



E.M.C.D.D.A.

European Monitoring Centre
for Drugs and Drug Addiction

INSIGHTS

Outreach Work Among Drug Users in Europe

INSIGHTS
EMCDDA **2** SERIES





Outreach Work Among Drug Users in Europe:

Concepts, Practice and Terminology

Dirk J. Korf, Heleen Riper and Marielle Freeman (Netherlands)

Roger Lewis and Ian Grant (Scotland, UK)

Elisabeth Jacob and Chantal Mougin (France)

Margareta Nilson (EMCDDA, Portugal)

EMCDDA, June 1999

Content

Information about the EMCDDA and its work can be found on its web site at <http://www.emcdda.org>

A great deal of additional information on the European Union is available on the Internet. It can be accessed through the Europa server (<http://europa.eu.int>).

Cataloguing data can be found at the end of this publication.

Luxembourg: Office for Official Publications of the European Communities, 1999

ISBN 92-9168-062-1

© European Monitoring Centre for Drugs and Drug Addiction, 1999

Printed in Portugal

FOREWORD	4
ACKNOWLEDGEMENTS	6
INTRODUCTION	8
1 WHAT IS OUTREACH WORK?	13
2 TARGET GROUPS, GOALS AND WORKING METHODS	31
3 THE ORGANISATIONAL CONTEXT OF OUTREACH WORK	55
4 FOUR MODELS OF OUTREACH WORK	71
5 TERMINOLOGY IN OUTREACH WORK	83
6 DOCUMENTATION, DATA COLLECTION AND EVALUATION	89
7 COUNTRY OVERVIEWS AND EXAMPLES OF GOOD PRACTICE	107
8 SUMMARY AND CONCLUSIONS	155
GLOSSARY	171
REFERENCES	181
LIST OF WORKSHOP PARTICIPANTS	191



Foreword

Significant variations can be observed within Europe in the theoretical, political, social or practical backgrounds of outreach work among drug users, as well as in the ways such activities are practised. Among the problems this raises is that of linguistic comparability.

As one step towards including drugs outreach work in a European-wide information system, it is my pleasure to present this second volume in the EMCDDA's Insights series.

Outreach Work Among Drug Users in Europe is the culmination of a Europe-wide project on concepts, practice and terminology in outreach work among drug users funded by the EMCDDA and co-ordinated by the Bureau voor Onderzoek en Statistiek (O+S), Amsterdam. The study's main aims were:

- to assess the concepts, practice and terminology of outreach work in Europe;
- to construct a basis for further research in this area, including studies on the systematic evaluation of outreach work;
- to develop an adequate coverage of this type of work in European information systems; and
- to facilitate information dissemination and communication amongst professionals in Europe by establishing linguistic equivalents.

Investigating the practical and theoretical parameters of outreach work is not, however, merely of academic or linguistic interest. Instead, it is motivated by pragmatic considerations. The continuing efforts to monitor European drug policies require, first and foremost, a common definition of the concept of outreach work, together with a recognition of both the similarities and differences in practice and theory within and between Member States. Outreach work is a dynamic practice which evolves over time as a result of changes in the perceived problem, in the social contexts in which the problem is found and in professional, political and public attitudes to dealing with it.

In unraveling some of the complexities surrounding the concept of outreach work, identifying its positive qualities and highlighting its key features, this volume makes a major contribution to the assessment of such work as practised in Europe today.

Georges Estievenart

Director
EMCDDA

Acknowledgements

The research project that forms the basis of this volume was funded by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in Lisbon, and co-ordinated by the Bureau voor Onderzoek en Statistiek (O+S), Amsterdam.

Margareta Nilson, head of the EMCDDA Demand Reduction department, inspired the project members with her support and continuing interest in its progress and her thorough knowledge of the subject matter. Roger Lewis and Ian Grant, from Scotland, UK, and Elisabeth Jacob and Chantal Mougin of France were indispensable not only to the theoretical discussions that informed the project, but also to its practical completion.

The project team's international mix highlighted the widely divergent social contexts in which outreach work is undertaken in Europe, strengthening the motivation to continue the study and to do justice to both the unity and diversity that is found in Europe.

Contacts with key informants from the European Union Member States were the most important source of data for the study, together with drug-related journals and other publications. A minimum of two key informants were sought per Member State, including one national expert and one at local level. Essential contributions were also made by the National Focal Points of the REITOX network. There were too many contributors to mention

individually here, but their names and addresses are given at the end of the book.

Thanks to their efforts, information on outreach work in almost every EU Member State plus Norway was made available. Despite attempts through a number of different channels, however, it was impossible to obtain an overall view of outreach work in Sweden, where the concept is as yet fairly undeveloped. Given the many dissimilarities in terms of both the history and current practice of outreach work between all the countries covered, the information received varied in both its nature and scope. Such cross-cultural differences will always be apparent in any study, making the issue of comparability – whether conceptual, practical or linguistic – all the more salient.

The project team would also like to express its thanks to the participants in the expert meeting held in Amsterdam on 29–31 March 1998. They are also too numerous to list here, but their names and addresses can likewise be found at the end of the book. These participants presented their reports on outreach work with great enthusiasm, demonstrating the dedication with which this type of work is being undertaken throughout Europe.

Several European researchers also attended the meeting and made excellent contributions to the more theoretical discussions, based on their own research data and their familiarity with outreach work in a cross-national perspective. Their efforts, too, were clearly inspired by a deep commitment to outreach practice. It is particularly gratifying to see that the contacts made between outreach workers at that conference have already led to an ongoing exchange of experiences and initiatives extending across national borders.

Last but not least, we would like to thank all those involved in producing the final project report and the present publication.

Introduction

The history and practice of outreach work in the drugs field in Europe has undergone substantial changes over the past few decades. Broadly speaking, there has been a gradual shift in focus from the poor in general, to the youthful poor, to 'flower-power' youth and then to drug users. In the wake of the HIV epidemic in the 1980s, emphasis shifted further to 'hidden' drug users, and the most recent developments in the 1990s include targeting users of the so-called 'new' or synthetic drugs, such as ecstasy. These latest efforts are, however, still at an early stage and the predominant focus for European outreach activities remains the users of 'old' drugs, chiefly heroin and cocaine.

Throughout the EU, four general aims of drug outreach work have been defined at national level:

- to identify and contact hidden populations;
- to refer members of these populations to existing care services;
- to initiate activities aimed at prevention and demand reduction; and
- to promote safer sex and safer drug use.

A further aim, defined in national policy in only a few of the 15 Member States, is to identify the needs and perceptions of drug users regarding existing drug-care services and to relay this information back to those services. This emerging task of outreach work can greatly enhance the effectiveness and co-ordination of drug-care services.

Three outreach working methods are distinguished in this volume:

- detached;
- domiciliary; and
- peripatetic.

Of these methods, detached outreach work is by far the most common.

In their external relations, outreach services interact with other drug agencies as well as in a wider organisational context. While networking and co-operation between agencies is important, practical problems abound. Most of the outreach services in the EU emanate from drug agencies or from youth-work organisations. In north-western Europe, outreach services are often based in health agencies, while in southern regions they are more commonly part of community welfare services. Most outreach activities in all regions still lack sufficient financial, legal and human resources to perform their tasks well. Furthermore, adequate training facilities focusing specifically on outreach work are virtually non-existent in Europe.

Three main types of workers are active in the field of outreach work:

- professionals;
- 'peers' (current or former drug users) or indigenous workers; and
- volunteers.

In the light of the ongoing professionalisation of outreach work, the involvement of peers and volunteers is crucial for maintaining contact with target groups. However, the use of peers is often controversial, not so much in theory but in practice, and particularly in relation to 'old' rather than to 'new' drugs.

Four main models of outreach work can be distinguished:

- the Youth Work Model;
- the Catching Clients Model;
- the Self-help Model; and
- the Public Health Model.

The Youth Work Model is the oldest in Europe; since the 1960s, youth workers have been actively seeking contact with ‘problem youth’. Characteristically, their aim is to find solutions to young people’s problems in their own environment, rather than deciding behind a desk what they consider is best for the person concerned. The goal is to prevent further marginalisation and encourage social integration.

The Catching Clients Model has its roots in the early-to-mid-1970s, and originated in therapeutic communities. Its primary aim is to draw drug users into care programmes, in particular into drug-free, inpatient treatment. Abstinence, followed by social reintegration, is the ultimate goal.

The Self-help Model, like the Youth Work Model, responds to the wishes and motivation of the drug users themselves. It focuses more explicitly on drugs than the Youth Work Model, and its actions are based more on the perceived interests of the group than on those of the individual. Originating in the late 1970s, it has clear links to drug users’ self-help organisations, as well as to the concept of accepting drug-taking as a social reality.

The Public Health Model is built on the Self-help Model, the main difference being that it assigns a more important role to professional interventions. This model came into its own in the mid-to-late 1980s, notably under the influence of HIV and AIDS. Its primary aim is harm reduction through safer drug use and safer sex. More recently, outreach work along the lines of the Public Health Model is also being practised among users of ‘new’ drugs, with peers recruited more for such initiatives than in the case of ‘old’ drugs.

In most EU countries, outreach work occupies a significant place in national drug policies, although it is at a more developmental stage in south-western countries. Most Member States have nationally defined aims for some form of outreach work, although the activity itself is not always referred to specifically in national drug-policy documents. The degree of diffusion of outreach work among drug users is greatest in north-west Europe and lowest in southern countries. A great deal of variation exists between countries in the funding of outreach work, and different funding models may be applied concurrently. The two most common approaches are direct state funding and direct municipal funding.

National overviews reveal both similarities and differences in national policies and practices, and both differences and similarities in terminology. One major difficulty at present is that the term 'outreach work' itself is scarcely known – much less used – in most countries among the people who carry it out. Instead, people outside the UK normally use terms such as 'street work' (see Glossary).

Outreach projects report on their aims and activities in different ways depending on the audiences they are addressing. Formal reports are usually aimed at funding agencies, policy-makers or the larger organisation of which the project is a part. It is common practice for most outreach projects to collect at least some basic data about their own activities and target groups, although few standardised guidelines exist, even at local or regional level, let alone at national or European level. In addition, such quantitative types of data collection are perceived by many workers as far from ideal.

The need for evaluation is widely recognised, both within individual outreach projects and at regional, national and European level. Three types of evaluation are discussed in this volume:

- structural evaluation;
- process evaluation; and
- outcome evaluation.

Of these, process evaluation appears to be the most frequently applied. Yet the evaluation of outreach projects is still rare in many countries. Data collection and evaluation instruments are often invented *ad hoc* and geared to specific projects, making comparison of different projects on a nation-wide or European basis very difficult. The questionnaire used to collect data for the EMCDDA's Exchange on Drug Demand Reduction Action (EDDRA) information system could serve as a prototype for evaluating outreach activities, although it would need to be revised to make it more appropriate for evaluating outreach practice.

This could be achieved by formulating working standards and methods, creating training facilities, strengthening inter-organisational working relations, and developing methods for recruiting peers and volunteers.

What is outreach work ?

OUTREACH WORK DEFINED	14
THE EUROPEAN DIMENSION	16
HISTORICAL BACKGROUND	17
ACADEMIC INTEREST IN OUTREACH WORK	23
CONCLUSION	29

OUTREACH WORK DEFINED

Defining outreach work is more problematic than it may at first appear. Outreach activities in the drugs field have often been aimed at so-called 'hard-to-reach' or 'hidden' populations of drug users who are not effectively served by existing drug-care efforts. Two underlying assumptions can be distinguished here:

- that hidden populations of drug users do exist who are not being reached effectively by drug services; and
- that contacting such 'hard-to-reach' populations might serve some useful purpose.

Contact with these populations is not directly requested, although experience does show that hard-to-reach drug-using populations are willing to be contacted if the approach is compatible with their lifestyles (Rhodes *et al.*, 1991a). A specific characteristic of outreach work is that professionals, peers or volunteers make contact with drug users primarily in their 'natural' settings – on the street, at home, in clubs or in other meeting places.

These aspects are also central to the definition of outreach work proposed by Hartnoll *et al.* (1990):

A community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels

The above definition reflects the early roots of outreach work. Actively contacting users 'out there' has been one of its answers to the perceived limitations and constraints of the existing, more conventional drug services. It is not, however, always an easy task. In addition to many other criticisms, outreach activities have been perceived as a threat to existing drug-care services (Jacob, 1997).

The Hartnoll *et al.* definition also makes clear, by virtue of omission, that 'outreach' does not refer to any specific working method, nor to any specific type of organisation or type of worker. Outreach work can serve a variety of purposes, and very different types of activities are conducted under its label. This diversity is also the distinctive characteristic of outreach work and explains why it can be difficult to pin down or define.

Outreach work assumes different forms (Stimson *et al.*, 1994; Rhodes, 1994b), with detached and peripatetic work often cited as the principal types, yet the balance between them varies from project to project. Detached work, which often focuses on individuals or groups, is undertaken outside any agency setting, with outreach staff taking their services into the community, for example on to the streets, to pubs, clubs, railway stations and squats. Elements of outreach work can also be identified in domiciliary service delivery, where staff take services directly into people's homes. Elements can likewise be found in community development, where staff promote change directly in the community.

Peripatetic work focuses more on organisations than on individuals, with outreach staff providing their services in community agencies and institutions, such as prisons, shelters, youth clubs and schools. In addition to contact with individual users in these settings, the aim is to expand current knowledge of drug-related problems and the services available to address them.

Detached outreach work appears to be the most common form in Europe, even though in some European countries it is still hardly practised. Peripatetic outreach work is uncommon in most countries, and domiciliary outreach activities are rarely found (see Table 1, below).

It is, however, questionable whether the Hartnoll *et al.* definition as a generic explanation of outreach work is suitable for the latest developments in such work in the synthetic drug and 'rave' scene. Instead, their definition seems mainly to cover outreach work in the field of 'old' drugs.

TABLE 1: APPLIED METHODS IN OUTREACH WORK IN THE EU

COUNTRY	METHODS USED BY OUTREACH WORK		
	DETACHED	DOMICILIARY	PERIPATETIC
Austria	frequently	n.a.	occasionally
Belgium			
<i>Flemish-speaking</i>	regularly	not used	rarely
<i>French-speaking</i>	occasionally	rarely	rarely
Denmark	frequently	frequently	rarely
Finland	occasionally	not used	rarely
France	frequently/occasionally	not used	frequently/rarely
Germany	occasionally	rarely	regularly
Greece	rarely	not used	rarely
Ireland	frequently	rarely	occasionally
Italy	regularly	n.a.	n.a.
Luxembourg		no information available	
Netherlands	frequently	occasionally	regularly
Norway	frequently	rarely	regularly
Portugal	rarely	not used	occasionally
Spain	regularly	not used	rarely
Sweden		no information available	
UK	frequently	frequently	frequently

THE EUROPEAN DIMENSION

Linguistic equivalence – achieving consensus on a number of key terms – is currently one of the central issues facing drug researchers across Europe (ISDD, 1997). Linguistic differences are not simply a matter of using alternative words for the same concept, but also reflect social and cultural variations at regional, national and international level. Some linguistic equivalents in professional and technical terminology pertaining to outreach work, as well as key concepts in the language and lore of drug users, are given in the Glossary at the end of this book.

Specific definitions of outreach work draw primarily on UK and North American – and therefore English-language – sources, while in other languages different terms are used. That is the case not only for ‘outreach work’, but also for its wider conceptual

framework, from the theoretical to the grassroots level. Even what is meant by the term 'drug' can vary from country to country. For example, the French word *boutique* to describe a low-threshold drop-in outreach facility has a very different resonance to an Anglo-Saxon ear. Interestingly, the word *Fixer*, widely used in German for injecting drug users, is not used in the UK at all, except to describe someone who arranges deals.

