Rethinking young people's drug use

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Abstract

Reports on a unique five-year longitudinal study of several hundred English 1990s adolescents, exploring how they make decisions about whether to try or use illicit drugs. Shows how young people make and re-make decisions and journey down distinctive drugs pathways as abstainers, former triers, those in transition and those who are current, regular drug users. Discusses how official interventions (particularly drugs education) have only marginal impact on a generation of drugwise youth, because they fail to understand the complexities of these decisions.

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Introduction

The 1990s have seen an unprecedented rise in the "recreational" use of drugs by young people. Young people's drug use has been high on the political agenda and dealing with it has created a new mini "drugs prevention industry" and an annual expenditure of £1.4 billion (White Paper,1998) targeted at drugs prevention and problems. Yet the efforts of this new industry have curbed neither incidence (new triers each year), nor prevalence (the total number of young people who have ever tried a drug). In short, drug-taking has climbed relentlessly. While different techniques of measuring this – for instance household surveys as against self-report questionnaires in schools – produce different rates, the trends created have all pointed upwards (ISDD, 1996; POST, 1996) towards what will probably be a plateau level of around six in ten young people having tried drugs by the age of 16.

Elsewhere, we suggest that official responses to illicit drug misuse by young people have been badly misconceived, because the debate has become politicised in a particularly unhelpful way. The political blaming of youth and the search for sound bites to produce an apparently vote-winning "war on drugs" discourse has marginalised complexity and indeed contradiction (Parker *et al.*, 1998a). The Government's new White Paper on tackling drugs is more realistic than previous policy statements. Nevertheless, it remains uncritically wedded to prevention through education, although insisting that this should now begin in the primary school, thereby putting further faith in prevention through formal education.

In this short paper we will concentrate on trying to illustrate the complexities involved in the development and sustenance of young people's "recreational" drug use. While we are critical of the inconsistencies and inadequacies of much current drugs education, our key point is that it is simply unrealistic to rely on health education strategies to challenge what are major changes in youth culture in general, and in consumption in particular. The rise in illicit drug use during the 1990s is in fact part of several wider "structural" processes. Young people who drink are now drinking more regularly and far more per session (Brain and Parker,1997; Wright, 1998). Today's youth are smoking more once

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again, particularly young women (Rowlands *et al.*, 1997). In short, as effort and expenditure aimed at preventing or restraining the use of all these drugs increases, so does their consumption by contemporary youth. In most other areas of public policy, such contrary performance indicators would produce a major strategy review. Health promotion-drugs education policy is bizarrely immune and the reasons for this are political and ideological. As a consequence, a free market has been created where different packages and programmes – ranging from DARE to Tacade and Global Rock to Healthwise – are all in use alongside homespun curricula from teachers and personal and social education co-ordinators. The end result is that what and how much young people get by way of drugs education depends on where they live and which school they attend.

The findings we present here are based on a unique, five-year longitudinal study of several hundred young people who have been tracked as they have had to grow up, "drug-wise", in the 1990s. We argue that almost all 1990s adolescents are drugwise because in our study even drug abstainers still had to get up to speed on drugs (Wibberley, 1997). The main aim of this paper is to outline how young people make and remake decisions on drugs as they journey through adolescence. We also suggest why they usually do this without consulting adults or trusting official messages or messengers, relying instead on "drugs stories" and everyday observations and experiences.

