

POLICY DEVELOPMENT

APPROACHING DRUGS

Harm minimisation as a technique for minimising the abuse of drugs

A Commonwealth Youth Programme
Publication

This document is part of the series
CROSS-REFERENCE: POLICY DEVELOPMENT
A set of cross-cultural materials for
youth development

FOREWORD

The issue of drugs is one of the more difficult matters that national youth policy makers are faced with. Despite various attempts at controlling the supply of drugs and despite measures to reduce the demand for drugs by young people, the abuse of drugs has continued to grow.

At the CYP Drugs Conference held under the title "Dealing in Solutions: a Commonwealth Conference for young people working in the drugs field", two participants and a member of the planning group presented a paper on Harm Minimisation as an approach to the drugs problem. There was much controversy about this approach but everyone agreed that its different facets needed further study by policy makers so that appropriate possibilities from the spectrum of techniques (eg. access to limited quantities of drugs or total stoppage) may be chosen according to national needs and relevance.

This edited version of the paper is one of the many publications on the problem of drugs, including other conference materials, being issued by CYP. It is particularly appropriate in the light of the comments made at the Conference that it appears as a document in CYP's Cross Reference series. We hope it contributes to and stimulates the debate and discussion which conference participants wished to see.

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NB The views in this paper are not necessarily those of the Commonwealth Youth Programme. They are presented as part of CYP's contribution to the ongoing debates about drugs issues.

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1 OVERVIEW OF APPROACHES TO DRUGS WORK

Young people, by definition, are in transition. This transition process, while generally characterised as a movement from the dependence of childhood to the independence and responsibility of adulthood, actually involves change across the full experience of physical, social, economic and political life.

In this period of change young people are particularly vulnerable. They are changing emotionally and physically, becoming used to being treated in a different way to that of children. An important part of being young is to seek new experiences, try different ways of behaving and, perhaps, to test the limits of new-found freedoms. It is not surprising, then, that drug use and abuse has such a large impact on the lives of young people.

Commonwealth countries have long been concerned that drugs too often turn what should be an exciting and rewarding time of life into a troublesome one. In their meetings in Nassau (1985), Vancouver (1987), and Kuala Lumpur (1989) Commonwealth Heads of Government considered a variety of actions to stem the tide of drug-related problems. Similarly, Commonwealth Health and Law Ministers have considered the medical and legal aspects of the problem at their respective meetings.

Recognising the importance of a youth perspective on what is, largely, a young person's issue, Youth Ministers at the Commonwealth Youth Affairs Council meeting in Apia (1988) asked that a conference of young people involved in the drugs field be organised. The Malaysian Government offered support for the initiative through the provision of the venue and administrative and technical support.

The Conference, 'Dealing in Solutions', was held in Kuala Lumpur in June, 1989. It brought together a group of 72 young people - government officials, youth workers, psychiatrists, ex-addicts and outreach workers - from 46 countries who, through a process of stimulating and creative exchange, sought to develop responses to the problem of drug use and abuse that would be relevant and practical for all Commonwealth countries.

Direct outcomes of the Conference included the compilation and distribution of a Conference Report, development of a training kit for

youth workers in the area of drug use and preparation of a Conference Statement that was considered by Commonwealth Heads of Government at their meeting in Kuala Lumpur (October 1989).

This Statement made recommendations on the full range of possible measures to combat the use and abuse of both licit and illicit drugs. The proposed measures covered reducing the demand for drugs, reducing their supply and harm minimisation.

Measures identified to reduce the demand for drugs included:

- prevention programmes, including drug education programmes in both school and non-school settings, incorporation of preventative work into mainstream school curricula and outreach work to the settings where young people gather;

- early intervention and treatment programmes, which acknowledge that drugs are a symptom and not a cause and which add to the currently inadequate store of knowledge about fundamental issues in the drugs field; and

- measures to combat the abuse of alcohol and tobacco, including the banning of advertising of tobacco, controlling the advertising of alcohol and increasing the cost of alcohol and tobacco through the imposition of taxes so that they are beyond the financial reach of young people.

Measures proposed to reduce the supply of illicit drugs included:

- security operations to destroy crops that are the basis of illicit drugs;

- ratification of the 1988 United Nations Convention Against Illicit Trafficking in Narcotic Drugs and Psychotropic Sub-stances;

- allocation of resources to encourage crop substitution; seizure of financial assets of convicted illicit drugs dealers; and

- stringent legal punishments.