Although often found in the international scholarly literature, neither the English word 'outreach' nor other-language equivalents are in common usage in European settings (see Glossary). The sporadic mentions of the term 'outreach work' that are found in policy documents outside the UK and US do not always conform to the letter of the concept.¹

'Low-threshold' is a concept closely linked to outreach work and refers to services that have attempted to remove traditional 'thresholds' – like intake procedures, diagnostic interviews or waiting lists – to give their clients easier access. In this context, clients are no longer called 'patients', and sometimes not even 'clients', but 'users' or 'visitors'. Many outreach workers use a low-threshold institution such as a drop-in centre as their base. Despite this close relationship, however, outreach work and low-threshold remain different concepts: drug users must *come* to low-threshold services, whereas outreach workers *go* to the drug users.

HISTORICAL BACKGROUND

Although some outreach work is practised in many countries in Europe (Grund *et al.*, 1992), genuine outreach work in the drugs field, organised in systematic working strategies, is still at an early stage. This kind of work, however, developed long before it was applied to drugs.

¹ The term 'outreach work' is, for example, applied to services to which users must report themselves. In Belgium, the term *boule de neige* (see Glossary) appears to refer to outreach activities, but the term 'outreach' itself is not used.

The earliest groups targeted for outreach work by organisations such as the Salvation Army or social-work agencies in the late nineteenth century (Hazekamp, 1976) were in the United States. These organisations focused on relieving the hardship experienced by poor, often immigrant populations.

Following the Second World War, outreach work expanded to encompass the youth field. The focus on 'youth' was also first apparent in the United States, arising from concern over 'socially deviant' young people, particularly gangs, whose behaviour was defined as a major social problem. As a result, social work and the applied social sciences were assigned a central role in correcting this 'deviant' behaviour. Although the social and economic backgrounds of youth gangs were acknowledged, these factors were not perceived as targets for change. Intervention focused instead on correcting individual behaviour (Hazekamp, 1976). In the US, this type of outreach work thus evolved within a strong tradition of social work and the applied social sciences – already well developed there prior to the Second World War, in contrast to most European countries.

In Europe, it was in the UK that 'youth' first came to be targeted by post-war outreach activities. Like other European countries, the UK was in a phase of reconstruction, and in the 1950s the first 'war generation' entered adolescence in large numbers with a culture perceived as very different from that of previous generations. A specific 'youth culture' arose, and the accompanying lifestyle, especially that of the working-class young, began to concern UK policy-makers. The gap between traditional youth services and young people themselves was seen as a potential source of social instability, as new ways of life challenged traditional norms and values. Outreach activities were introduced to contact the 'unattached' or 'unclubbable' youth (Spencer, 1950; Morse, 1965), to gain insights into their social problems and to help link them to traditional youth services.

In France, outreach activities also began shortly after the war, in the framework of specialised preventive help to juveniles. Originating

as private initiatives, the work was recognised and financed by the authorities from 1963 onwards (see also Chapter 7). A formal decree officially confirmed this recognition and defined the tasks, mode of organisation and funding for outreach work. The aim was to meet youngsters in their own environment, without recourse to judicial or administrative measures, and interventions had to respect the anonymity of the individuals and take place with their consent (Monier, 1982).

Similar concerns were evident in other nations, including former West Germany (Schelsky, 1958) and the Netherlands, but at the time they did not result in any reorganisation of youth services or specific outreach interventions (Hazekamp, 1976). The further spread of youth outreach activities in Western Europe to Belgium, Germany (*Jugendarbeit*), the Netherlands and Norway (Svensson, 1994) did not occur until the 'flower-power' era of the mid-1960s.

Whilst the social unrest of the previous decade had been attributed to lower-class youth, the latest challenges were mounted by other social classes, with young people, students and even intellectuals playing crucial roles in the new hippie youth culture which involved experimenting with drugs such as cannabis and LSD. Youth workers took to the streets to contact both mainstream and disaffected young people. Although drug use was no new phenomenon in itself, it became more of an issue now that it was happening in different social classes and on an unprecedented scale (Korf, 1995). These circumstances gave rise to various outreach initiatives targeting young people and, from the late 1960s to the mid-1970s, these came to focus increasingly on drug-using youth.

In the UK in the 1960s, outreach activities initially set out to preach abstinence from drugs. Most of these efforts originated with policy-makers or professional youth and social workers. In other countries, outreach work developed within the voluntary sector, where bureaucratic constraints tended to be weaker. Flexibility, accessibility and adaptation were common key characteristics of innovative non-governmental organisations (NGOs). In Belgium, a 1975 law to control substance abuse and provide care broadened

the role of the voluntary sector, which adopted these tasks as one of its core activities.

In the Netherlands there was a different pattern. Interestingly, it was not policy-makers or professional youth workers who were the catalysts; it was the young people themselves who organised alternative forms of support. One initiative was fieldwork with drug users. Around the same time, awareness grew among professionals working with young people and among policy-makers of the disadvantages faced by working-class youth and of the poor social and recreational services available to them.

The rapid spread of heroin use in many European countries from the 1970s onwards brought with it additional difficulties, including the emergence of so-called 'problem' drug addicts. The dominant view at the time included the criminalisation of users, drug-care services based on abstinence and a medical model of treating addiction. Outreach activities for drug users were still very sparse except in the Netherlands and the UK. In the UK, the growing awareness that few drug users were in touch with drug-care services resulted in outreach projects aimed at tracing users and drawing them into services (Gilman, 1992). In Amsterdam, alternative approaches to drug addicts sprang up alongside cure and treatment services. These alternative practitioners criticised the conventional services for their high-threshold nature and their 'unrealistic' focus on total abstinence for all users. More than anything, the traditional services were seen as being organised top-down and not user-friendly, reaching only a tiny percentage of users.² In the meantime, various aspects of public health, including drug use, had acquired a higher place on the political agenda. Such developments directly or indirectly inspired outreach efforts, which tended to employ more unconventional, and unconditional, modes of thought.

² Most drug users experienced frequent and usually brief periods of abstinence (e.g., during jail sentences) which helped to reduce their tolerance level and improve their general physical health; 80–90% then relapsed into drug use.

The AIDS epidemic of the 1980s, and associated concepts of harm reduction, prompted many European countries to develop outreach activities, albeit with different motives and intensities. AIDS has proved to be a strong catalyst for change in approaches to drug users, leading to greater emphasis being placed on public health, on ways to effect behavioural change in drug users and on the need to contact larger groups of drug users and to reach hidden populations. The goals of outreach work have been extended, and now specifically include safer injecting practices (especially through needle exchange) and safer sexual practices.¹ Some countries, particularly the Netherlands and to a lesser extent the UK, built on already established infrastructures for outreach work, while other countries had to start from scratch.

While outreach activities have spread swiftly throughout Europe, they remain unevenly distributed and often operate under severe constraints, for example in France (Jacob, 1997). Health-oriented policies continue to be implemented top-down in France.

In general, outreach activities are influenced both by existing practices targeting young people and by existing drug policies. In countries with pragmatic approaches to drugs, such as Denmark and the Netherlands (Moerkerk and Aggleton, 1990), outreach activities have been introduced more easily than in countries where a more biomedical approach prevails, such as Belgium, France, Greece, Italy and Spain (see also Chapter 7). Countries characterised by Moerkerk and Aggleton as taking a political approach, such as Germany, Ireland and the UK, are somewhere in the middle.

Stimson *et al.* (1994) have argued that outreach work reached a peak of innovation in the late 1980s and early 1990s, and established a profile in most Western European countries during the 1990s. Only now is a more active culture of outreach assistance gradually spreading in the field of drug care. Self-help and outreach

¹ For example, the first Amsterdam needle-exchange programme was launched in 1984 by the users' self-help group *Junkiebond* in response to the spread of hepatitis B among injecting drug users. Similar programmes began in Sweden in 1986 and in England and Scotland in 1987.

groups have also begun undertaking harm-reduction activities in relation to synthetic drug use, although not yet on a large scale.

In informal contexts, outreach work covers more than just drugs, extending to the wider concerns of young people (Gregory (ed.), 1995). Some remarkable initiatives have been developed in mobile, detached youth work with the unemployed, delinquents and juvenile drug users. Street and community work has been carried out with informal group leaders within the user's own environments and settings (Eisenbach-Stangl, 1994; Specht, 1991; Villalbi, 1997).

Outreach services are now facing new challenges in their co-operation with other prevention, care and cure services and with different public authorities, especially the legal and social welfare systems. The context in which outreach work is developing is therefore quite different from that of the 1980s. Outreach activities are also professionalising, as can be seen in the nature of the relationship between the worker and the user. In some countries, this relationship appears to be developing on a kind of 'contract' basis: on the one hand, with greater emphasis being placed on community development, outreach activities are becoming more integrated into the localities in which they take place, including neighbourhood co-operation. On the other hand, there is also a stronger focus on law and order, nuisance control (e.g., in Belgium, France and the Netherlands) and sometimes a greater orientation towards abstinence which may at times obscure the initial aims of many outreach activities. For example, in Belgium the voluntary sector is having increasing difficulties safeguarding users' legal rights due to tightening controls over their activities.

ACADEMIC INTEREST IN OUTREACH WORK

The relationship between practice and theory is complex and hard to disentangle. To some extent, outreach agencies and projects have applied an empirical 'pick-and-mix' approach that has resulted in a variety of generic detached models. Typically, outreach work has been modelled on bottom-up rather than top-down approaches. Although some theoretical elements may have trickled down through training and research, the central force has been an empirical understanding of what will or will not work in a local environment. From an academic perspective, it may seem as if theoretical models have found their way into actual practice. However, these may be relatively autonomous parallel social developments. Nor should the influence of academic research on outreach practice be overestimated, for outreach is a highly pragmatic concept, albeit not without philosophical or well defined reasons. Nonetheless, academic endeavours have contributed to outreach work as it is known today, and research into outreach practices is still expanding. This is specifically the case in so-called 'action' research projects, which combine outreach activities and empirical research in pilot projects.

Outreach work has been influenced by several different academic disciplines and has been studied by the fields of social work and youth work at both micro (psychological) and macro (sociological and anthropological) levels. Outreach work as an object of academic interest dates back to the early 1950s. Not surprisingly, such interest first arose in the United States where the first research literature focusing on youth and outreach work was published. Disciplines such as sociology and anthropology were already more firmly established in the US before the Second World War than they were in most countries in Europe. Sociologists in particular, operating within the dominant functionalist paradigm, began focusing on youthful deviant behaviour with the intention of devising blueprints for 'correcting' such behaviour (Hazekamp, 1976). From the 1960s onwards, scholarly interest broadened,

partly under the influence of critiques of functionalism. The number of disciplines interested in outreach work multiplied, the paradigms and methods applied became more diverse, and new target groups were defined. From this point on, there was a greater diffusion of knowledge, due in part to the increasing mobility of ideas between the US and Europe and vice versa.

From the 1960s onwards, the social sciences also blossomed in Europe. Various paradigms and notions about deviant behaviour were proposed as alternatives to the functionalist ones; these applied not only to youth, but also to groups such as the mentally ill (with the anti-psychiatry movement as a case in point). Such ideas arose at a time when subcultures and oppositional youth cultures were emerging that transcended the boundaries of social class.⁴ Social 'deviance' began to be explored from different angles, and new insights were gained into the exclusion of groups which had little or no access to health and social services. Cultural anthropology demonstrated the need to understand the features of subcultures in order to explain group behavioural patterns. The anthropological perspective was, for instance, crucial to the design of the first youth outreach services in Scandinavia in the 1960s and 1970s (Svensson, 1994). Social psychology research on peer interaction and peers as role models also influenced outreach work at the same time (Milburn, 1996). However, epidemiological and ethnographic studies focusing specifically on drug users remained rather scant, mainly clinical in nature and based upon treatment populations until the onset of the HIV epidemic.

HIV has made drug users, and the outreach work targeting them, into objects of social research. Alongside the disciplines cited above, public health and health education have come to take centre stage.⁵ As a result, theories of behavioural change and prevention

⁴ Hazekamp (1976) has argued that by and large this did not lead to any major changes in the then-prevailing ideas about deviant behaviour by working-class youth, nor in the nature of street work.

⁵ Public health education approaches ranged from theories based on the health belief model to theories of reasoned action, Bandura's model of self-efficacy, the theory of planned behaviour and social-support models or integrations.

began to influence outreach practice and vice versa. Such theories were informed by new explanations of other types of health-related risk-taking behaviour, such as smoking, alcohol abuse or teenage pregnancy (Skinner, 1992). HIV prevention was also influenced by sociological theories developed by the Chicago School (Wiebel, 1988) and by sexual theories in health education. An important shift in social work theory can also be observed away from traditional individually oriented casework and towards community work and the mobilisation of client groups and minorities.

The European drug problem came to be associated primarily with heroin (and more recently with polydrug use) because heroin is linked far more closely than any other drug to HIV and AIDS, morbidity, and social and public health problems. Prevention strategies have been developed in all EU Member States, although on different scales and at different times. Calls for alternative approaches to illicit drug use grew stronger with the recognition that older approaches, based on abstinence treatment (the disease model of addiction) and control (through law enforcement and the criminalisation of users), were grossly inadequate, while the financial resources required to implement such approaches continued to mushroom. Such alternative approaches are commonly grouped under the umbrella concept of harm reduction (see Chapter 2). The harm-reduction approach is rooted in the public-health and health-education concepts, but touches on all aspects of illicit drug use as well. Theories of harm reduction have drawn on the sociology of deviance (Young, 1976) and of youth-work practice first developed in New York, the Netherlands and the UK in the 1960s. Harm reduction as a basic philosophy lies at the heart of many outreach activities today.

In examining the theoretical developments that have influenced outreach work, Longshore's distinction can be very useful (Riper *et al.*, 1995). At the beginning of the HIV epidemic, there was a strong focus on the practice of needle- and syringe-sharing by intravenous drug users (IDUs). Research samples were drawn mainly from clinical settings, detoxification centres and law-enforcement agencies, since such sites afforded easy access to

the IDU population. Longshore (1992) labelled these 'first-generation issues'. With the changing face of the epidemic and the knowledge and experience gained, an observable change took place in the topics addressed and the research methods applied, summarised by Longshore as 'second-generation issues'. Greater emphasis was placed on the idea that injecting (and sexual) behaviours – and changes in them – are influenced by the individual, group, social and cultural conditions within which such behaviours occur.

Similar notions figure in theories about peer education (although the latter are probably less extensively developed than those pertaining to outreach). Research into peer support and coping strategies developed by drug users (Power *et al.*, 1992) has suggested that an emphasis on lifestyle and survival in the subculture is more effective for accessing and influencing drug-user networks than approaches based primarily on health-education methods for young people. It would appear, however, that drug users are more open to selective peer influence with regard to some types of habits than to others.⁶

The complexity and diversity of the target group defined as IDUs, the different scenes these drug users may operate in, and the implications these factors have for prevention strategies have thus moved to the forefront of outreach research. The focus is now on 'hidden populations', defined as drug users not in contact with health or drug services. Better access to these hidden populations is perceived as a powerful means for disseminating preventive messages (Franken and Meulders, 1994). However, the degree to which IDUs are in touch with health and drug-care organisations varies widely among Member States.

This also has consequences for outreach work. Low-threshold facilities enable better access to and contact with 'hidden'

⁶ For example, with the advent of HIV, many European injecting drug users spontaneously, or with modest group support, changed their injecting practices. HIV prevention, including outreach work, has had little impact on the sexual behaviours of injecting drug users.

populations, including referral possibilities. In such a context, outreach work may be even less important (although still necessary) as a high number of users of hidden populations are contacted through low-threshold services. In contrast, where there are no or few such facilities, access to and contact with hidden populations is more difficult and outreach work becomes even more urgent.

The focus on hidden populations has also inspired a variety of sampling and research methods (e.g., targeted sampling, 'snowball' sampling, combinations of quantitative and ethnographic methods).