Methodology

The North-West longitudinal study has involved following several hundred young people from year 1, when they were 14 to 15 years olds, for five years, until they were 18-19 and moving into young adulthood. Initially representative of two outer metropolitan borough youth populations in North-West England, by gender, social class and race, this study is unique in that it has been able to track how 1990s youth have negotiated their way through adolescence, in schools and social worlds where drugs are readily available, tried, and used by a significant minority. The original sample (N = 776) was initially created from eight state secondary schools using whole year groups. Annual, confidential, self-report questionnaires administered by the researchers were used. A total of 86 of these respondents were also interviewed in year 4, when they were approaching 18. Inevitably, there was some attrition, whereby some respondents were lost each year, coupled with some recruitment and recapture, whereby new respondents were surveyed. In addition, in year 3 we attempted to recapture some of those lost after GCSEs/school leaving. This is described in Table I. The key impact of the attrition was to make the sample more conforming in the later years, as the main losses were of working class young men who left school at 16 and who tended to be early risk-takers/drug takers. We also lost a clutch of Asian/Muslims. However, there were very few further losses and a core cohort of 229 remained with the study throughout. Given that most of these were among the 86 respondents we interviewed in year 4, we have an enormous developmental data set for these young people. Once we begin to understand how drugs decisions develop through adolescence and over time, the complexities of young people's drug responses flood in. The exact details of how this study has been conducted, including sampling and representativeness, are available elsewhere (Aldridge *et al.*, 1996; Newcombe *et al.*, 1994; Parker *et al.*, 1995).

Trying specific drugs

Table II provides an overview of the drug-trying behaviour of the young people involved in this study, who, in total, numbered more than 1,000. The row labelled "Tried at least one drug" demonstrates the steep annual rises, culminating in nearly two-thirds of the samples having tried an illicit drug by the age of 18. In many ways, the most important issue here is the fact that first-time triers (incidence) continue to emerge right through adolescence, into young adulthood and well beyond the reach of classroom education or indeed any venue where young adults can be effectively "targeted".

Table II confirms that cannabis dominates "recreational" drug use among 1990s adolescents, with amphetamines, amyl nitrite "poppers" and then LSD being the next most-tried drugs, followed by ecstasy. This particular age cohort, who had just started secondary school in the midst of the HIV/AIDS and "Heroin screws you up" public health campaigns, have eschewed

Table I Samples, cohort and attrition over five years

	Year 1	Year 2	Year 3	Year 4	Year 5
Total respondents each year	776	752	523	536	52
One year only returners	197	129	28	8	
Two years only returners	247	252	109	37	3
Three years returners	92	131	146	115	11
Four years returners	240	240	240	147	14
All five years returners*	229	229	229	229	22

Note: * = the core cohort

heroin and all drug injecting (but see Parker *et al.* (1998b) for commentary on heroin's return among today's adolescents). The small proportion who have tried cocaine are the most drug-experienced/ current users, more of which later.

What this table does not show is a further clear pattern in respect of initiation or first-ever-time trying. Basically, those who first try a drug in early adolescence are most likely to use cannabis, poppers and – most worryingly – solvents and gases. Those who initiate in mid-adolescence are more likely to try cannabis, amphetamines and particularly LSD; and those who first try in later adolescence are more likely, alongside the ubiquitous cannabis, to try Ecstasy – thanks to their new-found access to nightclubs. These patterns and profiles, although they shift predictably through adolescence, are rarely reflected in the timing or curricula of drugs education. While most drugs education distinguishes between drugs, it all too rarely takes this differentiation as seriously as drug-wise youth. Thus, the quantification of risk between substance and, as important, the different benefits, pleasures and experiences associated with different drugs, are underplayed. In some programmes, the essential message is that all drugs are "dangerous"; this message is perceived, certainly by most young drug users in our study, as simplistic and inaccurate, thus undermining the programme's authority.

Young drug triers and users, particularly in later adolescence, make major distinctions between drugs as part of an elaborate cost-benefit assessment. This process involves assessing the risk of drug use generally in respect of "getting caught", dealing with any side- or after-effects of particular drugs, "losing control", and their financial cost, as against other consumption options such as alcohol. These factors are weighed against the benefits and pleasures and the particular effects of specific drugs (Measham *et al.*, 1998a; Parker *et al.*, 1998a).