The Harm Minimisation Strategies covered approaches to minimise harm to:

- individual drug users;
- family and friends of drug users; and
- the community.

The concept of Harm Minimisation was an issue that generated a great deal of debate and controversy at the Conference. Some saw it as little more than condoning the use and abuse of drugs by young people, while others saw it as a responsible approach to the realities of young people's involvement with drugs.

The central idea underpinning the concept of harm minimisation is a recognition of the intense difficulty many young people have in coming off drugs. It therefore seeks to assist them to minimise the harm they do to themselves, their families, communities and colleagues through their drug use.

The controversy generated by the concept of Harm Minimisation is an indication that a great deal of further debate on it is required before a final assessment of its validity or otherwise can be made. It was for the purpose of contributing to this debate that the Commonwealth Youth Programme (CYP) decided to publish this paper. The paper itself is based on information presented to the Conference in Kuala Lumpur, but represents only a portion of the work and discussion that occurred at the Conference.

It should be clearly understood that the views and ideas presented in the paper in no way represent the views of CYP, member countries or the formal view of the delegates who attended the Conference. The purpose of publishing the paper is not to add fuel to the controversy over the concept of Harm Minimisation; rather, it is to contribute to a full and open debate about the most appropriate responses to the pressing issue of drug use and abuse by young people.

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.

"Conventional approaches...are based on the principle that complete abstinence is the only acceptable goal"

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.

3 HARM MINIMISATION TO THE INDIVIDUAL DRUG USER

If the initial focus is to be on the person most directly involved, the individual drug user, we need, then, to be able to identify what programmes can be put in place to minimise the harm an addict does to him or herself through hazardous drug use. Here we focus on alcohol and illicit drugs.

CONTROLLED DRINKING

Many individuals who have alcohol related problems do not necessarily have a physical dependence on it or health problems specifically associated with their drinking. Rather, the drinking may cause a range of other problems: it could have an effect on the family; impair their performance at work; or relationships with friends and colleagues may be effected. It may be that the person drinks in a hazardous 'binge pattern'. Excessive intakes of alcohol could take place in dangerous situations such as before driving a car or going swimming. It is not just the long-term effect on the general physical health of the individual that is of concern.

"...young people who have been assessed as not having alcohol related physical problems or a physical dependence can learn ways to control their drinking behaviour"

Many individuals who drink excessively are not prepared to stop, and may not need to stop drinking, so recommending abstinence for them is sure to fail. It follows that if abstinence is the goal of a particular programme, then that programme is highly likely to fail the individual concerned. Alternative strategies need to be developed.

Controlled drinking programmes provide one viable option. In these programmes young people who have been assessed as not having alcohol related physical problems or a physical dependence can learn ways to control their drinking behaviour.

Some of the strategies that could be learned, include:

- changing from high alcohol to low alcohol drinks;
- counting or pacing drinks;
- alternating alcoholic and non-alcoholic drinks;
- avoiding drinking in binges;;

- not drinking every day
- not drinking when feeling depressed, anxious, or upset;
- avoiding situations where they know there will be pressure on them to drink; and
- not drinking if driving or involved in other hazardous activities such as water sports.

An essential part of all of the above strategies is to inform the 'client' of the limits of safe alcohol use.

A wide range of techniques is available to encourage young people to adopt such strategies. They include:

"An essential part of all of the above strategies is to inform the 'client' of the limits of safe alcohol use"

- individual counselling (formal and informal);
- group therapy;
- social skills training;
- assertiveness training;
- problem solving skill development;
- diversion therapy;
- behaviour modification programmes;
- acupuncture; and
- hypnotherapy.

Workers need to be trained in the use of the above techniques so that they can use them in a considered and effective manner.

'SAFE' DRUG USE

The problems associated with illicit drug use are often related to the way in which the drug is used rather than the chemical property of the drug being consumed. The most extreme example of this is the sharing of contaminated needles that convey the AIDS virus, but it can also apply to the environment in which the drug is used.

Therefore, if people continue to use drugs, for whatever reason,

they should still have access to information on the ways in which these illicit drugs may be used more safely until they feel ready and able to stop using drugs altogether. To not have such information available is to abandon the drug user simply because they are not in a position to stop using a particular substance. They deserve more assistance than that.