It should be noted that the transition from first- to second-generation issues has not occurred at the same pace and the same time, nor to the same extent, in all Member States. For example, in countries like the Netherlands and the UK, where outreach activities were introduced early in, or even prior to, the HIV epidemic, it is no surprise that the shift came sooner than in countries where outreach work developed at later stages, such as Ireland or Portugal. The prevailing academic cultures also play an important part. For example, there are strong empirical traditions in the Netherlands, the UK and the US, while France has a strong philosophical orientation.

In the United States and some European countries, direct outreach interventions have been justified, or even disguised, as pilot research demonstration projects in order for measures to be implemented that were prioritised elsewhere as emergency HIV prevention. There has been a dynamic interaction between research demonstration projects employing ethnographic methodologies and outreach work conducted by professionals and indigenous workers. For example, social world and arena theory have proved helpful in developing 'bridging work' between services and marginalised minorities that require mediation and outreach interventions (Broadhead and Margolis, 1993).

In some instances, research has been used to implement interventions that might not have been acceptable at the time as openly stated public policy (Boullenger *et al.*, 1992; Jacques and Goosdeel, 1990). Kinable (1994) has described how, in a study on the Belgian streets, considerable effort had to be put into convincing drug users that there was no clandestine strategy, such as police surveillance, behind the study. In France, outreach action research projects, influenced by the general principles of street work for juveniles, have even been disrupted by the police. In French texts on outreach work (e.g., Barraud, 1994) there is, not surprisingly, a firm emphasis on anonymity.

In sum, the themes and practices of outreach and detached work have been governed by a number of traditions – British empiricism, Dutch public-health approaches, French ethnography and North American sociology – as well as by anthropological studies. In France, a creative liaison between ethnology and sociology has begun to develop within somewhat circumscribed limits (Ehrenberg (ed.), 1992). The former discipline underwent a transition from the study of traditional societies in exotic landscapes to the study of industrial and post-industrial contexts. Readings of US interactionist and ethnomethodological literature and of UK interpretations of the sociology of deviance further enriched these discussions (Foote 1943; Becker 1963; Glaser and Strauss, 1967; Young, 1976). Life-history research and ethnography at the Universities of Barcelona and Madrid has informed Mediterranean thinking on community interaction. This is reflected in particular in outreach developments in Barcelona, Madrid and Seville. By the early 1990s, similar research interests had arisen in the Netherlands and the UK.

More recent outreach work in the synthetic drug and ‘rave’ scenes has also incorporated countercultural experiences from the 1960s and 1970s, Guy Debord’s situationist theory and more recent postmodernist thinking (Debord, 1983; EMCDDA, 1997).⁷ However,

⁷ Research into synthetic drug use among young people is increasing and uses different methods. Surveys of young and school populations exist in most countries (see Kort and Riper (eds), 1997), as well as on a European scale (see, for example, Hibell *et al.*, 1997). Ethnographic research is also undertaken in some countries, such as the UK (Ward and Pearson, 1997), Spain (Roldan *et al.*, 1997) and the Netherlands (Kort *et al.*, 1991).

no one single theoretical, conceptual model can be identified as forming the basis for outreach practice in relation to 'new' drugs, and there is also considerable overlap between models.

CONCLUSION

The practice of outreach work has altered considerably over time in terms of its objectives, target groups and the actors involved. In conclusion:

- both similarities and differences exist between European Union Member States;
- outreach work has a longer tradition in the United States than in Europe;
- the Netherlands and the UK have, within the brief span of three decades, established an outreach tradition specifically tailored to drug users;
- a similar pattern can be distinguished in scholarly practice with a gradual shift in focus from the poor in general, to the youthful poor, to 'flower-power' youth, to drug users and subsequently on to 'hidden' drug users in the wake of the HIV epidemic;
- targeting users of so-called 'new' drugs in the rave and party scene has broadened the scope and methods of outreach work – this pattern does show many differences between countries, however, for example in the points and the pace at which outreach work is initiated; and
- in both Europe and the United States, outreach interventions have been influenced or initiated by action research projects.



Target groups, goals and working methods

TARGET GROUPS	32
THE AIMS OF OUTREACH WORK	39
WORKING METHODS	46
CONCLUSION	53

TARGET GROUPS

Target groups tend to be defined according to specific criteria or characteristics. Chapter 1 highlighted the changes in outreach target groups over time from deviant lower-class youth to hippy youth from a range of social classes to drug-using youth to drug addicts to hidden problematic drug users and, most recently, to party youth or 'ravers'.

At present, two broad target groups for outreach work in the drugs field can be distinguished: users of 'old' and users of 'new' drugs. In general, outreach work in Europe focuses more on users of 'old' drugs. The definition provided by Hartnoll *et al.* (1990 – see Chapter 1) characterises these groups as not effectively contacted by existing services or by traditional health education. Professionals perceive this absence of contact as a problem – it is through such contacts that they try to motivate and support people to change their behaviour (although they may have different and multiple aims in doing so, such as to benefit individual drug users, the community or society at large). As illustrated below, this type of definition is better suited to the users of 'old' than of 'new' drugs.

This section focuses on the target groups of detached and domiciliary outreach efforts, while peripatetic activities are discussed later in the context of the aims of outreach work.

Figures 1–4 illustrate the frequency of outreach contacts with:

- users of 'old' drugs (HIV-oriented);
- users of 'old' drugs (harm reduction- rather than HIV-oriented);
- users of 'new' drugs (demand reduction-oriented); and
- users of 'new' drugs (harm reduction-oriented).

In most cases, the data are derived from the National Focal Points of the REITOX network or other key informants.⁶

⁶ In Denmark and France, two and three key informants respectively provided information. Where the informants did not provide the same answer, the most 'positive' answer is presented in the case of Denmark, and the 'average' answer in the case of France. Findings for both the Flemish- and French-speaking communities in Belgium are presented separately in the tables, but not in the maps.

FIGURE 1: USERS OF 'OLD' DRUGS (HIV-ORIENTED)

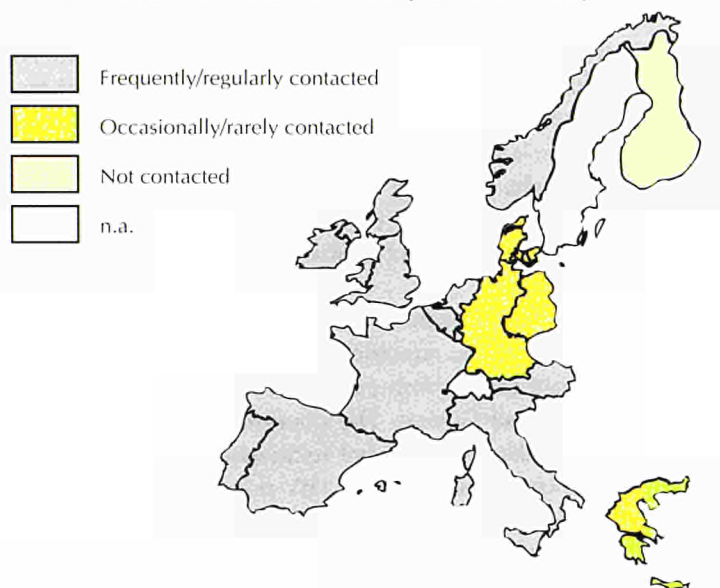
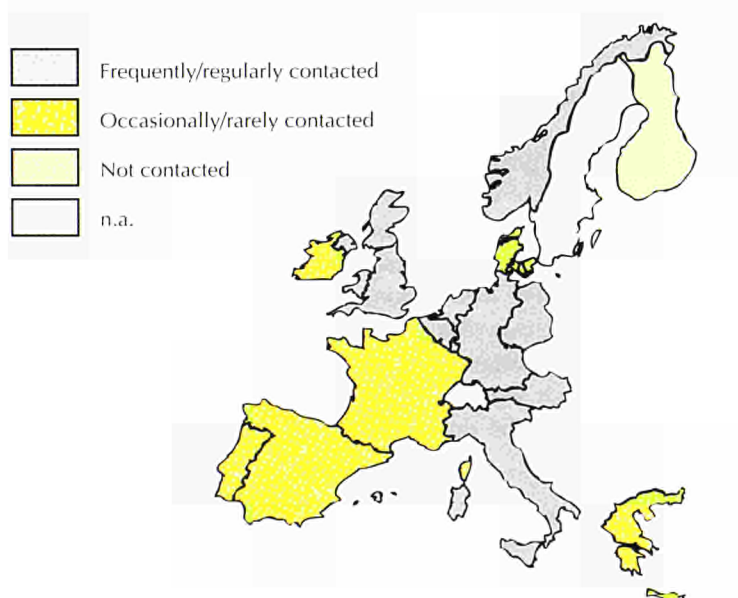


FIGURE 2: USERS OF 'OLD' DRUGS (HARM REDUCTION-ORIENTED)



Users of 'old' drugs

Hard-to-reach drug users exist in every country in Europe. As a result, a whole range of activities has been developed to contact them, of which outreach work is one.⁹ Currently, the group designated as users of 'old' drugs is made up predominantly of heroin users, most of whom are actually polydrug users. They are the primary target group of all outreach activities, notwithstanding existing variations across Europe (often reinforced by local cultures and traditions).

The majority of outreach workers have frequent-to-regular contacts with users of 'old' drugs, specifically or exclusively concerning HIV. Exceptions are the Flemish community of Belgium, Denmark, Finland, Germany and Greece. The countries where contact with such users is high also tend to have relatively high levels of other, non-HIV-related or not specifically HIV-oriented harm-reduction outreach contacts. In Germany, outreach work among users of 'old' drugs appears to focus more on general harm reduction than on HIV-specific activities. However, in some other countries (e.g., France, Ireland, Portugal and Spain) outreach work among users of 'old' drugs is more focused on HIV-specific activities than on more general harm reduction (see also Figure 1). This can be explained by the fact that outreach work among drug users is relatively new in these countries, and that, in the southern European countries mentioned, HIV rates among intravenous drug users are rather high.

In reality, this target group consists of many subgroups. One of the main characteristics of those in this category is their dependence on the drugs in question. Some users may operate simultaneously in similar or in very different scenes, and the problems they face may differ considerably. For this reason, drug users cannot be targeted as a homogeneous group (Bravo, 1994). Nor do all drug-dependent persons need to be targeted for outreach intervention since the purpose of outreach work is to contact specifically those people who are presumed to be out of touch with conventional services.

⁹ Mobile units, drop-in and contact centres and other interventions have been established in Amsterdam, Barcelona, Berlin, Brussels, Edinburgh, Glasgow, Hamburg, London, Marseille, Milan, Paris, Utrecht and Zurich.

Given these considerations, the following factors can help define target groups of users of 'old' drugs:

- risk behaviour;
- perceived vulnerability and need of support;
- characteristics of set and setting;
- perceived size of group;
- degree to which users are out of touch with services; and
- degree to which users are 'hidden'.

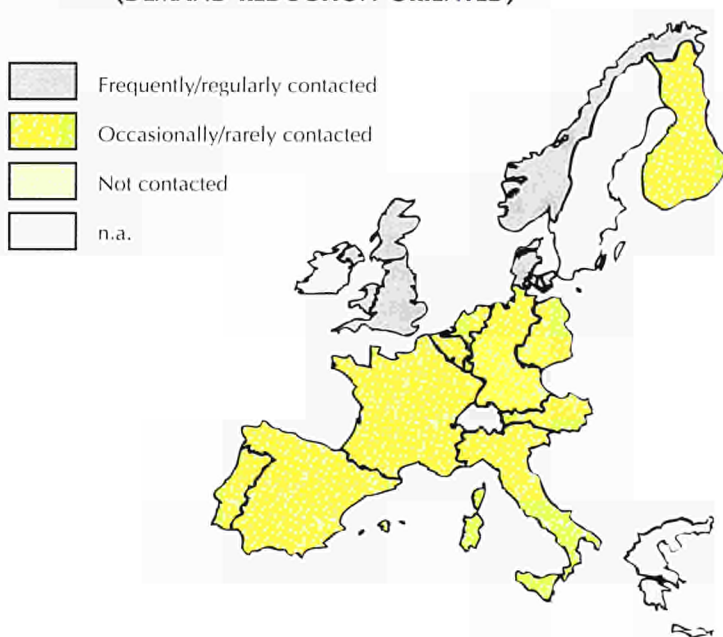
Users of 'new' drugs

Since the late 1980s, the use of ecstasy and other synthetic drugs has spread rapidly amongst young people across Europe. The pace of this spread has been quite remarkable, especially when compared to that of other illicit drugs such as cannabis and heroin in the 1960s and 1970s (Fromberg, 1995). It is beyond the scope of this book to explore the factors behind this rapid spread, but it could be argued that the use of synthetic drugs fits well both into the *Zeitgeist* – which includes a revival of symbols from the 1960s – and into developments in youth entertainment patterns and life styles. Youthful recreational drug use is now invariably linked to the popularity of the 'rave' music scene (Pearson *et al.*, 1991), which is why these types of drugs are also referred to as 'dance drugs'. In a time of persisting heroin addiction and AIDS, synthetic drugs can boast a more positive image as safe, clean, non-addictive and conducive to empathy and erotic communication. While heroin is perceived as a 'loser's drug', synthetic drugs are 'cool'. Compared to drugs such as LSD and stimulants like amphetamine sulphate, the 'new' drugs produce 'lighter', more stimulating and less mind-altering effects. Moreover, their ingestion in oral form is seen as an advantage over illicit drugs that must be injected, inhaled or smoked (Gamella *et al.*, 1997).

During the 1990s, concern has grown about the widespread use of synthetic drugs among young people. Drugs such as ecstasy are now legally defined as illicit and are prohibited. Patterns of manufacturing and distribution, however, change rapidly and ways are

sought to develop chemical alternatives and to produce the drugs in different geographical areas. One consequence has been extensive pollution of the market.

**FIGURE 3: USERS OF 'NEW' DRUGS
(DEMAND REDUCTION-ORIENTED)**

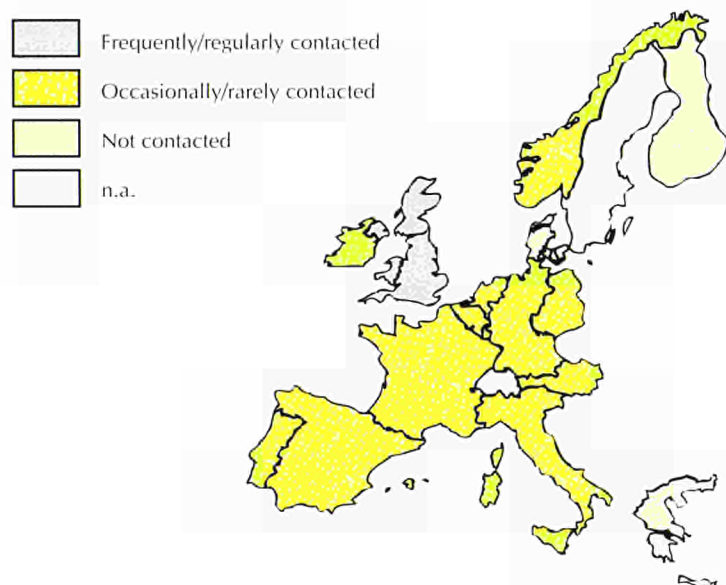


Only in a few countries have the consumers of 'new' drugs been targeted by outreach projects on a scale similar to that for users of 'old' drugs (see also Figure 2). The majority of EU countries seldom, if ever, approach users of 'new' drugs. Denmark and Norway do so mostly from a demand-reduction perspective, while the UK promotes substantial demand- and harm-reduction activities for 'new' drugs. The six countries that reported occasionally targeting 'new' drugs do so more from a harm-reduction than a demand-reduction perspective. In general, countries with frequent outreach contacts to users of 'old' drugs also tend to do more than an

average amount of outreach work among users of 'new' drugs from a harm-reduction perspective. Examples include the Netherlands, Norway and the UK. On the other hand, countries with no or less frequent outreach contact to users of 'old' drugs (such as Finland and Greece) have no outreach contacts to users of 'new' drugs.

