

Key Concepts in Drugs and Society

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Drug Risks and Health Harms

Drug risks refer to behaviours that are likely to produce drug-related harm. Psychoactive drugs can contribute to health harms that affect an individual's physical and psychological well-being.

Individuals assess and negotiate risk as part of everyday life. Research into various social problems, for example, teen pregnancy, poverty, school drop out and crime, has described individuals or groups who are 'at risk' or at 'high risk' for harm. Individual actions are characterised as 'risky', or as 'risk behaviours', although at times these concepts are not clearly defined. Moreover, engaging in risk taking is not the same as being 'at risk'. Scholarly work as well as social policy has focused on risk as it applies to and affects young people in particular. Youth are often perceived as irrational decision makers, that is, they risk inappropriately or for the wrong reasons. Other scholars have suggested that risk taking can serve important functions for youth, that is, youth have little power in society, and the use of psychoactive substances helps young people to 'defy their demeaned status' (Skager, 2009: 576). Although adults and youth can perceive drug-related risk in different ways, risk taking and experimentation can be important for shaping youth identities.

RISK AND DRUG-RELATED HARM

The underlying assumption of the 'abstinence only' perspective is that all psychoactive drug use is harmful. However, there are degrees of harm and many individuals who

consume drugs subsequently desist without ever experiencing drug-related health, social or legal problems. Nutt et al. (2007) offered a useful method for categorising drug-related harm. They suggested that these harms can be broadly classified as: (1) physical harm; (2) dependence; and (3) social harm. Drug-related *physical harm* refers to outcomes that can affect people's physical well-being. These outcomes include fatal or non-fatal overdose, injury and accidents, damage to nasal passages, throat, skin and vital organs, hangovers, effects from ingesting adulterated substances that contain harmful ingredients, and polydrug combinations that can amplify the pharmacological effects of drugs. *Dependence* includes physical dependence and psychological addiction (see also **4 addiction**). Harms associated with drug dependence include tolerance, cravings and withdrawal. *Social harm* refers to the ways in which drug use can affect 'families, communities and society' (Nutt et al., 2007: 1047). These harms include stigma and marginalisation, problems associated with social relationships, work difficulties, involvement with the legal system, and costs that are associated with drug-related health problems.

Although this classification method is useful for understanding harm that can result from drug use, some drug-related harms do not fit within the three-tiered system. For example, drugs can produce psychoactive effects that were not intended by their pharmaceutical make-up. Drug taking can contribute to paranoia that can be psychologically but not physically induced. Paranoia can be brought on initially by the social setting in which drugs are consumed; Zinberg (1984) observed that 'set' and 'setting' (as well as the pharmaceutical effects of a drug) can contribute to drug experiences (see also, **15 drug effects**). At times, this drug-related harm can extend well beyond the timeframe of the drug episode.

Risk taking can create and amplify drug-related harm. Traditionally, risk taking was viewed in terms of individual decision making and action. This perspective fails to consider the wider structural factors that can exacerbate risk taking, and in turn drug-related harm (Rhodes, 1997).

PERCEPTION OF RISK

Drugs are generally consumed because individuals wish to alter the way they think – even if the effect is temporary. Many young people engage in drug use for pleasure, although Skager (2009) observed that scholarly work often fails to acknowledge this motivating factor. The perception of drug-related risk refers to how individuals perceive the risk of using particular substances. Drug-related risk as interpreted by government policy can differ substantially from how individuals perceive risk. For example, cannabis products are illegal in most industrialised nations, however, vast numbers of people have used and continue to use cannabis or marijuana. Attitudinal surveys conducted in various countries have shown that moderate to large percentages of people are in favour of decriminalisation or legalisation of cannabis (see also **40 decriminalisation, legalisation and legal regulation**). In the USA, a survey of adolescents who self-reported marijuana use during the past month found that only 1.4 per cent of young people believed that smoking the drug once a month produced *great risk* for physical and other harm (Substance Abuse and Mental Health Services Administration, 2009). Users of other drugs often share these views. In other

words, governments and individuals often differ in how they perceive the extent of risk that might be associated with drug taking.

Perceptions of risk can change in response to new experiences and different settings. In a follow-up study of youth in Ireland, Mayock observed that ‘drugs previously deemed dangerous moved gradually to a position of greater acceptance’ (2005: 37). Other individuals reduce their drug use as they age and take on more responsibility relating to family or employment. Thus, perceptions of risk can be reduced or enhanced over time. Perceptions of risk can also be affected by the legal status of psychoactive substances. Alcohol and products known collectively as ‘legal highs’ generally are perceived as less risky to health, simply because they are legal (see also **5 legal drugs** and **18 novel psychoactive substances**).