A quantifiable illustration of this sophistication can be found in the following lists. In year five, 287 of the sample had used cannabis and 100 reported that they had taken Ecstasy. When we look at the four most-elected

Table II Lifetime prevalence – ever tried at least one drug over five years

	Year 1 (N = 776) (%)	Year 2 (N = 752) (%)	Year 3 (N = 523) (%)	Year 4 (N = 536) (%)	Year 5 (N = 529) (%)
Amphetamines	9.5	16.1	18.4	25.2	32.9
Amyl Nitrate	14.2	22.1	23.5	31.3	35.3
Cannabis	31.7	41.5	45.3	53.7	59.0
Cocaine	1.4	4.0	2.5	4.5	5.9
Ecstasy	5.8	7.4	5.4	12.9	19.8
Heroin	0.4	2.5	0.6	0.6	0.6
LSD	13.3	25.3	24.5	26.7	28.0
Magic mushrooms	9.9	12.4	9.8	9.5	8.5
Solvents	11.9	13.2	9.9	10.3	9.5
Tranquillisers	1.2	4.7	1.5	3.9	4.5
Tried at least one drug	36.3	47.3	50.7	57.3	64.3

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reasons or expectations for using these two drugs we can see how quite different meaning is attached to the two substances.

The primary reasons nominated for last-occasion use of Ecstasy and cannabis were:

Ecstasy (n = 100):

- have fun, 80 per cent;
- enjoy music, 74 per cent;
- dance, 73 per cent;
- give me energy, 74 per cent.

Cannabis (n = 287):

- relax, 64 per cent;
- socialise, 63 per cent;
- have fun, 59 per cent;
- forget worries, 23 per cent.

This relative sophistication is too rarely reflected in drugs education and is part of the reason why drug users have difficulty engaging with, and why they are far more critical of, the drugs education they received during their school days, than abstainers. While we cannot use quotations from our subjects routinely, in a short article, the comments below illustrate how articulate our interviewees were on this subject.

> We didn't actually get that much. We had some things in school, but they don't really go into all the situations. It's just this is this drug, that is that drug. Don't take this, don't take that … they go on about pot and LSD – about how bad LSD is but when I was on it I didn't have a bad experience at all, so I can't see it … basically you don't get that much, you have to find out for yourself … like one of my friends is always asking me about my experiences on drugs because she wants to know more (Female, 17 years, current user, 43,366).

> I think everything was aimed at what it'll do to you and how bad it's going to affect you … look at this, your face'll come out like this, don't sniff it … They should've looked at it from both points of view, and then we could have weighed the pros and cons maybe, but it was always don't do it, don't do it … if the school tells you not to do it, well, you're going to do it anyway … It was quite accurate I suppose, but some of it was pretty condescending, talking down to you like an idiot, nice little pictures next to it (Male, 18 years, former user, 73,739).

> Had about two weeks with the teacher, but she didn't know what she was on about [Was it accurate?] Not inaccurate, it was just pointless, it was just like "Don't take it", that's it. You weren't told why you should take that, why you shouldn't take it, or anything like that, you were just told "Don't take drugs" that's it, an absolute waste of time (Male, 18 years, cannabis user, 63,543).

> All the information was accurate. I knew myself that drugs would be bad anyway before I got that information … it was helpful hearing stories about all the negative effects, and daft things that can happen. That really helped to make up my mind. [So you found the information helpful and useful?] "Yes" (Female, 18 years, non-trier, 23,184).

Drugs pathways

If we accept that drugs education, wherever it is delivered, should combine the provision of impartial information about drugs that all young people need to know, including issues of health and safety when things go wrong, together with more targeted information in relation to a young person's drug status, then another problem emerges. It is extremely hard to devise curricula which mesh with the drugs status of young people and, thus, the differences between them at any one time. First, 1990s youth, whether they try drugs or not, must continuously respond and negotiate in respect of drugs situations throughout their adolescence and into young adulthood. Second, their actual decision-making journeys are distinctive and far more complex and sophisticated than the adult responses around them.