The same factors used earlier to define target groups of users of 'old' drugs can help define target groups of users of 'new' drugs.

FIGURE 4: USERS OF 'NEW' DRUGS (HARM REDUCTION-ORIENTED)



Target group characteristics

Three issues require further reflection when defining target groups for outreach work. The first two issues pertain to 'old' drugs and the third to 'new' drugs.

'OLD' DRUG USERS

Should being out of contact with drug services be the principal qualifying criterion for a target group, since the extent to which drug users are out of touch with such services differs widely between countries? In practice, those users reached are often presumed to be 'problem' groups – the heaviest long-term polydrug users who exhibit risky or nuisance-causing behaviour. A connection thus exists between the degree of problem drug use and the probability of being targeted – the more problematic the behaviour, the greater the chance of being targeted. This lays bare a serious paradox for outreach work: contrary to its ostensible focus on 'hidden' populations, it is often the most visible, ostentatious drug users (many of whom are already well known to a large number of agencies) who are contacted (Strang, 1994). On the other hand, not being in touch with services does not always mean not having access to them, and those users who are 'out of touch' in this respect might often be deliberately so. The real hidden drug users are thus not always targeted, let alone reached.

The second issue also involves hidden populations. Some common perceptions may be obscuring and excluding groups that are very much in need, and which, from a public-health perspective, may be at even greater risk than more visible groups. For example, if HIV prevention is a major aim of outreach targeting, an exclusive focus on socially very marginal drug users could overlook recreational, non-dependent or non-conspicuous marginal users, who could greatly benefit from HIV prevention.

'NEW' DRUG USERS

As a target group for outreach intervention, users of 'new' drugs cannot be equated in any way with users of 'old' drugs. In the first place, being out of touch with services does not qualify as a target-group indicator; neither do marginalisation, dependency or addiction, other prominent motives for outreach work. These are a new type of drug user – not the street junkies from the lower social classes, but predominantly healthy, 'normal' young people from diverse social backgrounds. Moreover, the potential group to be

targeted is far more heterogeneous, and possibly much larger, than the 'old' drugs group.

Synthetic drug users are found in diverse subgroups and subcultures which use different symbols and exhibit different patterns of drug-taking and other behaviours (Fromberg, 1995). These may differ widely both within and between countries. Although 'new-agers', 'clubbers' and 'ravers', to mention just a few, constitute different groups, they are not entirely distinct from one another (Nabben and Korf, 1997). People may belong to different groups, either simultaneously or over time; others do not identify with any group, but may still attend the occasional party or 'rave'. Subcultures can change rapidly and can be perceived as 'trendy' or outdated, mainstream or outlandish. Some subcultures are easier to join than others, even for researchers and outreach workers. Such factors play a part in defining potential target groups for outreach intervention and in selecting suitable outreach workers.

Risk behaviour in most such groups varies, but it appears to be associated above all with the use of poor-quality pills, improper use (e.g., not drinking enough water or combining pills with alcohol or other drugs), or features of the setting, such as overcrowded venues or excessive temperatures. Unsafe sex could also be a potential risk factor, although little consistent and empirically based information is yet available about the relationship between 'new' drugs and unsafe sex. Providing safe-sex information in youthful entertainment scenes seems to be a good idea in the best of cases.

THE AIMS OF OUTREACH WORK

If one term could summarise the aims of outreach activities it would be 'harm reduction'. Harm reduction is an umbrella concept applied at many different levels, from the philosophical to the practical. It aims to curb the negative effects of illicit drug use by reducing the risks that drug users will harm themselves and/or their environment (the individual, the

community and society at large – O'Hare (ed.), 1992). A harm-reduction philosophy espouses the view that actively attempting to reduce the damage caused by drugs is of greater benefit to the common good than simply trying to prevent drug taking. Such a view openly acknowledges the difficulties inherent in attempting to ban all forms of illicit drug use, and emphasises instead maximising benefit and minimising harm. Harm reduction is primarily targeted at improving public health, rather than at the mere criminalisation of individual drug users.

Although outreach activities emphasising harm reduction had already begun to evolve before the onset of the AIDS epidemic in the 1980s, HIV has been a catalyst in the dissemination of this philosophy. The Netherlands, Switzerland and the UK have been particularly active in promoting harm-reduction policies in relation to drugs. Some other EU Member States, in particular France and Sweden, have shown less enthusiasm, given that harm-reduction measures, including outreach work, are not free from controversy. There has been heated debate, for example, on whether providing clean syringes simply encourages more drug use.

From its initial outsider's position, harm reduction has meanwhile firmly established itself at operational, policy and research levels. However, ideas on harm reduction are now being applied in the service of a wide spectrum of ideologies and policies, ranging from anti-prohibition standpoints to prohibitory programmes that use harm-reduction measures to promote abstinence (Fromberg, 1995).

The objectives of outreach work are many, varied and sometimes difficult to unravel and, not surprisingly, they vary both between and within countries. Differences are also found at regional, municipal, neighbourhood and service levels. The nature of the set, the setting and the target group determines the nature of the outreach work.

Broadly speaking, four main aims of outreach work can be distinguished, all relating in one way or another to reducing risk:

- prevention;
- peripatetic outreach work;
- policy information; and
- combined outreach service delivery and research.

A particular outreach activity may pursue one such aim or a combination of them. 'Prevention' applies directly to drug users, while the other aims affect drug users indirectly, by providing information to local policy-makers or through peripatetic outreach work.

Prevention

Prevention is usually the primary aim of outreach efforts, whether directed at HIV prevention and education, or at broader, drug-related issues (Rhodes *et al.*, 1991a).

Prevention encompasses various aspects of risk reduction through behavioural change, including safer drug use, abstinence from drug use, safer sex or curbing other risk-taking behaviour. Unlike conventional health education, outreach work emphasises the need for:

- context specificity;
- active participation by actual or potential users; and
- recognition that providing accurate information alone may do little to modify behaviour.

This means that outreach interventions need to contact drug users in a manner that will enable them to make healthier choices. This promises to be more effective than merely providing individuals or groups with health recommendations or assuming they will seek help themselves if their health problems become serious enough. Health educators have distinguished four models of health education:

- behavioural change and information-provision models;
- self-empowerment models;
- community-oriented models; and
- social-transformation models.

Outreach work has more in common with the self-empowerment and community-oriented models than with those concentrating on providing information.

PRIMARY PREVENTION

Traditionally, primary prevention in the drugs field focuses specifically on young people who are not yet using drugs, to deter them from doing so in the future. Briefly the message is 'don't take drugs'. Primary prevention is provided mostly to small groups, such as school classes, or to broader groups through, for example, public campaigns. This type of primary prevention is not perceived as outreach work.

Defined this way, the concept of primary prevention might seem difficult to apply to users of 'old' drugs, unless it refers to preventing the use of additional types of drugs (for instance, cocaine or crack-cocaine in the heroin users' population). Yet the concept is applied nevertheless in cases where prevention activities are directly related to the drug use, for example in attempts to prevent injecting or to deter former drug users from relapsing. Here the prevention message can be summarised as 'don't inject'. For injectors and non-injectors alike, outreach efforts aimed at preventing unsafe sex are also primary-prevention activities.

With regard to 'new' drugs, primary prevention seeks to deter people from taking these substances, for example by providing information at 'raves'. Here, too, the message is 'don't take ecstasy', which may also be combined with safe-sex information.

SECONDARY PREVENTION

Secondary prevention is directed at those who are already using drugs. For users of 'old' drugs, secondary prevention may promote HIV risk reduction by providing prevention materials (condoms or injecting equipment), or it may indirectly facilitate change by referring individuals into existing health services.

The purpose of secondary prevention for 'new' drugs is to inform people who already take synthetic drugs about safer ways to use them. Pre-

vention may include testing pills or providing information about doses, frequencies or risky combinations. Condoms may also be supplied.

Secondary prevention for users of both 'old' and 'new' drugs could be summarised in the message: 'If you take drugs, do it safely' and 'if you have problems, contact the drug services'.

Peripatetic outreach work

Peripatetic outreach work is concerned primarily with training and educating other professionals, building alliances with them (Stimson *et al.*, 1994), and changing public attitudes towards drug users and the marginalised in general. It also encompasses activities in which outreach workers contact institutionalised drug users, such as in prisons. This type of outreach work is the most developed for users of 'old' drugs, but faces many challenges with regard to 'new' drugs.

Policy information

Many outreach projects collect data about their target populations and potential new target groups. Together with their field observations, such data can provide information for local and national policy-makers and for care services. The outreach workers can also provide feedback to existing health services, based on identified user needs and user perceptions of these services.

Service delivery and research

Some outreach projects are based on a combination of service delivery and research. This combination can have both negative and positive consequences for the aims pursued. Although ethnographic research and detached outreach work may overlap, particularly in pilot or demonstration projects, they may also involve different priorities. Research is usually time-limited, works with clearly formulated questions and objectives, and has few ongoing responsibilities apart from general ethical considerations.

Those who have been employed in both capacities at various times will recognise the researcher's impatience with the reservations of some workers about initiating contacts, as well as the frustration of the worker who sees researchers moving in and out of situations with no long-term responsibility for delivering services and achieving objectives. The 'bleach and teach' projects in the US are an illustration of this dilemma.¹⁰ Adler's (1985) deprecatory characterisation of her own ethnographic research as 'whoring for data' is particularly resonant, as is the feeling of some workers that they are 'earning a crust out of another's misery'.

Despite such differences there are, of course, also many similarities between the experiences of researchers and outreach workers. As they 'snowball' their way through concealed drug users' networks, as they undertake street work, as they observe and participate in public spaces and drug-dealing arenas, researchers and outreach workers often experience the same pressures and subject themselves to the same risks.

Nationally defined aims

Most EU Member States have defined certain aims for outreach work (see Table 2), except for Austria, Belgium, France, Spain and the UK. There are different reasons why these countries have not established such aims. France, for instance, has not done so at national level, but aims are defined instead within the context of local and regional outreach projects. Spain, likewise, has no nationally defined aims, but this is probably because the country is organised into autonomous communities, which may diverge in how they define outreach work. The same may be true for Belgium with its Flemish- and French-speaking communities, and for the UK (where outreach work is defined differently at English, Scottish, Welsh and Northern Irish levels).

Where national-level aims for outreach work have been defined, they generally include identifying and contacting hard-to-reach

¹⁰ These projects responded to a ban on distributing sterile needles by providing bleach to IDUs and teaching them how to clean used needles safely.

populations, referring users to other services, and promoting safer drug use and safer sexual behaviour. More than half of the countries surveyed also target prevention and demand-reduction initiatives. One further aim – identifying user needs and perceptions of drug-care services, and providing subsequent feedback to those services – is only cited by Greece, the Netherlands and Norway.

These data should, however, be interpreted with great caution for several reasons:

- the study from which they are taken was only a first step in exploring the field of outreach work in a European context;
- the questions asked to key informants were open to personal interpretation; and
- countries may have different reasons for not defining certain aims.

TABLE 2: NATIONALLY DEFINED AIMS FOR OUTREACH WORK

COUNTRY	Aims defined at national level	Identifying and contacting hard-to-reach populations	Identifying user needs, perceptions of services and feedback	Increasing access and service update	Promoting adequate services, accurate prevention and demand reduction	Promoting safer drug use and safer sexual behaviour
Austria	no	n.a.	n.a.	n.a.	n.a.	n.a.
Belgium						
<i>Flemish-speaking</i>	no	n.a.	n.a.	n.a.	n.a.	n.a.
<i>French-speaking</i>	yes	yes	n.a.	yes	yes	yes
Denmark	yes	yes	ambiguous	ambiguous	ambiguous	no
Finland	yes	yes	no	no	no	no
France	no	n.a.	n.a.	n.a.	n.a.	n.a.
Germany	yes	yes	no	yes	yes	yes
Greece	yes	yes	yes	yes	yes	yes
Ireland	yes	yes	no	yes	yes	yes
Italy	yes	yes	no	yes	yes	yes
Luxembourg	yes	no	no	yes	no	yes
Netherlands	yes	yes	yes	yes	no	yes
Norway	yes	yes	yes	yes	yes	yes
Portugal	yes	no	no	yes	no	yes
Spain	no	n.a.	n.a.	n.a.	n.a.	n.a.
Sweden			no information available			
UK	no	n.a.	n.a.	n.a.	n.a.	n.a.

Notwithstanding such limitations, a tentative conclusion can still be drawn. Relative homogeneity exists among the countries involved. Identifying and contacting 'hidden' populations and referring them to available drug services are broadly recognised aims. HIV-oriented harm-reduction activities, combined with prevention and demand reduction, are recognised in Germany, Greece, Ireland, Italy, Norway and the UK. Some countries, such as Denmark and Finland, appear to place more emphasis on demand reduction, while Luxembourg and the Netherlands stress harm reduction. On the other hand, taking into account the target groups actually contacted by outreach work, Finland seems hardly to practise outreach work at all in contacting users of either 'old' or 'new' drugs (see Figures 1–4), while Denmark seems mostly to target 'new' drugs from a demand-reduction perspective.

More the exception than the rule is the aim of recording the needs and perceptions of drug users with respect to drug-care services in order to benefit and improve the services in question. This seems odd, since presumably all organisations have to identify their users' needs and perceptions in order to legitimise their own existence and enhance their effectiveness. Such information would also facilitate referral, which is widely attributed to outreach work.

From the data thus far, it is difficult to determine why needs and perceptions are not, in fact, a generally defined aim for outreach work. Perhaps the services are presumed already to know their potential users' needs, perhaps such needs are considered less important, or perhaps it is not considered the task of outreach work to gain insight into them. It is an important issue, at any rate, and one with obvious implications for the position of outreach work in the overall field of drug services.

WORKING METHODS

The working methods employed in outreach work vary, and may be based on different models of making contact and intervention. In practical terms, however,

many of the same elements can be recognised in the ways in which outreach workers approach and communicate with their target groups. One of the most salient distinctions between outreach methods and those applied in either inpatient or ambulatory settings is that contact is made in the drug user's 'natural' setting and on the initiative of the worker (although things may change when more lasting contacts have been established). Much outreach work is practised outside the normal service settings, working hours and other conventional work arrangements.

Chapter 1 distinguished three types of working methods: detached, domiciliary and peripatetic. Of these, detached outreach work is the most common in the EU (see Table 1, above), with most countries practising this method frequently or regularly. Peripatetic outreach work is generally less common: only the UK frequently applies it, and six countries rarely do. Domiciliary outreach work is the least common, used frequently only in Denmark and the UK, while in southern parts of the EU it is not practised at all. In Finland, Greece and Portugal, outreach work is not yet commonly practised at all in the field of drug care.

It is not only the ways contacts are made, but also the nature of outreach contacts that differ from those in other drug services. Outreach working methods seldom focus on longer-term therapeutic or social-work relationships, as the more traditional drug services tend to do. This does not mean that outreach workers contact each drug user only once, but rather that the contacts are not regular in the traditional sense of the word, taking place at fixed times or in regular meeting places. Instead, the effectiveness of outreach service provision hinges on stable, reliable long-term street or community contacts.

Rhodes *et al.* (1991a) argue that outreach work is most effective when direct, 'aggressive' contact strategies are employed. They suggest that 'cold' contacts should take priority, backed up by adequate resources to respond to the resulting increases in client and casework loads. This proposition, while certainly valid for community net-

work approaches, reflects a research agenda that may underestimate the complexities of a detached worker's position.¹¹

Community versus individual methods

In the late 1980s, most outreach interventions tried to change individual lifestyles, rather than bringing about collective, community or social change (Rhodes *et al.*, 1991a). Since then, there has been a growing emphasis on targeting the communities or social networks of drug users. Not surprisingly, debate on this issue is most common in those countries where outreach practice is more or less established. In fact, the community approach was already visible by the late 1960s in youth and community development work. By 1994, 'community outreach work' was being propagated in the UK as a model for new practice, although to practitioners it may not seem as conceptually new as it does to those unfamiliar with the field.