Some of the possible options include encouraging:

- any user who is taking drugs by injection to use an alternative method of administration, e.g. from injecting heroin or smoking cocaine to snorting;

- individuals who continue intravenous drug use to choose healthier injecting practices and techniques, e.g. how to clean injecting equipment and the appropriate location for the injection, i.e. knowing where the vein is;

- users to find a safe environment for injection, e.g. not to inject in the street, with strangers or alone;

- the individual user to use the particular drug in a less chaotic way, e.g. not to indulge in binge drug taking where large quantities of a drug are taken at once;

- single, rather than poly-drug use (the latter, involving the mixing together of a range of drugs, e.g. heroin, alcohol and tranquilizers is much more dangerous);

- anyone using drugs to manage their finances well, including giving priority to the purchase of food, rent and clothing rather than solely drugs;

- a healthy diet and lifestyle; good food needs to be eaten, a regular routine entered into and personal cleanliness attended to;

- women drug users to stop using any drugs if they are planning a pregnancy or are already pregnant (this includes alcohol and tobacco as well as illicit drugs), and

- users who are unwell or are infected, e.g. by hepatitis, to stop using;

Encouraging safe drug use enables the drug user to be engaged in a supportive, positive programme until they feel able to stop using drugs altogether. It may enable them to come out the 'other side' in a comparatively healthy state, when abstinence programmes, with their inevitably high failure rates, may not.

4 HARM MINIMISATION TO THE FAMILY

The family provides the very foundation of life in most societies. Whether in its nuclear version or the extended concept it is an integral part of all communities. Ideally, the family should be a close-knit and supportive unit. A member of the family taking drugs can seriously jeopardise this role.

The whole family will live with and experience the drug problems of one of its members. Roles and duties are likely to be neglected, relationships will be impaired and people's respect for their own family is likely to be damaged. Many family members will feel ashamed at what they see as the disgrace that has fallen on their family. Many of them are likely to blame themselves and ask where they went wrong. The family is harmed by the experience of drug abuse, be it from illicit drugs, alcohol or prescription drugs.

"The whole family will live with and experience the drug problems of one of its members"

One of the most telling observations of families that include a drug user is that family members can take on the behaviour of the user even though they themselves are not using the drug. They may lie about an illness in order to avoid going to work, to school or socialising. Performance at the work place or in school is likely to be impaired as most of the attention is on the abuser. Many experience stress or stress-related illnesses because of worry and lack of sleep. At times even appetite can be affected. The influence of drug use touches every member of the family unit.

The family can become the centre of increasingly destructive behaviour. Nasty verbal exchanges between the user and the rest of the family are likely to be a regular occurrence. Physical abuse can occur frequently and, at times, even sexual abuse can come into play. Naturally, these incidents have a dramatic effect on family life.

Children are likely to be the most affected. Though there is an innocence in childhood, they will know that something is wrong. This is likely to result in major confusion and misunderstanding. They are likely to feel fear, particularly if they are the subjects of physical and sexual abuse. This has a dramatic effect on their individual development.

One of the most effective ways of minimising harm to the family is to involve them in self-help groups. These are groups of people who

find themselves in a similar position. Their sons and daughters or husbands and wives, perhaps even parents, are using drugs in a hazardous or harmful way. The sameness of their position, the common issues and problems they share, the recognition that they are not the only ones in a particular situation, can be of great comfort and help.

The group provides family members with an opportunity to talk through their particular problems with people who will understand. They are able to air their feelings and concerns. Many groups take turns to focus on one or two situations per meeting. Some groups share people's experience of their worst moments, funniest moments in hindsight, and so on. All of the groups are designed to assist people to develop their own answers to their own difficulties.

The suggestions for these answers will come from other group members. The common experience that they share is likely to provide an insight that can suggest something practical and reasonable that someone can do about their situation.

Self-help groups often have two less tangible outcomes. First, the family realises that they are not alone. Second, family members come to accept that they are not responsible for the user's behaviour. These are important breakthroughs.

Of course, self-help groups are not the only approach. To minimise harm some people become involved in:

- family therapy sessions that use professional therapists who seek to assist the family to understand what is happening to them, accept the reality of that situation and explore what they can do;

- stress management sessions that seek to equip the family with the skills and knowledge necessary to manage the inevitable tensions that will exist; and

- individual therapy for particular family members effected by the drug use of another family member.