By having profiles of several hundred young people in terms of their social background, use of leisure time, tobacco, alcohol and drugs status and "deviant" activities, over five years, we have been able to identify several clusters of attitudes and behaviour. In short, we can allocate a distinctive drugs status to each respondent each year. However, because there are so many changes in their status as they make and remake drugs decisions through adolescence, and do so for explicable reasons, which we monitored, we use the term drugs pathways to describe these journeys (Parker *et al.*, 1998a). We identified four quite distinctive pathways, distinguishable by attitude to drugs, drug trying and regular using behaviour, self-defined drugs status and intentions regarding future drug use.

Abstainers are those who have never tried any illicit drugs and who currently never intend to try any drugs in the future. They also hold relatively anti-drugs attitudes.

Former triers or ex-users are those who have tried an illicit drug, often experimentally, but who do not intend to do so again. Former triers or users tend to have developed relatively negative attitudes towards drug use.

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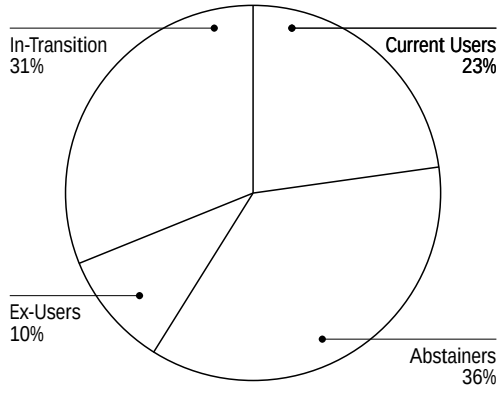
In transition refers to a group who may have tried a drug but who all think they might do so in the future. They hold fairly pro-drug attitudes towards illicit drug use.

Current users have all tried drugs and nearly all will have periods of regular drug use in their biographies. They hold pro-drug attitudes and all intend to take drugs again.

Figure 1 shows the proportions of respondents in each pathway at the age of 17. The proportions change again towards more drug users at 18 (see Parker *et al*., 1998a), confirming the dynamism of decision-making journeys.

The proportions of young people travelling down different pathways in any, say, year group will vary. In some parts of the country, perhaps, there might be fewer current users than in this study; but it is the general point which is significant. If we are looking for drugs education to meet the needs of all young people and, moreover, that deals with changes in their status through time, then it is almost impossible to do so using a universal pre-set curriculum and delivering it, as is the norm, to whole classes or groups. Public health advertising such as that employed by the health education authority suffers from similar difficulties and dilemmas – how to reach specific target populations unambiguously. Warning against Ecstasy use may well encourage a switch to amphetamines among night-clubbers, for instance. Similarly, abstainers, while they need to be drugwise, arguably do not need, nor should necessarily have to hear about, the benefits and costs of combining drinking and drug use; and regular poly-drug users will be at best amused by the rantings of the "war on drugs" warriors insisting that cannabis can make you mentally ill, give you cancer or turn you into a chaotic, thieving junkie. Supply-led drugs education is extremely difficult to target effectively when the intended audience is so segmented and at different levels and stages of drugs knowledge, experience and information needs.

Figure 1 Drug use status by age 17



Acknowledgement of drug-taking by adult worlds

Another reason why much drugs education has difficulty connecting with young people is because the delivery settings make admission and discussion of drug use very difficult. With so much of the curriculum being delivered in school by teachers, police officers and strangers, it is very difficult for young people routinely to trust the process.

This reticence extends to the home. While we found signs in the latter part of our study that a minority of older adolescents and their parents were in dialogue, certainly, for most young people, discussing their drug use with parents is fraught with danger. Those who voluntarily engaged in or – having been "caught" – are obliged to enter such a discussion tend to be very economical with the truth. Admissions beyond cannabis smoking are perceived as bad for parents' mental health, thus use of LSD, amphetamines and Ecstasy is usually denied.