In daily practice, a distinction between individual and community outreach methods may appear academic, artificial or even absurd. Yet such a distinction is important, for it can govern the aims and working methods of outreach work. For some, like Stimson *et al.* (1994), outreach work must still realise its full potential through 'community outreach', promoting change throughout entire communities and networks of individuals, rather than through one-to-one interactions.

Although a kind of general consensus exists that outreach work should take a social-network approach, how to define the concept of 'community' is not so clear. For example, to what degree can the concept of community be applied to the 'heroin scene'?

In brief, the criticism of individual outreach methods can be summarised as follows. Based as they are on one-to-one contacts, they do not devote sufficient attention to the social context in which risk behaviours take place, nor to the existing obstacles to, as well as

¹¹ The vigour with which this is argued may arise from the dismay felt by some researchers in certain British HIV projects around 1990 when many contact opportunities were lost due to poorly conducted detached outreach work.

possibilities for, changing such behaviours. In other words, in order to be effective, specific social interventions may require changes in group norms, consensus-based problem-solving and social dynamics. According to the critics, individual outreach work can only progress towards improvements in its target population on an 'arithmetical' basis. It fails to allow sufficiently for the influence of basic units of human interaction, such as networks of family and friends, work environments or other affinity and interest groups.

There are inherent limitations to encouraging and sustaining behavioural change when 'choices' are limited by situational contexts, such as close personal and social relations (Rhodes, 1993). One limitation of individual outreach work is said to lie in the traditional worker-user relationship. Drug users in 'hidden populations' can often look back on less-than-successful interactions with professional helpers. Before such drug users can be reached, they must believe that their story will be heard. To this end, so-called 'opinion leaders' are now often deployed, chosen specifically for their experience and their networks in drug scenes.

These types of criticism of individual-centred prevention programmes have been aired by Trotter, Bowen and Potter (1995), as well as by Stimson *et al.* (1994) and Rhodes *et al.* (1991a). Although individual contacts through outreach work can have some success, they seem limited in their ability to encourage and sustain behavioural change. This requires a transition from health-promotion measures that advocate personal change towards ones that try to bring about social and community changes (Rhodes, 1993; Friedman, 1992).

Community approaches focus on drug users within their own 'scene', 'community' or 'network', as well as within a broader 'community', such as the family, an extended social network or a local community.

'BRIDGEHEADS' AND THE BROADER COMMUNITY

Community-based outreach work strives to make contact with individual drug users, extended networks and 'communities' through indigenous key informants or opinion leaders. Network-associated

outreach work follows the track of existing social relationships so that, once the first few individuals have been recruited, the outreach group itself has an impetus to enlarge. With regard to HIV, individuals who have links with or bridge different networks can form 'bridgeheads' for infection by transmitting HIV to other networks. If such individuals can be recruited for outreach work, they can also become bridgeheads for prevention.

Drug-using volunteers (or 'peers') incorporate outreach work into their daily lives by promoting safer practices (Bolton and Walling, 1993). Community-oriented outreach work can lead to change regardless of whether drug users are also in contact with sedentary, office-based services with prevention advice and safer practices spread on a 'pyramid-selling' basis, with messages passing through networks.

In the 'indigenous leader' model of community outreach, developed in Chicago by Wiebel (1988), drug users 'sell on' prevention messages. While this requires individual behavioural change, it also endows status and provides norms through which opinion leaders can effect such change. Commonly held beliefs are the target for change, rather than the individuals themselves. Harm-reduction techniques and other information are disseminated according to principles of 'network diffusion'. Credible messages are transmitted through social networks that might otherwise facilitate the physical transmission of HIV or hepatitis C. The British self-help drug users' groups, the Dutch Junkiebonden and some German AIDS projects could be categorised as community action or mobilisation models.

The broader community model thereby shifts the focus from individuals to social networks and communities, defined according to specific criteria based on first-hand familiarity. Especially in working with specific groups of drug users from different cultural backgrounds, fieldwork has proven to be a successful method.

THE CONCEPT OF COMMUNITY

A community approach is a very complex one, as reflected in the heterogeneity of the hidden populations of drug users and the

different communities in which they operate. At the theoretical level, there is debate about how 'community' should be defined. While some outreach theorists stress the importance of drug user 'communities' or 'scenes', others put more emphasis on relational aspects. Auge's work (1995) offers very useful insights into the importance of 'non-places', such as railway stations, hamburger bars and abandoned buildings, where a sense of both community and anti-community prevails. Cohen (1995), on the other hand, points to the amorphous nature of the concept of community, defining it instead as a relational concept – insiders are defined merely in relation to those who are seen as outsiders.

In view of the importance ascribed to 'community outreach' in northern European theory, the most immediate need is to identify more precisely what 'communities' are, and to determine whether they are something more than complex, overlapping structures defined primarily in terms of everyday shared norms, values and practices. Particularly in the case of 'drug communities', the heterogeneity of belief systems across networks and the absence of any specific political and social identity (despite the effects of illegality and marginalisation) are problematic. Drug communities are not passive, strictly bounded, traditional, pre-existing entities but continually recreate themselves, often in reaction to whatever people become defined as 'others', and may well even recreate themselves in response to the kind of outreach work offered.

THE COMMUNITY AND 'OLD' DRUG USERS: HIV AND AIDS

Thus far, preventing the sexual transmission of HIV among injecting drug users and their partners has been less than successful, both as a component of drug-related outreach work and as an intervention specifically targeting sexual behaviours. It seems plausible that, even though drug users as an 'expert' group in their scene have shown themselves capable of manipulating and adjusting their drug use as subcultural norms change, they prove unable to adapt their sexual risk behaviours in the same fashion. Other high-risk groups, such as gay men, seem to experience the same difficulties, despite rigorous outreach activities in high-prevalence areas. Female sex workers, while apparently successful in negotiating the use of

condoms with customers, tend to be less consistent in sexual relations with significant others.

It seems likely that most outreach workers in drug projects feel more confident in conveying HIV-prevention messages relating to drug paraphernalia or needle-sharing than they do in broaching condom use or other sexual matters. Both outreach workers and drug users may find sexuality a more delicate and private area for communication. While it has evidently been both plausible and effective to convey prevention messages by mobilising networks of drug-related relationships that could potentially transmit HIV, mobilising sexual networks seems a more complex task.

THE COMMUNITY AND 'NEW' DRUG USERS

The distinction between community and individual approaches is also relevant to outreach interventions aimed at 'new' drug users.

In the past five years, efforts at demand reduction and harm reduction in relation to synthetic drug use have focused in particular on outreach work and peer education as effective modes of service delivery. For many projects working in the dance-drug scene, the chief mode of expression, at least initially, has been flyers and other materials. Although a leaflet is an important first step, it is only a tool. There is a professional consensus that personal contact is the most effective means of communicating the message. As one outreach worker in Belgium observed: 'When people are interested, they come and ask things. Having a brochure or a flyer is fine, but it's better to talk' (EMCDDA, 1997).

That many services use a peer-education approach seems to confirm the continued growth in the popularity of this method. Outreach work by salaried project workers alone is not considered enough. In terms of both credibility and practicality, the involvement of peers and volunteers is essential. The increasingly sophisticated treatment of young people demands that messages and messengers also need to be sophisticated and credible to have any chance of being accepted (Shiner and Newburn, 1996). Moreover, small agencies with one or two workers cannot be expected

to cover the full scope of the scene or the droves of people encountered at a large rave event.

The question remains of whether the concept of community can also be applied in outreach work for users of 'new' drugs. It has been argued that traditional outreach and detached work are inappropriate in noisy clubs where the target group is seeking pleasure and not counselling (McDermott, 1993; Rhodes, 1991). McDermott *et al.* (1992) suggest that such a population is not most at risk and is also not particularly hard to reach. This is not a universal view, however, and is based on a rather narrow concept of what is meant by detached outreach work. There is certainly dissatisfaction at the inability or failure of traditional drug services to understand and respond more rapidly to the rave culture. Some notable exceptions include the Lifeline Project in Manchester and the Servizi Pubblici per le Tossicodipendenze (Ser.T) treatment service in Padua, which has become an Italian centre of expertise.

Outreach activities aimed at people who take 'new' drugs are nevertheless few and far between, and the same can be said of the assessments made of such people's risk behaviours. From previous studies (Fromberg, 1995; Nabben and Korf, 1997), it appears that users of 'new' drugs do pick up any available information and share it with others. The development of self-help groups throughout Europe is one indication of this (Fromberg, 1995). This tendency would seem to call for more network outreach methods in this area, too. On the other hand, a case can also be made for basing outreach work for users of 'new' drugs more on 'settings' than on 'communities'.

CONCLUSION

Outreach work still focuses predominantly on users of 'old' drugs. Outreach activities for users of 'new' drugs, with an emphasis on demand reduction, appears to be more common in the Nordic countries than in other parts of Europe. To date, harm-reduction outreach initiatives among users of 'new' drugs have been most common in the UK. Throughout the

EU, four overall aims of outreach work appear to have been defined at national level. They include:

- identifying and contacting hidden populations;
- referring these populations to existing care services;
- initiating activities aimed at prevention and demand reduction; and
- promoting safer sex and safer drug use.

A further aim, defined nation-wide in only three EU countries, is identifying the needs and perceptions of drug users regarding existing drug-care services and subsequently relaying the information to the services as feedback. This provides food for further thought, because such information could greatly enhance the effectiveness and co-ordination of drug-care services.

The debate on the distinction between community and individual working methods and the applicability of the notion of community to users of 'old' and 'new' drugs could produce valuable insights, since the differences between the two types of drug users have major implications for the future of outreach work. In outreach work for users of 'old' drugs, debate centres around two questions: is it more effective to contact hidden populations to try and improve their access to existing centre-based treatment and care services? Or is it better to contact them with the aim of developing health education, prevention and even treatment services in their communities, within the social environments and localities frequented by drug injectors, where the drug taking and the risk behaviour actually occurs (Rhodes *et al.*, 1991a)?

With regard to the users of 'new' drugs, it is not so much the aims of outreach interventions that differ, but the target group characteristics and settings, necessitating radically different working methods. Compared to the efforts for users of 'old' drugs, outreach work with users of 'new' drugs is still in its infancy. One of the most intractable aspects of behavioural change confronted by efforts targeted at both types of users is the prevention of unsafe sex. In part, this is because sexual behaviour often crosses the boundaries of the target groups. Promotion of safer sex in the general population, although not easy, is therefore still urgently needed.

The organisational context of outreach work

DRUG MONITORING SYSTEMS

56

OUTREACH WORK AND
THE DRUGS FIELD

56

TYPES OF OUTREACH WORKERS

61

JOB REQUIREMENTS, TRAINING AND
SUPERVISION

65

CONCLUSION

68

DRUG MONITORING SYSTEMS

Outreach work is practised in a broad range of organisational contexts, from stand-alone agencies to broad institutional frameworks, by people from many disciplines (including youth workers, social workers and nurses) whether professionals, volunteers or peers. Funding sources also differ, ranging from national or municipal subsidies, to charitable support, to self-help groups with no structural funding. To be effective, outreach services require efficient teamwork and smoothly operating organisational frameworks. As these services have relatively short histories as 'professional' organisations, they must often make do with unreliable, time-limited and inadequate sources of funding. Thus, from an organisational point of view, many outreach services are still struggling, by trial and error, to establish themselves as 'professional' organisations.

OUTREACH WORK AND THE DRUGS FIELD

The large majority of outreach services were not originally set up as stand-alone organisations, but as subsidiary activities of a wider organisation (see Table 3). In almost all the EU Member States for which information is available, drug agencies are among the organisations performing outreach work. Many youth work agencies do so as well, although apparently not in southern Europe, while a link with health agencies is found particularly in north-western Member States. Outreach work as part of general community services is practised mainly in southern Europe. Outreach work organised in the form of self-help groups, either independently or from within an existing self-help group (such as an AIDS organisation) is not very common. The relative scarcity of self-help outreach activities may be attributable to the situation of the target group concerned, the users of 'old' drugs. Among many other factors, their struggle to survive in a world of illicit activity is not particularly conducive to organising self-help groups. More recently, quite some 'new' drugs projects have been launched by users themselves.

TABLE 3:
TYPE OF ORGANISATIONS OFFERING OUTREACH SERVICES

COUNTRY	ORGANISATION						Operating independently self-help group
	drug agency	health agency	youth agency	social care	community care	self-help groups	
Austria							
Belgium	x		x	x			
<i>Flemish-speaking</i>	x		x				
<i>French-speaking</i>			x		x		
Denmark	x	x	x				
Finland		x	x	x			
France	x		x				
Germany	x					x	x
Greece				no information available			
Ireland	x	x	x				
Italy	x						
Luxembourg				no information available			
Netherlands	x	x	x				
Norway				no information available			
Portugal	x				x		
Spain	x				x		
Sweden				no information available			
UK	x	x	x				

Organisational variations notwithstanding, a number of basic prerequisites for outreach services to be effective can be identified. It should be borne in mind, however, that most outreach activities are not initiated on the basis of a clear-cut blueprint. In other words, the preparations, planning and implementation does not proceed in a sequence of determining aims and objectives, detailed research, project design, project implementation and built-in evaluation. Yet now that outreach work is establishing itself as an organised activity in the drugs field, it is necessary to reflect more deeply on its organisational aspects.

In every outreach activity, two intertwined organisational features can be distinguished:

- the internal (e.g., management structures, personnel policies and accommodation); and
- the external (establishing relations with policy-makers, funding bodies, other drug agencies and the community at large).

Internal organisation

Accurate knowledge of the chosen target groups, and sufficient experience in their midst, is essential because outreach services must be as relevant, well-informed and non-judgmental as possible in dealing with potential contacts and clients. The activities of drug users should be deconstructed into their component parts in order to understand what constitutes the life of a drug user as a whole person (Ehrenberg (ed.), 1992; Power, 1994). Harm-reduction measures are best implemented when their planners and promoters fully understand the forms and types of drug consumption, the modes of administration, and the roles and functions of all protagonists.

Empirical knowledge is needed about the social milieu around which drug consumption revolves. How do drug users organise, express and represent themselves and what are the rules of entry? Who consumes what and where, and how are these consumption patterns perceived? What kind of apprenticeship is required and in what arenas and venues do users meet? What hierarchies and power relations can be identified, and to what extent will outsiders, outreach professionals or indigenous workers be accepted or rejected? These are important issues for every outreach service. The point of departure for any activity, at both policy and practice level, is an acknowledgement of the expertise of the drug users and an absence of condescension.

Outreach activities require visible management structures and well-informed managers with clear lines of responsibility and accountability. There should be firmly established procedures for recruitment, induction, support and supervision, given the diffuse, unpredictable nature of the work and the complexities of accurate data recording. Managers and funding bodies should also be aware of the length of time required (1–2 years) for projects to establish viable working patterns and outreach strategies. In some countries, planners have been able to draw on the experiences of mental-health outreach models (Barrow *et al.*, 1991). As a result, individual clients have become involved in prevention or care

services who would not normally have sought them out on their own initiative. Broader peer-education models have also assisted service planners in assessing the relevance of their provisions – or lack of it – to outreach work with drug users. Since the majority of outreach services are part of wider organisations, the inter-relationship between the outreach activities and other services provided by the organisation needs careful monitoring, because tensions can arise unexpectedly.

Yates and Gilman (1990) from Lifeline in Manchester have provided a checklist of drug-agency provisions which outreach workers can use to inform their work. These include injecting-equipment exchanges, prescribing substitutes, emergency shelter, geographical proximity, welcoming staff, legal advice, general health care, advice on safer drug use, quality counselling, welfare rights information and alternative ‘fun’ or ‘learning’ activities. Outreach workers can act as advocates or ‘guides’ in easing access to provisions, interpreting professional jargon and explaining how services fit together.