Through self-help groups, family therapy, stress management and individual therapy families can minimise the harm done to them by the presence of a family member with a drug problem.

5 HARM MINIMISATION TO THE COMMUNITY

The use of drugs, licit and illicit, poses a threat to the wider community. Inevitably, most programmes that work with individual drug users will have an effect on that wider community, though often that effect is indirect.

It is possible to think of some programmes as being primarily designed to minimise harm to the wider community, even though the focus of such programmes is the individual drug user. These include:

- Substitution Therapy;
- Needle Exchange Schemes;
- Anti-Drink Driving Programmes; and
- Decriminalisation of certain drugs.

Substitution Therapy involves the replacement of one drug with a less harmful alternative.

The most widely used substitute is methadone, a long acting synthetic opioid which requires one oral dose daily. It is used for individuals with an established opioid dependence such as heroin, codeine, morphine or pethadine. While on a methadone programme users may be monitored for other drug use.

Many users of illicit drugs are involved in other illegal activities. They support their habit through prostitution, stealing or dealing in drugs. They can become involved in violent activity and be criminally disruptive to the community.

Methadone treatment seeks to minimise the use of illicit drugs, thereby reducing the need for criminal activity to support the drug habit. Its more diluted effect on the individual is also likely to minimise any disruptive physical behaviour that results from drug usage. Methadone is an effective harm minimisation technique and provides an opportunity for drug users to stabilise their often chaotic lives.

"The sharing of needles has been shown to be one of the most effective ways of passing the AIDS virus from one user to another"

Methadone assists the community in another important way. As a programme it provides a contact point with the drug user. Those who find themselves in a situation in which they cannot, at this time, give up drugs, but know they should, have a halfway house available. This link provides the opportunity for discussing the reality of the drug user's life and the options available to him or her. Progress in handling the situation is of direct benefit to the community.

Needle Exchange schemes are increasingly being considered by governments as they recognise that the threat of AIDS is greater than the threat of intravenous drug use.

The spread of AIDS is a major threat to all countries and there is an increasing recognition that major steps need to be taken to control its spread. The sharing of needles has been shown to be one of the most effective ways of passing the AIDS virus from one user to another.

The spread of the virus among intravenous drug users also represents a major potential avenue for the spread of the virus to the community generally. If people are sharing dirty needles and syringes, a supply of clean, new ones, and encouragement to use them, could be an effective way of halting such a disturbing and fatal trend.

Needle exchange schemes give users access to supplies of clean needles and syringes. Many such schemes use the incentive of this 'service' to communicate with young people about the dangers of drug abuse and safe drug and sexual practices, while also providing an opportunity to convince them to refrain from using drugs. Such activities provide a clear indication to the 'client' that their drug use is not being condoned.

The United Kingdom and Australia are two countries that have commenced such programmes. In Sydney there are over 40 outlets, 50 per cent of which are pharmacists, who distribute the needles and syringes. In the U.K. the programme was established in 1987 and there were, in 1989, 47 outlets. In Liverpool (U.K.) research has shown that 80 per cent of drug users using the Needle Exchange Scheme were no longer sharing needles and that a smaller percentage had altered their sexual activity. It is particularly encouraging that many of the individuals attending the Scheme had not previously sought help with their drug problem.

Although Needle Exchange Schemes may be a contentious proposition in many countries, it needs to be acknowledged that the threat of AIDS is greater than that of drug use. If harm to the community is to be minimised clean needle and syringe use needs to be promoted amongst users.

Anti-Drink Driving programmes seek to protect the community from

the very real harm that is caused by drivers who are affected by alcohol when in charge of a motor vehicle.

Alcohol and other drugs are a major cause of morbidity and mortality associated with traffic accidents. In many countries the major cause of drug related deaths under the age of 25 is due to traffic accidents. In many of these it is innocent people that die.

One way of reducing this appalling situation is to introduce random breath testing. Under the appropriate legislation police are able to randomly stop drivers at any time of the day in order to check their alcohol level. The breath testing involves the administration of a scientifically authorised test to determine the alcohol concentration of a driver's breath. If the test shows that the driver is above the legal limit, a blood test will be taken (often administered by a doctor in a police station or hospital) to confirm the blood alcohol concentration. Severe penalties, including loss of license, fines and imprisonment, are applied to those convicted.