These fears about adult misunderstanding or outrage thus constrain discussion about drugs. While the media (including magazines) remain an important source of information (Roker and Coleman, 1997), it is primarily with their peers that young people become drugwise. Here, there is great store placed on observation, conversation and the role of drugs stories – tales told and retold among young people (Measham *et al*., 1998a).

Because young people contemplating taking drugs normally wish to make a cost-benefit assessment of any drug taking, they seek out information about the effects of specific drugs. They hear that LSD can give you flashbacks or panic attacks, that amphetamines will not let you sleep for days, that poppers give you headaches. They also hear that their mates had a brilliant night "tripping", or clubbing on amphetamines. Much of this anecdotal information is contained in drugs stories. Drugs stories are, of course, not always accurate and anyway are not the best vehicle for transmitting complicated information. Their significance, however, is enormous

and that this is so is, in our view, a sad reflection of the lack of honest communication between young people and adult worlds. This all stems, of course, from the discomfort, ambiguities and lack of sophistication in adult conceptions of what is involved in discussing "recreational" drug use. Indeed, even acknowledging that young people in one's care or supervision take drugs causes most adults great difficulty.

Drug taking as enjoyment

At the heart of this generational, conversational dilemma is the belief on the part of many adults, particularly parents, that drug use is dangerous and could kill or permanently injure their children or, at the very least, bring stigma to the family. These are genuine parental feelings which they feel are "natural". These views and feelings are supported by the way the media present drug use and the way politicians warn against it – and, of course, recreational drug use (occasional use of largely non-addictive drugs) carries risks and a casualty rate, as do smoking, drinking, horse riding and driving too fast.

However, for young drug-triers and users, the risks are seen as being far more remote – if you are sensible and careful. This is because the vast majority of drug-taking episodes they see and talk about have positive outcomes and are otherwise uneventful. Table III, based on responses from over 300 of our year 5 sample who had taken a drug, demonstrates this unequivocally. Former triers obviously have the least positive experiences, hence their desistence. However, nearly 70 per cent of those in transition who have already tried a drug and nearly 90 per cent of current users defined their last drug experience as mostly, or very good. Moreover, becoming familiar with a drug's effects and learning to expect certain psychoactive experiences makes further use more predictable and, thus, usually more enjoyable.

The reluctance of adult worlds and drugs education to acknowledge the benefits of hedonistic consumption adds further unreality to the equation. "Getting out of it" and "buzzing" is made into a secret, not to be mentioned, let alone celebrated. So the very aspect of drug use young people share with each other – the brilliant night out – must not be mentioned elsewhere.

The recreational use of certain drugs by modern youth is sustained because of these "on balance" benefits. Young drug users find their drugs of choice beneficial both to celebrate success and create "time out" from the bad times. They move in a fast, uncertain world where leisure, pleasure and even social identity are purchased. They increasingly perceive their decisions to take drugs not as acts of rebelliousness but acts of consumption. To deny this or criticise and condemn

Table III Last drug experience

		Drug status category			
	Sample (n = 332)* (%)	Current users (n = 164) (%)	Former triers (n = 55) (%)	In transition (n = 113) (%)	Significance
Last drug experience was (n = 309):					***
Very bad	8	2.6	0.6	11.1	2.0
Mostly bad	19	6.1	3.1	22.2	4.0
Equally good and bad	53	17.2	8.0	31.1	25.7
Mostly good	148	47.9	47.9	26.7	57.4
Very good	81	26.2	40.5	8.9	10.9
Last drug experience was (n = 309):					***
Not at all as expected	17	5.5	0.60	22.2	6.0
Not really what expected	29	9.4	4.90	26.7	9.0
Some of each	42	13.6	6.70	20.0	22.0
Mostly as expected	118	38.2	38.40	24.4	44.0
Exactly as expected	103	33.3	49.40	6.7	19.0

Note: *Only respondents in the sample who have ever had a drug were included

those that report it (Ramsay and Spiller, 1997) is to "lose the plot", to further misunderstand what most young people's drug use is about and to close down the opportunity for rational debate, especially at the level of policy development.