Sufficient financial, legal and labour resources and a clear commitment to outreach work are necessary preconditions for successful interventions. It is important for safety measures to be built into every project for the sake of both clients and workers, and there should be regular and systematic monitoring of the clients contacted and the services provided. Workers require safety guidelines and assurances, guidelines for working practices, and adequate supervision, training, feedback and review.

External organisation

Of equal importance is the external organisation of outreach work – its relationship to its environment. Outreach work has been defined as an important complementary service in the drugs field. This is especially true of outreach activities for ‘old’ drugs. Outreach services obviously do not exist in a vacuum, and their nature and form is dependent on the wider contexts in which they

operate. Such contexts include other drug agencies ('vertical tuning' or co-ordination between the various facilities concerned with drug treatment), the wider organisational context ('horizontal tuning', such as contacts with mental-health services, the police and justice system and welfare institutions), the community where the outreach services operate and the funding bodies.

VERTICAL TUNING

For every outreach service, it is of paramount importance to determine organisational aims and to acquire the necessary information and insights about the target populations. This will ensure that time and energy will not be diverted into secondary priorities. The identified aims need to be based on an accurate picture of the local drugs scene ('mapping'). Before developing outreach interventions, existing services should be reviewed and their accessibility and suitability for the relevant target groups assessed. This organisational mapping will not only pinpoint gaps in service provision, but will also determine which existing provisions are unsuitable for potential clients. The problem is not always that drug users cannot articulate their needs; some also deliberately avoid services because they do not believe they are appropriate to their needs. If this proves to be the case, there is little point in trying to improve the uptake of such provisions (Rhodes *et al.*, 1991a; Rhodes, 1994b).

Vertical tuning, also known as networking, is a widely appreciated goal, although not an easy one. When resources are limited, and organisational and professional cultures differ in their approaches (abstinence-oriented versus harm reduction, for instance), difficulties can arise. A distinction should be drawn between institutional tuning and actual tuning on the street, as when different types of outreach workers or outreach activities cross each other's paths. One danger of formalising vertical tuning is that it can make organisational networks too large, thus diverting time and financial resources away from the clients. The challenge in vertical tuning is to achieve it creatively at the lowest possible cost.

HORIZONTAL TUNING

Most countries are now carrying out general innovations in health and social welfare services, characterised in many cases by a decentralisation of policy and funding from national to municipal or community levels.

This process clearly has consequences for outreach work, creating greater potential to respond to local needs, but often tighter financial constraints and greater pressures to evaluate the effectiveness of drug services, including outreach work. This demands, in turn, a greater degree of professionalisation, and more attention to tasks such as record keeping for evaluation purposes. Outreach work is also influenced by present trends towards a greater focus on 'new' drugs and on ambulatory treatment as opposed to residential services.

One key goal of outreach work is to achieve an optimal alignment between the care demand from drug users, as registered 'from within', and the supply of care on offer. By extension, outreach workers must ensure that provisions are tailored to the needs of their clients. It is not the case, however, as some people believe, that the primary or exclusive task of outreach workers is to steer drug users towards existing institutions. Outreach work also constitutes an 'autonomous' mode of action, with its own methods for aiding and supporting drug users.

TYPES OF OUTREACH WORKERS

Three types of outreach workers can be distinguished:

- professionals;
- indigenous workers or 'peers'; and
- volunteers.

Professionals

Professionals are in paid employment and fulfil their job requirements on the basis of professional accreditation. In practice, the term 'outreach work' encompasses the activities of professionals who may visit their clients at home on occasion as well as those involved solely or primarily with detached outreach work. As a rule, no specific educational training exists for outreach work, nor does the work belong to a particular discipline. Professional outreach workers come from diverse educational and professional backgrounds, including social work, sociology, nursing, psychology or education.

Indigenous workers

Indigenous workers, also referred to as 'peers', are experts on the grounds of their own personal experience and affiliate themselves with an outreach organisation. They may be paid or unpaid. The term 'indigenous worker' has not yet taken hold outside English-speaking countries. Instead, these workers are usually called 'peers', or sometimes 'community fieldworkers' (see, for example, Blanken and Barendregt, 1998). In practice, the former notion often includes 'birds of a feather' who are familiar with the lifestyles of certain populations of drug users (for instance, fellow prostitutes or immigrants) without actually taking drugs themselves.

At various times, indigenous drug users and former users have been employed as specialist advisers, as trained volunteers, as peer group leaders or as research collaborators. Power (1994) identifies five different roles that indigenous workers might play:

- fieldworker;
- interviewer;
- contact tracer;
- community guide; or
- observer in networks and arenas to monitor trends and act as an 'early-warning system'.

For some indigenous workers, outreach work may be the first step on a temporary path that will help them enter the broader world of employment. Their greatest asset is their social and intellectual capital, which they can use to negotiate and mediate between health-promotion or drug professionals and the drug-using networks to which they have access. Recruiting them for outreach could also turn them into bridgeheads for prevention (see also Chapter 2).

Power (1994) has proposed the recruitment of a tier of indigenous workers who would be paid on a casual, part-time basis while at the same time serving an apprenticeship to acquire full-time outreach status. Such a stratum of indigenous workers would provide a conduit through which hard-to-reach networks and communities could be contacted in order to promote collective change. McDermott (1993) warns of the dangers of over-professionalisation, whereby professionals usurp and marginalise the role of indigenous workers, or whereby the indigenous workers themselves become so professionalised that they lose touch with their original milieu and its values.

While many projects are positively inclined to use indigenous volunteers, they may be less keen on employing them as paid workers, despite the advantages they could bring to harm-reduction efforts (Power, 1994). Despite the proven success of former and current drug users in furthering prevention initiatives in drug-user networks in the early 1990s, Hartnoll *et al.* (1990) found that only 10% of outreach projects in the United Kingdom were employing indigenous workers.

Volunteers

Volunteers may have attributes of either professional or indigenous workers, but are called volunteers because their work is unpaid (or they are only reimbursed for expenses). They may also be committed members of the public who are neither former drug users nor professionals.

The extent to which these three types of workers are incorporated in outreach work varies from project to project. If professional workers, indigenous workers and clients share certain characteristics, such as gender, sexual orientation, class, race or lifestyle, this may facilitate contact and communication. It should be noted that the general over-representation of males in the drugs field, especially in detached outreach work, shows up here too, perhaps not surprisingly in light of the predominantly male clientele and the difficult circumstances under which outreach workers operate. When female drug users are a specific target group in outreach work, they are often predominantly or exclusively sex workers.

Professional workers should keep certain methodological considerations in mind when operating through indigenous workers. As indigenous workers record their activities and perceptions, they may fail to note essential points that are so obvious to them that comment seems unnecessary. Whereas professional outreach workers may fail to influence behaviours because they remain outsiders unable to bridge cultural divides, indigenous workers may unconsciously reinforce the group's behaviour rather than encourage change, predisposed as they are to the prevailing beliefs and practices in the target group, for example, that it is impossible for injectors to switch to non-injecting modes of use.

The potential roles of drug users, ex-users, indigenous volunteers, indigenous workers and professionals have been subject to more controversy in outreach circles for 'old' drugs than they have within youth work or outreach work for 'new' drugs. As stated earlier, in recent years, the demand-reduction and harm-reduction responses to 'new' drugs have primarily embraced outreach and peer education as effective modes of service delivery.

JOB REQUIREMENTS, TRAINING AND SUPERVISION

Practising outreach work often means working with people with many psychosocial problems, and operating in hectic, chaotic contexts and unpredictable situations. Working conditions are markedly different from those of mainstream jobs: work is outside office hours, outside a secure agency base, in unsafe environments, in semi-illegal contexts and often at low pay. A job as an outreach worker demands personal commitment, familiarity with the target group and a wide range of psychological and social skills (Majoor, 1994). The personal attributes of outreach workers are, therefore, a key factor in successfully fulfilling the task.

Beyond such general characteristics, little written information is available about the job descriptions and skills required of outreach workers. It is not that outreach services do not know what types of worker they are looking for, but framing such information into detailed criteria is very difficult.

A prime condition for outreach workers to function adequately (even though it is not always met in practice) is that they immerse themselves as fully as possible in the culture of the target group with whom they are working. This entails learning the language, norms, values and attitudes of the group and building a relationship of trust. As a basic principle, workers must understand that when entering a contact's world they do so on the contact's terms and not on their own terms (Gilman, 1992).

Outreach workers also need to 'contextualise' lifestyles, so that any interventions will be grounded in the everyday realities of the group. Credibility and respect are required for workers in settings such as youth clubs and other venues, and even more so for detached work in informal or drug-using settings. More specifically, in the latter case, workers may even have to work with, rather than just in, that world, running into situations where illegal activities may challenge professional boundaries.

Second, workers must perceive their role differently from that of the traditional expert, substituting various other roles such as guide, friend, therapist, mediator, communicator or influencing agent (Svensson, 1994). The traditional helper–client relationship is inverted in the sense that the amount of access a worker gets is contingent on the local community.

Third, the outreach worker needs a large store of knowledge (epidemiological and field) and skills (general diagnostic and counselling), and must furthermore be able to network with very different types of clients and experts (Majoor, 1994; McDermott, 1993).¹² In their interaction with drug users, especially of ‘old’ drugs, workers will have to cope with game-playing and manipulation as well as differences in norms and values. However, while workers need to maintain a flexible, open attitude towards drug users, they must never totally identify with them, and they should be constantly aware of the users’ limitations and possibilities. As Majoor (1994) has put it, the outreach worker needs ‘hardware’ (knowledge, skills) and ‘software’ (motivation, personality traits, involvement); this might also be expressed by the head and heart metaphor.

In sum, whether outreach work is detached, domiciliary or peripatetic, it requires large measures of skill, confidence and subtlety of approach. Workers should be prepared to face:

- their contacts’ ambivalence towards them;
- frustration at lack of contact;
- long waits for responses followed by rapid spurts of intense activity;
- unsocial hours;
- the demands of a scene governed by shifting locations, changing seasons, inclement weather, police pressure and the vagaries of the drug market;
- high-risk conflicts;
- suspicion from drug users and the police; and
- constant attention to confidentiality.

¹² Trotter, Bowen and Potter (1995), following Knoke and Voulinski (1982), define a network as a ‘specific type of relation, a defined set of persons’. However, although outreach workers may spend much of their time ‘networking’ in a technical sense, they would be unlikely to use the term itself, which has begun to acquire the frivolous overtones of the American word ‘schmoozing’.

All things considered, being an outreach worker is clearly no easy job. Given the complexities of the work, staff training, support and tutoring should be standard practice in every outreach organisation. This requires a flexible but well-structured personnel policy, focused on both individual- and team-related aspects of outreach work. The presence of such policies would also help in assessing the quality of outreach services. Training, for instance, could foster the development of service-based methodological approaches, including their evaluation. It could also be offered as peripatetic outreach work to other types of professionals and volunteers who come into contact with drug users, for example in geographically dispersed rural areas. Some drug projects have succeeded in successfully balancing minimal harm-reduction interventions, case-work and facilitation and training (Gilman, 1992). Unfortunately, in contrast to the abundant professional courses on addiction, training courses in outreach work are virtually non-existent in the EU Member States, except internally within organisations.

Staff tutoring and peer tutoring for individual workers and teams could provide support in emotional, cognitive and conflictual matters. This is by no means a luxury – employee burnout is a well-known phenomenon in the drugs field. Career planning and support is a further aspect of good personnel policy that is of special importance to outreach workers. Employment conditions for outreach workers are not optimal: low pay, unsocial hours, limited autonomy and limited opportunities for promotion can dampen enthusiasm and foster disillusionment. Contradictions between the values and perspectives in the voluntary sector, the legal system, self-help efforts and the streets can kindle resentment and conflict if the wrong management style is adopted.

Standards for outreach work have now been adopted in Germany and Portugal. In Germany, these standards include that outreach workers should always work in a team and never alone, that their work is subject to confidentiality, and that they should have a qualification for outreach work. In Portugal, these norms include that no interventions should take place without needs assessment, and that all interventions should be in partnership with local community groups.

CONCLUSION

Most outreach services operating in the EU emanate from drug agencies or youth-work organisations. Stand-alone outreach organisations are rare, as are outreach activities self-organised by current or former drug users (either independently or as part of a broader self-help organisation). In north-western Europe, outreach services are more commonly part of health agencies, while in southern regions they are often part of community services.

Outreach services include both internal and external organisational structures, and both aspects should be assessed in light of the cardinal aims of outreach work – obtaining a clear picture of the target groups, accessing them, and identifying and appropriately supporting drug users' needs. Both literature studies and observations of outreach practice show that most such services still lack sufficient financial, legal and labour resources to perform their tasks well. Practically nowhere in the EU do adequate training facilities exist with a specific focus on outreach work, and there is a consequent lack of professional accreditation and coherent job profiles. Much could also be done to improve the terms of employment and career opportunities of outreach workers. Experience shows that when welfare agencies are under threat, their outreach activities are often the first to be scrapped.

The external relations of outreach services involve interaction with other drug agencies as well as with a still wider organisational context. Such relationships are of crucial importance. Many fruitful outreach activities to promote safer drug use may be initiated, but if the drug users then face a host of obstacles putting the new techniques into practice (such as unavailability of clean needles or methadone or the presence of legal constraints), outreach work is condemned to failure at the outset.

Networking and co-operation are also very important, but practical problems abound. Scarce resources, different or opposing aims,

and divergent professional backgrounds and cultures all hinder effective networking. It should be noted that these types of networking problems occur not just in outreach work, but also in the entire drug field.

In the ongoing process of professionalising outreach work, the involvement of indigenous workers and volunteers is perceived as very valuable indeed. However, the inclusion of the former is often controversial, not so much in theory but in practice. Disagreements arise about methodological validity, legality and the position of workers within the wider organisation. Such conflicts are more likely to occur in the context of 'old' than of 'new' drugs, partly because of the different characteristics of their target groups. The composition of outreach teams and the degree of involvement of indigenous workers and volunteers vary from country to country, depending on the status of outreach work in the countries in question or pragmatic considerations. In Italy, for instance, where outreach work is not a professional endeavour, workers are often 'self-made', and many are former or current drug users.

With regard to 'new' drugs, the peer approach is gaining popularity. A view is developing in some countries that it may be more efficient and effective to train generic youth workers in drug prevention and demand reduction, thus integrating such themes into the totality of their work, which entails a multiplicity of other skills.

In sum, the major organisational problems that can arise in outreach projects include the structural isolation of workers, difficult relations with host organisations, over-involvement with clients, disagreements over methodology and objectives, duplication and overlaps with other services, and the lack of an adequate career structure.

In the light of such difficulties, it would seem advisable to allow outreach services enough autonomy to develop working methods that are responsive to the needs and situations they encounter.

A fundamental aim in developing future services for drug users should be to make them more accessible to clients. Outreach work has an important part to play in this process.

Four models of outreach work

INTRODUCTION	72
OUTREACH WORK AND 'NEW' DRUGS	79
A FIFTH MODEL?	80
THE FOUR MODELS IN EUROPE TODAY	81

INTRODUCTION

Outreach work in the field of drug care encompasses a wide range of activities and can vary with regard to:

- *who* – the people that practise outreach work (professionals, indigenous workers, volunteers) and their target groups (users of ‘old’ or ‘new’ drugs);
- *what* – the objectives of outreach workers (abstinence, harm reduction);
- *how* – the methods applied (individual- or community- oriented); and
- *where* – the settings in which these methods are practised (detached, peripatetic or domiciliary).

Based both on the literature and on data obtained from the field, four models of outreach work can be identified, although they are intended purely as typological constructs. Each model has its own ‘who’, ‘what’, ‘how’ and ‘where’. The order in which the models are presented coincides more or less with the chronological periods in which they came into being. The models are the:

- Youth Work Model (1960s);
- Catching Clients Model (1970s);
- Self-help Model (late 1970s to early 1980s); and
- Public Health Model (mid-to-late 1980s).