Individuals who are repeat offenders may be required to be assessed for any alcohol problem and referred for counselling and rehabilitation. Such an approach may be effective not only in halting the dangerous practice of drink driving but also in identifying individuals with drinking problems. New techniques are being developed to test for other drug use by drivers which may affect their driving performance.

Decriminalisation of certain drugs (e.g. marijuana) is argued for on the grounds that the main problems associated with their use are related to the criminal activity that results from their illegal nature, and the cost of supporting what could be an expensive habit.

Available evidence suggests that drug use usually progresses from legal drugs to cannabis to other illicit drugs such as heroin and cocaine. Further, some people believe that if the availability of one drug is restricted people will choose to use another drug which, possibly, may be more harmful, e.g. if the availability of marijuana is reduced an individual may turn to heroin because it is readily available.

Some arguments for the decriminalisation of certain drugs are:

- to flush the individual out into the open in order that they can receive help without the fear of legal repercussions; and

- to remove them from a criminal environment.

Various countries are seriously considering the decriminalisation of

marijuana and the controlled supply of other drugs such as heroin. The major concern is that such legislative change may increase the use of these drugs. However, there has been no solid research to either support or counteract such a view.

6 HARM MINIMISATION IN THE WORK PLACE

A person under the influence of any drug in the workplace, particularly if they are in control of machinery, represents a very real physical threat to:

- themselves;
- colleagues;
- clients; and
- bystanders.

At an economic level, accepted recreational or social use of drugs such as alcohol and marijuana can have significant adverse effects on productivity. These can include:

- reduced productivity and output due to absenteeism and tardiness;
- decreased profitability and economy of the work; and
- an increased requirement for quality control as a drug user's work needs to be checked and rechecked.

Employee Assistance Programmes, which provide on-site medical and personal assistance to drug users, could be considered as one harm minimisation technique. Large companies and government departments should consider the need to establish teams to provide such support. Obviously, they would need to be separate from management so that workers have no fears about visiting and using such a service.

The economy would benefit from such an approach. Accidents would decrease, productivity would rise and relationships in the work place would be more positive. Harm to the economy and the work place would be at least lessened, if not prevented altogether.

7 HARM MINIMISATION TO THE ALCOHOL AND DRUG WORKER

The person that works with alcoholics and/or drug users operates under major stress. Burn-out is rampant for workers in this area, and it is the drug worker who often seems to be the last person whose needs are considered. At times the worker takes on the role of 'God' and tries to solve the drug users problems, to fix the users life. This is dangerous.

The worker needs to know his or her limitations. Provision should be made for workers to ventilate their feelings and to relieve stress. Counselling for workers in this field should be a high priority.

When working within a team, burn-out is less likely. The team members can look after each other by, for example, pointing out to each other the need for time-out. Continuous workshops and seminars on stress management should be provided. It is easy to forget that workers in this area are people too, and need to be cared for and protected against 'burn-out'.

8 CONCLUSION

Young people are using and abusing drugs. Reality dictates that we must assume that this situation is not going to change in the foreseeable future. As unpalatable as this situation is, it has to be recognised and addressed.

Young people themselves are the only ones who can decide to stop using drugs. If a young person has not made, or is not willing to make that decision then any number of drug education programmes, any operations to restrict the flow of a particular drug or any increases in penalties for trafficking will, in the long term, fail.

That such a situation exists can in no way resolve a society from its duty to assist and care for its young people. If young people are going to take drugs we need to attempt to ensure that, as far as possible, the harmful effects of those drugs are minimised. This does not mean condoning or encouraging drug use; rather, it means taking a detached view of the situation and ensuring that any strategies implemented are realistic.

As there is no single or simple solution to the drugs problem we must accept the need to look more widely, to accept our limitations, and through our frustration and desperation to seek alternatives which have realistic chances of success. Harm minimisation strategies, as controversial as they may seem, need to be considered as viable options in any comprehensive drug policy.

The fact that some governments have already decided to supplement their drug policies with harm minimisation strategies which operate in tandem with a policy of eradication, indicates that this questioning and seeking of alternatives is underway.

CROSS REFERENCE TITLES IN THIS SERIES TO DATE:

POLICY DOCUMENT 1
Approaching Youth Policy

POLICY DOCUMENT 2
Approaching Youth Unemployment

POLICY DOCUMENT 3
Approaching Drugs

TRAINING DOCUMENT 1
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