Worries about drug use

This does not mean that drug users do not worry about taking drugs. They do, both as part of the ongoing cost-benefit assessment about particular drugs repertoires and in making sense of the bad experiences and downsides they, or friends, occasionally experience. Table IV identifies those issues that are both current worries and/or concerns for the future. The sophistication in identifying such a range of concerns should again remind us of the rational approach being taken. It is particularly important to note how current users have, statistically, significantly more concerns. It is to these user-defined assessments and concerns that official drugs interventions should routinely tune in.

In Table V we can see how these concerns have, for a small minority, already manifested themselves in visits to the family doctor or local hospital. While 70 per cent of this sub-sample, all of whom have tried drugs, say they would discuss a possible drug-related health problem with their doctor, it is significant that when faced with the real need so to do, far fewer (41 per cent) felt able to. This is, alas, another sign of our society's communication difficulties over drug use.

Discussion

Some drug use by young people is extremely damaging and those who begin to use heroin or crack cocaine are quite likely to become

Table IV Problems associated with drug use for the sample and by drug status

			Drug status category			
	Sample (n = 332)*		Current users (n = 164)	Ex-users (n = 55)	In transition (n = 113)	
	n	(%)	(%)	(%)	(%)	Significance
Current worries regarding drug use:						
Unpleasant "comedowns"	69	24.4	33.5	14.7	12.1	***
Take drugs too often	66	23.2	32.9	17.1	8.8	***
Spend too much money	61	21.6	30.4	17.6	7.7	***
Take too much/many	52	18.3	23.4	20.0	8.8	*
Feel "run down"	52	18.3	24.1	17.6	8.7	**
Life without drugs "boring"	51	18.0	24.1	17.6	7.7	**
Take sexual risks	49	17.3	20.1	20.6	11.0	n.s.
Falling behind with work/studies	48	16.9	22.6	14.7	7.7	**
Others dislike drug use	47	16.6	20.8	14.7	10.0	n.s.
Fallen out with parents	36	12.7	15.1	20.6	5.6	*
Am dependent on drugs	35	12.4	13.4	20.6	7.7	n.s.
In trouble with police	32	11.3	11.5	17.6	8.8	n.s.
Losing interest in sex	28	9.9	11.4	14.7	5.6	n.s.
Future worries regarding drug use:						
May spend too much money	87	30.5	43.7	14.3	14.1	***
May get into trouble with police	84	29.5	39.9	22.9	14.1	***
May develop bad "comedowns"	80	28.1	37.3	11.4	18.5	***
May begin taking drugs too often	76	26.8	34.4	17.1	17.4	**
May fall behind with work/studies	70	24.6	32.3	11.4	16.3	**
May fall out with parents	61	21.4	29.7	11.4	10.9	**
May begin taking too much/many	54	19.0	24.8	14.3	10.9	*
Life without drugs may be "boring"	50	17.5	23.4	11.4	9.8	*
May become dependent	45	15.8	20.4	11.4	9.8	n.s.

Note: *Only respondents in the cohort who have ever had a drug were included

Table V Seeking help over health worries

	Sample (n = 332)*		Drug status category: Current users (n = 164)	Ex-users (n = 55)	In transition (n = 113)	
	n	(%)	(%)	(%)	(%)	Significance
Consulted GP regarding health problems, possibly related to drug use (n = 307)	23	7.5	10.4	7.0	3.0	n.s.
Of those who consulted GP, told GP of drug use (n = 22)	9	40.9	41.2	33.3	50.0	n.s.
Admission to casualty regarding problem related to drugs (n = 301)	10	3.3	3.7	2.4	3.1	n.s.
Would tell GP of drug use if health problem occurred (n = 297)	207	69.7	75.3	73.7	58.8	*

Note: *Only respondents in the sample who have ever had a drug were included

problem users and indeed get involved in acquisitive crime. This paper, however, has focused on "recreational" drug use by 1990s youth. This type of non-dependent drug use, centring on cannabis and supported by poppers, LSD, amphetamines and – in late adolescence – Ecstasy, dominates youthful illicit drug use.