Not all the models have found practical expression in every EU Member State, nor have they always succeeded one another in the temporal order described. In the field, working practices classifiable according to one model will usually contain characteristics of other models as well.

Youth Work Model

In Europe in the 1960s, youth workers began emerging from their offices and actively seeking contact with ‘problem youth’. Characteristically, the goal they set for themselves was to seek

solutions to problems with the young people concerned instead of deciding behind their desks what they thought best (Hazekamp, 1976). This was closely linked theoretically to concepts such as alternative youth work and radical social work. In the course of the 1960s, such youth workers began to focus increasingly on marginal youth, and especially on those who used drugs (Gilman, 1992).

The Youth Work Model is used mainly by professionals, but also by some former drug users who have undergone specific educational or on-the-job training (generally referred to as mobile or outreach youth workers or street workers). Their target groups are not necessarily defined as drug users, but often by other terms such as homeless youth or underprivileged youth. Nor is drug use as such the primary focus; instead, it is regarded as one of the problems of marginalised young people, and the aim is to prevent any further marginalisation and to encourage social integration. The approach is usually detached outreach work, and involves making contact with marginalised youth, including drug users, in their 'natural environments' (e.g., neighbourhoods with high unemployment rates, railway stations), encouraging them to make use of their 'natural networks' (e.g., relatives, neighbours), and guiding them in their contacts with traditional institutions (e.g., probation services). Much attention is devoted to education, job training and leisure activities. The latter activities are clearly linked to the so-called *Erlebnispädagogik*, in which youth workers spend a few weeks sailing, mountain climbing and so on with target groups.

Today, the Youth Work Model is frequently found in Austria and the Nordic countries as well as in France, Germany and Portugal. A good example can be found in Turku, in Finland (see also Chapter 7). Here, groups of volunteers mainly perform outreach work at youth festivals. Many youth workers also like to call themselves outreach workers since they work on the streets, talking and listening to young people with social problems. Some workers have special training, but many have not and often work with no supervision.

In Austria, the Youth Work Model predominates, and the majority of outreach workers are youth workers who organise a variety of activities like mountain-climbing expeditions. Youth workers are not oriented specifically to drug users, and when they do deal with

drug use their primary emphasis is on prevention. There are regional variations, however. In Vienna, some youth workers work specifically with drug users, mainly on an individual basis, and 'drug workers' also perform some outreach work, particularly in the more visible 'street scene'. In the latter case, this proceeds more according to the Public Health Model than the Youth Work Model.

In France, street workers (*éducateurs de rue*) first appeared in the 1970s and worked with young people in neighbourhoods with social problems. Although they were indeed confronted with drug users, they often tried to steer clear of the drug problem. Youth street work still exists today as a regional task, and as far as drugs are concerned concentrates on prevention. Specific work with drug users, including outreach, is a national-level responsibility (see Chapter 7). In practice, specific outreach work among drug users is informed largely by the Public Health Model.

In Germany, two concepts, originating from different traditions, are central to outreach work (Fontana, 1997). Mobile youth work (*mobile Jugendarbeit*) evolved in the youth-work system in south-western Germany (Stuttgart area), inspired by a study visit to the US in the late 1960s. It was community-oriented, targeting specific groups as a whole. What was to become known as 'street work' (*Straßensozialarbeit*) emerged in the early 1970s with the onset of the 'drug problem'. Street work was more individually- than community-oriented and focused more specifically on drugs. Theoretical debates and conflicts occurred between the followers of these two approaches, but since 1990 they have been united in one national organisation, Bundesarbeitsgemeinschaft Streetwork Mobile Jugendarbeit. The separation between youth work and 'drug work' also derived from their funding structures. Until 1995, youth work confined itself to minors under 18, while drug outreach work dealt with adults. Virtually no outreach projects existed for young drug users. Today, the two areas of focus are more integrated.

In Portugal, outreach work is more similar to community development work than to youth work. Families, the natural network, are contacted first, as some kind of agreement with the family is important for working with young people.

Catching Clients Model

This model originated in therapeutic communities in the early-to-mid-1970s. The original practitioners were predominantly therapists and ex-patients, or professionals and volunteers working in religious organisations. Most could also provide access to residential care institutions. The primary task of this type of outreach worker was, and still is, to direct drug users towards care programmes, and in particular into drug-free, inpatient treatment. Abstinence, followed by social reintegration, is the prime objective. Originally, detached outreach work predominated, but today the work is mainly peripatetic, in places like police stations, prisons and hospitals.

It is important to stress here that other models also furnish information about treatment facilities and refer drug users to them. Many of these programmes, however, methadone provision for example, do not try to achieve immediate abstinence. Even if they refer people to abstinence-oriented programmes, the outreach work does not automatically qualify for the Catching Clients Model. A necessary condition is for drug-free treatment to be the primary aim of the outreach work.

The Catching Clients Model is currently practised most extensively in the Nordic countries, particularly Norway and Sweden, chiefly targeting users of 'old' drugs. Some workers in therapeutic communities also seek out former clients in the drugs scene. On a small scale, the original Catching Clients Model is still practised in Italy and the UK, predominantly by lay groups.

Although outreach work in Greece is generally defined as a harm-reduction activity, in practice it bears a close resemblance to the Catching Clients Model. This is probably due to the developmental phase in which the work currently finds itself. Outreach work is considered important, but drug-care infrastructure is still closely bound to therapeutic communities and most street workers have a therapeutic background.

Self-help Model

Like the original Youth Work Model, the Self-help Model responds to the wishes and possibilities of the drug users themselves. Two major differences are that it focuses much more explicitly on drugs, and that its actions are based more on the perceived interests of the group than on those of the individual. Originating in the late 1970s, it has clear links to the drug users' self-help organisations, as well as to the notion of acceptance – that is, acceptance of drug taking as a social reality – as opposed to the abstinence paradigm. More than any other model, this one is grounded in the drug scene itself, and is practised predominantly by current or former drug users (peers), community workers and volunteers. It aims mainly at harm reduction, organising community-based activities, and setting up or promoting user-friendly facilities, including places where users can take drugs. Nowadays there are few truly independent self-organisations, since most of them have found accommodation in drug-care agencies.

The Self-help Model has its longest tradition in the Netherlands, where so-called *junkiebonden* were active in all the larger cities by 1980. They are less active now. A good current example of outreach work following the Self-help Model is Mainline in Amsterdam. This independent, non-governmental organisation, founded by former employees and volunteers of the Amsterdam *junkiebond*, concentrates primarily on health education for users of 'old' drugs. One of its key instruments is a glossy magazine, distributed to drug users mainly by fieldworkers on the streets, at the premises of drug dealers, or even in institutions like prisons. Whilst handing out the magazines, the fieldworkers gather information about trends in the drug scene, which they then incorporate into the next issue. Mainline also supports women's self-help groups in Amsterdam and Rotterdam (see also Chapter 7).

In Turin, outreach workers have chosen a different approach. They support a group of drug users and help them find money to produce their own magazine, which is also sold to the general public. Only occasionally do outreach workers themselves write

anything in this journal. The magazine is very political, trying to promote the dignity of users and stressing the responsibilities they have in their own lives.

Outreach workers in Brussels have also had satisfying experiences with information provision by drug users to drug users in co-operation with a self-supporting group of former users. At a more general level in Belgium, and increasingly in other countries too, so-called *boule de neige* (snowball) projects are being implemented. These involve relatively brief campaigns promoting safe drug use and safe sex at local or regional levels. Users of 'old' drugs are targeted with the aid of peers (see Chapter 7).

Public Health Model

The Public Health Model is built upon the Self-help Model, the main difference being that it assigns a more important role to professionals (nurses, doctors, fieldworkers). The Public Health Model came into its own in the mid-to-late 1980s, notably under the influence of HIV and AIDS, and later of other diseases such as hepatitis. Its primary aim is harm reduction through safer drug use and safer sex, to be achieved by providing information and distributing syringes and condoms. Staff often work out of low-threshold facilities, such as methadone-maintenance programmes and drop-in centres.

Outreach work according to the Public Health Model is now practised among users of 'old' drugs in all EU Member States. In some it is the predominant model, while in others it is still at an early stage, as, for example, in Ireland.

More recently, outreach work along the lines of the Public Health Model is also being practised among users of 'new' drugs. More than in the case of 'old' drugs, peers are recruited for such initiatives, both for support and for education. Moreover, there is greater emphasis on detached outreach work, mainly at raves or in and around clubs. Guidelines for safer environments (e.g., air-conditioning and 'chill-out' rooms at raves) have also been devel-

oped, and sometimes facilities are provided to test the quality of pills as a form of consumer service.

Still newer is outreach work among crack-cocaine users. In part, this represents an adaptation of outreach work to the changing consumption patterns of veteran heroin users. But some new projects are also targeting young crack users (see the German example in Chapter 7).

TABLE 4:
FOUR MODELS OF OUTREACH WORK AMONG DRUG USERS

MODELS	WHO	WHAT	HOW	WHERE
YOUTH WORK MODEL	Youth workers, street workers	Prevention of any further marginalisation, support for social integration	Contacting marginalised youth, including drug users, helping them make use of 'natural networks' (relatives, neighbours), guiding them in their contacts with traditional institutions (e.g., probation services), education, job training, leisure activities	Mainly detached work in areas where marginalised youths live and 'hang out', e.g., squats, railway stations
CATCHING CLIENTS MODEL	Therapists, (ex-) patients, prevention workers, volunteers, religious groups	Abstinence, social integration	Contacting addicts to motivate them to enter drug-free treatment	Originally detached, today mainly peripatetic work in police stations, prisons, hospitals
SELF-HELP MODEL	Drug users, community workers, volunteers	Harm reduction, user-friendly facilities	Organising community-based activities and facilities, including settings where drug users can take drugs. Stimulating safer drug use and safer sex by providing information and distributing syringes and condoms	Indigenous detached work 'in the scene', particularly in self-organised settings, walk-in centres (e.g., drug users' self-help groups)
PUBLIC HEALTH MODEL	Nurses, doctors, drug workers, field-workers, peers	Harm reduction	Stimulating safer drug use and safer sex by providing information and distributing syringes and condoms. Facilities for testing the quality of ecstasy tablets. Guidelines for safer environments (e.g., air-conditioning and 'chill-out' rooms at 'raves'). Peer support and peer education	Often in low-threshold facilities (e.g., methadone maintenance programmes, drop-in centres), 'raves' and clubs

OUTREACH WORK AND 'NEW' DRUGS

Historically, these four models have predominantly targeted users of 'old' drugs. Outreach projects that target current or potential users of 'new' drugs are, however, more and more in evidence in Europe today. These projects undertake mainly detached outreach work at or near sites like 'raves' and 'techno' parties. Some projects organise events such as 'drug-free raves'. This type of outreach work is performed by youth workers and peers (including current and ex-users). The aims vary from deterring young people at risk from taking drugs (primary prevention), to persuading them to stop using drugs (demand reduction), or at least encouraging safer drug use and safer sex (harm reduction) and, frequently, all three.

One good example is the 'Stop the Drugs, not the Dancing' project in Norway. Its two objectives are to inform 'ravers' about drugs and to make sure that newcomers are aware of the project. The message is 'be a hip raver without drugs' (see Chapter 7 for more details). Conceptually, such projects could be classified by the Catching Clients Model. However, in reality treatment facilities for ecstasy users are practically non-existent: 'you cannot catch clients if you have no treatment to offer'.

When outreach projects emphasise abstinence in approaching current and potential users of 'new' drugs at 'raves' or elsewhere, they should be classified under the Youth Work Model. Other outreach projects for 'new' drugs place more emphasis on harm reduction (safe drug use and safe sex), such as the Unity Project now operative in Amsterdam, Hamburg and Manchester. Peers play a key role in this project too (see Chapter 7). As observed above, most outreach work performed amongst users of 'new' drugs can be categorised under the Public Health Model. Projects that are run predominantly or exclusively by peers or volunteers are perhaps more appropriately classified under the Self-help Model. Organising drug-free 'raves' is not generally seen to qualify as outreach work.

A FIFTH MODEL?

A possible fifth model for outreach work is the Service Network Model. This consists of a network involving youth work, drug care and public health care and focuses not on safe drug use or safe sex, but on rapid help to people in crisis and on the swift resolution of their problems. The aim is not so much to motivate people to change their situation, but to encourage them to use the youth, drug and health care systems. This model should not be confused with networking in the Self-help Model, which aims primarily to mobilise user networks.

Although networking is not a new idea, performing outreach work together on the streets is new. At least some co-operation and networking between different organisations is already necessary, if only because of the diverse sources of funding involved.

On the other hand, it can be argued that networks need a common goal, and that pooling resources from different agencies to combat a common problem may be more effective. To build a network, someone has to take the initiative. Sometimes this will come from the public-health side, sometimes from other officials; this is a general characteristic of drug care, not a fifth model. A general problem is that networking often does not work very well. In practice, co-operation between different disciplines often proves difficult. Networking may be seen more as a method than as a fifth construct and is useful in every kind of model. Changing risk behaviour, for example, is impossible without good networking and education, since risk behaviour depends on factors operating in specific contexts, on cultural aspects and not just on individual behaviour.

Expressed more pragmatically, networking is unavoidable in outreach work. Outreach workers in fact play a crucial role in improving the co-ordination of services. When several organisations join forces to perform or commission outreach work, that does not constitute a fifth outreach model. At the same time,

there is clearly a need, in all four of the existing models, to devote sufficient attention to networking between organisations. Networking is one of the essential characteristics of outreach work, and of any methods yet to be developed.

TABLE 5:
OVERVIEW OF PREDOMINANT MODELS OF
DRUG OUTREACH WORK, BY COUNTRY

COUNTRY	PREDOMINANT MODEL(S)
Austria	Youth Work + Public Health
Belgium	Youth Work + Public Health
Denmark	Youth Work
Finland	Youth Work
France	Public Health + Youth Work
Germany	Public Health + Youth Work
Greece	Catching Clients + Public Health
Ireland	Catching Clients + Public Health
Italy	Public Health + Catching Clients
Luxembourg	Public Health
Netherlands	Public Health + Self-help
Norway	Youth Work + Catching Clients
Portugal	Youth Work
Spain	Public Health
Sweden	Catching Clients + Youth Work
UK	Public Health + Self-help

THE FOUR MODELS IN EUROPE TODAY

These four models are all recognisable to outreach practitioners, even though in practice many projects embody features of more than one model, and few fit perfectly into any one of the four types. Historically speaking, the models emerged one after the other. That does not mean, however, that all models have been practised in every EU Member State, nor that the most recent model – the Public Health Model –

is now predominant in all countries. Although historically the most recent, the Public Health Model is not automatically superior to those developed earlier. Clearly, all four models have their value, depending on the specific target groups and settings.

In countries with longer traditions of outreach work, the first methods proceeded according to the Youth Work Model, sometimes with problem drug users as a specific target group, but more often with a general focus on young people in socially deprived groups. Outreach work targeting drug addicts as such now seldom conforms to the Youth Work Model. However, it is still commonly performed, particularly in Nordic countries, amongst young people who are experimenting with drugs. The Catching Clients Model is no longer common, although it, too, is relatively more prevalent in Nordic countries. The Self-help Model has flourished most productively in the Netherlands, where it can still be encountered, as well as in the United Kingdom.

The Public Health Model is the one most widely practised today, but *de facto* it is less common in Scandinavia and southern Europe. It is the most strongly developed in Germany, the Netherlands and the United Kingdom, although there is clear evidence of its growing acceptance in southern European countries.

Terminology in outreach work

INTRODUCTION 84

DEFINITIONS AND TERMINOLOGY 84

INTRODUCTION

What is drug-related outreach work called in the languages of the EU Member States? Are key concepts in the English language commonly applied in other countries and in what ways? What related terms and concepts are in use? How are the principal activities and methods of outreach workers referred to in other languages and how should they be translated into English?