Equally important is that the perception of risk is not necessarily related to risk taking. For example, people who inject drugs may be aware that certain injecting behaviours increase the likelihood of transmission of infectious disease, yet some continue to engage in these behaviours. Similarly, many individuals who smoke cigarettes are aware of the link between smoking and lung cancer, yet they continue to engage in the behaviour. Still others might understand the risk of driving while intoxicated but in certain contexts might engage in this behaviour or allow another intoxicated person to drive them.

THE ‘EXPERT’ VIEW

Definitions and assumptions of risk taking are socially constructed. ‘Experts’, that is, individuals with specialist knowledge often provide advice regarding the level of risk associated with particular behaviours. However, disagreements among experts can create uncertainty or doubt among laypersons (Giddens, 1991), and expert views can vary across countries and change over time. Still, expert opinion can influence the formation of drug policies. In a critical review of Australia’s drug strategy, Duff (2003) suggested that drug policy has neglected the opinions and experiences of people who take drugs, and relied greatly on expert opinion. Consumers of psychoactive drugs are rarely looked upon as having credible knowledge about the substances.

Government policy that labels all drugs as risky can lead to distrust among drug takers, many of whom have not experienced significant drug-related harms. Further, there is little evidence that negative or alarmist information about drugs can contribute to a decline in substance use among individuals (Skager, 2009).

Although ecstasy users might be familiar with media stories and research findings that describe long-term effects of the drug (for example, research claims about the link between ecstasy and neurotoxicity), they generally do not personally know individuals who have experienced lasting negative effects that they attribute to ecstasy. Similarly, cannabis and marijuana users may be familiar with expert claims that link those substances to psychosis, however, they often fail to internalise the information because they have no personal experience with the potential harms. In other words, the personal experiences of users and the experiences of others known to them, are often strikingly different than messages portrayed by the official line. These conflicting bases of knowledge can lead to the perception that government advice about drugs (particularly information that advocates abstinence) lacks credibility.

MANAGING RISKS

Over time, many people who use drugs learn to manage or reduce the likelihood of drug-related harm. For instance, some individuals will carefully monitor dosage and frequency of use, obtain drugs from suppliers whom they perceive as trustworthy and only consume drugs in the company of people they know. Peer groups can be important for reducing risks among group members. For example, group norms and informal social control within peer groups have been found to contribute to risk reduction associated with ecstasy use (Panagopoulos and Ricciardelli, 2005). Those authors noted that in-group norms took the form of judgments surrounding excessive use, requiring members to be sober while driving, and monitoring group members who were experiencing adverse effects of the drug. In several studies, however, the use of polydrug use during the same drug episode amplifies rather than minimises drug-related harm (see also **6 polydrug use/polysubstance use**). Findings from those studies suggest the need for more appropriate risk management among people who use drugs. Managing risk is not specific to particular drugs of choice; rather, proactive efforts to reduce drug-related harm can be practiced among individuals who use various drugs, including heroin.

SUMMARY

Drug-related risks are culturally situated and vary across individuals, time and space. Concerns about drug-related risk are often raised by government officials as well as health, social welfare and education professionals. However, these concerns are more focused on the *potential* for harm, rather than the risk itself. Individuals who use psychoactive drugs perceive risk according to their own experiences and the experiences of people they know. Negative health information is unlikely to affect their drug-taking behaviour to any great extent.

Although certain behaviours can create or increase the probability of drug-related harm, other behaviours can reduce the likelihood of harm. Some drug users actively engage in harm reduction practices whereas others actively participate in drug-related risk. There is a need for effective interventions that can further reduce harms associated with drug taking.

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Injecting Drug Use

Psychoactive drugs can be consumed in different ways, including swallowing, smoking, snorting/sniffing, inhaling vapours and injecting. The various ways that people take drugs are collectively known as routes or methods of administering drugs. Injecting drug use (IDU) is the process whereby drugs are injected into a vein (intravenous), muscle (intramuscular) or beneath the skin (subcutaneous; 'skin popping').

The hypodermic syringe was invented in Edinburgh in 1853 as a means to facilitate pain relief; injecting a drug generally reaches the brain more quickly than other methods of administration. Use of the hypodermic syringe spread to the USA and other countries shortly thereafter. The availability of medicinal morphine administered through injection led to large-scale addiction in some countries in the late 1800s. During this time and into the early 20th century, several patented and over-the-counter medicines were available to the general public. A high proportion of users included those from middle- and upper-income backgrounds, including large numbers of women. Syringe cases, containing a needle, syringe and other injecting paraphernalia became fashion accessories for the wealthy and in the USA were available for purchase from the Sears and Roebuck catalogue. Subsequently, sales of needles and syringes became available only through pharmacies, and possession without a prescription became a criminal offence in some countries.

CONTEMPORARY CONTEXT

The preferred route of administering drugs depends on cultural norms, individual factors and the method by which drugs are prepared and made available through drug markets. In an urban area of England, researchers have observed various social