In this paper we have argued that these epidemiological realities about youthful drug use need to steer future policy and practice, at least in part, rather than adhering to the vain ideological hope that such drug use can be eliminated through primary prevention. Around half of 1990s adolescents have tried an illicit drug by the age of 17-18 years. Perhaps one in four are regular recreational users. Nor should we forget that today's young users are from all social backgrounds. The time has now gone when characteristics such as being female, middle class, "from a good home" and academically successful would predict abstention and protect from drug use. The traditional link between drug use and other crime, while still central to "hard" drug careers, is also largely absent in today's young triers and users.

We have further complicated this picture by showing that the drugs pathways young people take are highly complex and dynamic, with their drugs status and involvement shifting right through adolescence and on into young adulthood, well beyond the compulsory school years. This makes targeting both preventive and "harm reduction" messages difficult, given young people's tendency to switch off from information which is not immediately relevant.

Young people do have mishaps in the drugs scene and accidents and incidents do occur. These include a small number of deaths, primarily associated with trying solvents and gases, poly drug overdoses, the increasing prevalence of mixing alcohol with other drugs, or a bad reaction to Ecstasy. However, in the wider context of adolescent accidents, concerning say alcohol, Paracetamol and so on, these are, thankfully, relatively rare. The vast majority of young drug users have no serious difficulties. What problems they occasionally have, they appear to accommodate as an acceptable price.

All this said, we must expect more casualties or at least more young users seeking out advice, help and perhaps treatment in the next few years. What concerns us is that in our research we have already identified a minority within our drug user pathway, who have been using drugs since mid-adolescence and who now meet each other partying, pubbing and in the nightclub (Measham *et al.*, 1998b). These frequent drinkers, who are often smokers and also combination drug users, are already reporting both drugs incidents and what appear to be drug-related disorders such as bad come-downs, depression, fatigue, underperformance at work or study and aches and pains (Parker *et al.*, 1998a). They seem to have stored few effective strategies from primary drugs education and place much emphasis on "learning as you go" in the drugs scene. There is, surely, a public health imperative here that these groups of users should be

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able, and should have been able, to receive sound advice and information, and indeed actual help, without rancour as their drug careers were developing. Instead, what help they get, if any, is delivered in an *ad hoc* way at the local level and is barely sanctioned, let alone encouraged, by central government.

The general failure of official "supply-led" prevention programmes to engage realistically, and without moralising, with young drug triers or users contrasts with the success of demand-led services like Childline and the National Drugs Helpline. This should be salutary. Great imagination and a break with professional atrophy over what education and "services" look like will be required to meet the needs of today's and tomorrow's young drug users. Our longitudinal study suggests that information should be in a format whereby it is always available and accessible when required, rather than when personal and social education is delivered. School may be a suitable venue for basic provision of information but it is not really the place where queries about drug use and problems with use can be discussed and resolved.

There will in our view be a strong demand for a young adults' drug information, advice and intervention service in the coming years. A minority of users will have to negotiate the personal, social and health problems that occur as a result of regular combination alcohol and drug use, as well as criminalisation and the beginnings of psychological dependency. What these users particularly need now is some insight into the ways drugs careers develop and how to steer them successfully without having to give up drugs altogether, which many will not contemplate in the short term.

The objections to this kind of secondary prevention remain, captured in the "war on drugs" discourse. It is this very same discourse that has placed unrealistic expectations on a free market of primary prevention despite its poor track record (Dorn and Murji, 1992). While the time for reviewing the whole drugs prevention industry has, based on a rational assessment, already come, the political moment when it will be allowed is still some years away.

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