This chapter draws primarily on documentation of outreach projects in several EU Member States as well as from contributions by participants in the expert meeting held in Amsterdam on 29–31 March 1998. Clearly, it is not possible to give an exhaustive summary of all the concepts and terms used in all European countries and in all the languages spoken in them. Instead, the most important and most common concepts are given here. Although many of these concepts are used in work with other target groups as well, this chapter focuses on the terms used in relation to drug users.

DEFINITIONS AND TERMINOLOGY

In its general meaning, the word 'outreach' refers to the act of reaching out, or the distance to be reached. More pertinent to the field of social welfare, the Collins Dictionary of Social Work defines the term as 'any attempt to take a service to people who need it and who would otherwise probably not use the service' (Thomas and Pierson (eds), 1995). The most commonly used definition in the field of drugs is that of Hartnoll *et al.* (1990) as cited in Chapter 1.

Leaving aside issues relating to theoretical aspects and methodology (should case-centred outreach work focus on the individual or on the group? Do target populations need to be drugs-

specific or not?), a few problems of a more practical nature are inherent in this definition. First, the term 'community' has several meanings; translating it into other languages and using it in the context of other cultures only compounds the confusion. This problem would appear to be solved by replacing 'community-oriented' with 'drug-scene-oriented'. But the term 'drug scene', although very familiar and often used in English, is also not without ambiguity.

Second, the Hartnoll *et al.* (1990) definition is stated in rather negative terms: 'not effectively contacted or reached by existing services and through traditional channels'. This renders the definition more readily applicable to users of 'old' drugs than to users of 'new' drugs. Given the current practice of outreach work in Europe, the following definition (which undoubtedly still leaves room for improvement) may be more appropriate:

Outreach work in the drugs field is a proactive method used by professionals, volunteers or peers to contact drug users. Its aims are to inform them about the risks associated with drug-taking, to support them in reducing or eliminating such risks, and/or to help them improve their physical and psychosocial circumstances through individual or collective means.

Even if this definition is more appropriate than the previous one, the problem of translating it and applying it in an international context remains. Although the term 'outreach work' is also used in international scholarly publications, it is not a common international term in the practical field. Sometimes it is relatively easy to translate into another language, as in the German *aufsuchende Arbeit*. However, the term *Arbeit* ('work') is actually too broad, and in practice it is common to speak of *aufsuchende Sozialarbeit* ('social work'), *aufsuchende Jugendarbeit* ('youth work') or *aufsuchende Drogenarbeit* ('drug work'). To underline the mobility of the workers, the adjective *mobil* is sometimes added to or substituted for the adjective *aufsuchend*: *mobile* or *mobile aufsuchende Sozialarbeit*, *mobile* or *mobile aufsuchende Jugendarbeit*, *mobile* or *mobile aufsuchende Drogenarbeit*.

In other cases, for example in the Netherlands, the word ‘outreach’ is commonly understood by outreach workers, but is rarely used in daily practice, in police documents or publications. Instead, it is more common to speak of *veldwerk* (‘fieldwork’) or *straathoekwerk* (‘street-corner work’), which both basically refer to detached outreach work in the drugs scene. However, these only cover part of what is meant by outreach work.

In still other cases, for example in France, the word ‘outreach’ is not commonly understood by the workers themselves and needs explanation. Perhaps the best translation is *travail de proximité*, but the term is not widely used. Common terms that come closest are *travail de rue* (‘street work’) and the more common, but broader, *travail bas seuil* (‘low-threshold work’).

Related key concepts

The first key concept related to outreach work is street work. Whereas, in everyday English usage, ‘street work’ is sometimes associated with prostitution, the phrase does not have such connotations in other countries, where it is considered to be a neutral reference to outreach work. In essence, street workers make and maintain contact with drug users in street scenes and other ‘natural’ social environments where users congregate. Outreach workers use the term, or literal translations of it, as the most frequent name for the originally US concept of street-corner work; it may be encountered in local and national policy documents as well. The term ‘street-corner work’ is less commonly used in Ireland and the UK, where the concept it refers to is closely associated with the term ‘outreach work’.

Amongst practitioners on the continent, notions such as ‘street work’, ‘street-corner work’ and ‘fieldwork’ appear to be fairly common. The term ‘detached work’ is little known outside Ireland and the UK, and those who perform such work are often called ‘street workers’, ‘street-corner workers’ or ‘fieldworkers’. Sometimes these English words are also common ‘on the work

floor' in other European countries, and in other cases they are translated literally.

Within the same language area there may also be regional differences, for example, between German-speaking countries. In both Austria and Germany, many tend to speak of *Streetwork*, while others use the word *Straßensozialarbeit*. In German-speaking parts of Switzerland, it is more common to speak of *Gassenarbeit*.

A second key concept closely linked to outreach is 'low-threshold', a literal translation of the Dutch concept *laagdrempelig*, meaning that clients have easy access to a service. *Laagdrempelig* has also been literally translated into other languages and has become common usage in countries like France (*bas seuil*), Germany (*niedrigschwellig*) and Italy (*bassa soglia*). It refers to simple, readily accessible facilities for drug users, which put more emphasis on harm reduction than on abstinence, although clients are referred on to detoxification programmes at their request. Low-threshold facilities are also user-friendly, in the sense that they focus primarily on the immediate necessities of drug users and have a minimum of house rules. Facilities provide food and drink, and many also offer hygienic services such as showers and needle exchange. They tend to be located in areas where many drug users live or meet, and include both fixed locations (e.g., drop-in centres) and mobile buses or vans that park in such neighbourhoods for a few hours a day and are usually staffed by social workers and nurses. Some low-threshold facilities also, or primarily, dispense methadone in maintenance programmes.

A third key concept is 'harm reduction'. In most countries, the English term is known on the work floor; sometimes it is also literally translated into the local language. Most outreach work among drug users today is based, explicitly or implicitly, on the philosophy of harm reduction (also called risk reduction). This is largely due to the rise and spread of HIV and AIDS. The disease has brought home to abstinence-oriented drug services that they must also pay attention to the health of drug users who do not wish to take part in detoxification programmes. Harm reduction basically

involves efforts to decrease the risks inherent in using drugs, such as encouraging and creating conditions for safer use and safer sex.

Directly related to this is the fourth key concept, 'needle exchange' or 'syringe exchange'. This is a very common term, both in English and in translation in other countries. It means the provision of new syringes and/or needles, usually free of charge, to intravenous drug users in exchange for their used ones. The practice originated in the Netherlands to prevent people, especially children, from getting infected from dirty needles found in the streets. Nowadays it is practised, at least to some extent, in all EU countries, although the condition of 'exchange' is more strictly upheld in some countries than in others. Needle exchange is not only carried out by outreach workers, but also by methadone-maintenance programmes and at drop-in centres. In some countries (such as Greece), syringe exchange by outreach workers is of less significance, because syringes are readily and cheaply available from pharmacies. The practice of furnishing new syringes and exchanging old ones is not without risk (see Glossary).

A fifth key concept is 'peer', derived from the concept of peer group. 'Peer group' refers to a group of persons of similar rank or standing, for example, youngsters of about the same age who are important to a person's basic orientation and to his or her norms and values (as in the phenomenon of peer-group pressure). More specifically in the outreach context, peers are trained volunteers who belong to the target population themselves (drug users, prostitutes) or previously did (ex-drug users, ex-prostitutes). Peers and peer groups provide 'peer education' and 'peer support projects'. In practice, especially in prevention projects, 'peer' is sometimes used incorrectly for trained volunteers who have never been drug users. 'Peer' has come to be an internationally applied term, reflecting the growing popularity of outreach work in many countries, in particular amongst users of 'new' drugs.

Further examples of terminology can be found in the Glossary at the end of this book.

Documentation, data collection and evaluation

INTRODUCTION	90
DOCUMENTATION	90
DATA COLLECTION	92
EVALUATION	95
TOWARDS A EUROPEAN INFORMATION SYSTEM	103
EDDRA	104
CONCLUSION	105

INTRODUCTION

The project that forms the basis of this volume was initiated as a first step in a more thoroughgoing study of outreach work. One issue for further research is how to improve the evaluation of outreach projects in the EU Member States. This would help to achieve a more systematic and comparable classification of, and information about, outreach work, which could then be included in the EMCDDA's *Annual Report on the State of the Drugs Problem in the European Union* and in its Exchange on Drug Demand Reduction Action (EDDRA) information system. It would also facilitate communication and the dissemination of information among professionals in the field in Europe and improve the quality of outreach practice.

Two interrelated questions are of particular interest here:

- What types of information about outreach work need to be collected and disseminated, and for what purposes?
- How feasible is such a classification at present, and what obstacles have to be resolved?

This chapter looks first at the practices of documentation, data collection and evaluation now being applied in European outreach projects. The information was compiled from a review of the literature, from materials provided by the experts who took part in the March 1998 Amsterdam meeting, and from the discussions at that meeting.

DOCUMENTATION

Most outreach projects are locally based, and most work as extensions of broader drug, youth or health agencies. They document their aims and work activities in varying formats, depending on the audience they are addressing. The reports they produce are often intended for funding agencies,

policy-makers or the project's 'parent' organisation. Such reports may be regular or irregular, and may include background information on the project, general profiles of target groups, overviews of the services delivered, or descriptive quantitative figures.

Some projects also produce, either independently or aided by the parent organisation, information materials for public relations (see, for example, Cranstoun Drug Services, 1997) aimed at wider audiences, such as other services, the community or the broader public. Formats can range from glossy magazines to simpler brochures, depending, of course, on the size of the organisation and the finances available.

Another target audience, and obviously the most important one, is the potential users of the outreach services. All kinds of different materials, such as brochures, leaflets and booklets, are produced providing, in lay language and sometimes even in several of the foreign languages spoken by immigrant target groups, information about the services on offer and where these can be obtained. They often also contain prevention messages.

Many projects distribute various types of materials, either of a general nature or targeting specific subgroups, such as HIV risk groups, sex workers, young people or the local community in which they operate. As with other types of documentation, such materials may take different forms. Outreach practices are subject to continuous change in response to the problems they are targeting, requiring materials with a practical format that can be modified quickly at low cost.

There are few professional journals specifically on outreach work, either in the academic literature or among the general drugs literature. There are, however, differences between countries as to the prominence of outreach work in such domains. Germany, for example, has a specialised journal on outreach work entitled *Streetwork*, which is both practically and theoretically oriented. The monthly magazine of the Dutch organisation Mainline, although specifically targeting drug users themselves, is also widely read by professionals and other interested actors.

DATA COLLECTION

It seems to be common practice among outreach projects to collect at least some basic data about their activities and target groups. The types of information collected largely depend on the requirements of external bodies such as funders or policy-makers, which often ask for quantitative data. All projects are more or less required to keep their funders informed. Notwithstanding the many differences between the projects reported at the Amsterdam meeting, a general pattern of quantitative data types can be distinguished, ranging from a minimum to a maximum version. Which version is used depends on the aims of the project, often on the nature of specific client contacts (initial or follow-up) and on the location where the contact takes place. It also appears that the more an outreach project aims for therapeutic intervention, referral or regular client contacts, the more detailed the information it records. For example, the data collection requirements of the Safe Community Drug Agency in London (Cranstoun Drug Services) are quite extensive. In contrast, the data format of the Uteseksjon in Oslo is much more concise, containing a minimal set of basic questions.

Types of quantitative information

The types of quantitative information collected include:

1. Individual client:

- name of worker;
- place and date of contact;
- general characteristics of client (age, gender, real name or alias, nationality, legal status etc.). Some projects, such as the Viennese Streetwork project, have a special form for clients' relatives on which they can apply for support either for themselves or for the person concerned;
- first ('cold') contact (yes or no);
- services on offer (advice, needles, condoms, referral, mediation);

- drug-behaviour characteristics (type of drugs used, route of ingestion, methadone use, overdose experiences);
 - health characteristics, in particular HIV status; and
 - social circumstances (marital status, children, employment, housing conditions, networks of family and friends, contact address, prison, court or arrest experiences).
2. Aggregated client data, often classified according to specific target groups.
 3. Individual and aggregated employee data for the outreach project.
 4. Material data for funding bodies or the parent organisation:
 - numbers of syringes and condoms supplied, etc.

There are two general ways of collecting these data, which are sometimes applied simultaneously: via a questionnaire or checklist that is completed on the spot; or recorded by the worker retrospectively, based on answers to specific questions or on guesswork. Most common is the regular monitoring of contacts through retrospective 'contact sheets' (Rhodes *et al.*, 1991b). More precise details about how data are recorded and how they are used would also be useful for future analysis and the development of evaluation practices. There are many examples of standardised data files to be filled in by hand, but it is not always known how these are processed afterwards. The Norwegian Uteseksjon enters them directly into a computerised system.

As indicated above, data collection is currently viewed by many workers as far from ideal. In theory, no one would disagree that the foremost aim of data collection should be to improve the services being delivered, in the interest of both the clients and the internal organisation. Nor would anyone oppose data collection for quality control and accountability to funding bodies. Clearly, the types of data collected should be consistent with the aims and needs of the outreach project itself. But such ideals are not always met in practice. Data collection may be influenced by internal and

external actors, whose aims and needs may differ from those of the outreach project. This is especially likely given the unique nature of outreach work. Despite the diversity of outreach projects, one general tendency is clear: funders demand quantitative, descriptive data, while outreach workers themselves are more interested in qualitative data that could help them improve their work.

Most detached outreach contacts are brief, and the information obtained on clients is therefore limited. Establishing the contact and providing health education have top priority, and gathering data for research and evaluation purposes is of secondary concern. Given the nature of contacts on the streets or (in the case of 'new' drugs) at parties or 'raves', it is obviously not easy to note down all sorts of quantitative data, and doing so could even interfere with the principal outreach tasks. Clients may be wary of the questioning, especially in repressive atmospheres or illegal situations, or they may not be in the right state of mind. Any data-gathering instruments should therefore be as 'casually unobtrusive' as possible (see also Richard *et al.*, 1996). Such instruments need to be publicly verifiable, in order to forestall suspicion, rumour and hostile responses. They need to be general and analytic, so as not to raise suspicions about how the information could be used. They also need to be unobtrusive, so that the measurement process itself will not influence behaviours or answers.

Some workers see no problems in asking questions as such, but are dissatisfied with the types of questions asked, which they do not perceive as useful. Figures alone give a very limited view of what is going on. Moreover, since most information is based on client self-reports, the potential unreliability of the answers must be taken into account, arising from factors such as social desirability (see, for example, the Turin survey results referred to in Chapter 7).

The purpose of asking questions about the outreach project itself is not always clear to the outreach workers. Some workers are reluctant to collect data that might later be used against the project.

Many outreach workers would like to have more time available to collect and reflect on other types of data they believe would be of

use. Many projects work with diaries or systematised field observations in which daily practice is recorded in a more qualitative light. Some projects allow the clients themselves to volunteer qualitative information on their experiences, for example in a 'guest book' in a drop-in centre.

Some projects are funded by two or more agencies, which further complicates the issue by requiring different types of data collection and presentation.

In some cases, data collection is demanded, but nothing is done with the information; it seems merely a bureaucratic rule.

As noted above, some general characteristics of data collection are common to most outreach projects, but the indicators and time frames applied vary widely. In a word, no standardised guidelines exist, not even locally or regionally, much less at national or European level.

EVALUATION

Data collection is closely related to the issue of evaluating outreach services. However, figures on the characteristics of a client population are not a sufficient basis for evaluating a programme. Although such data may be useful for describing outreach practice, they are not automatically suitable for a systematised evaluation procedure. Other forms of data, such as information on contacts and referrals as described above, may be an important first step towards evaluation (Thompson and Jones 1990; Richard *et al.*, 1996). In very general terms, 'evaluation' refers to any activities that assess the impact of outreach interventions.

The need for evaluation is recognised, although perhaps with very different motives, at various levels, from individual outreach projects to regional, national or European bodies. This obviously applies not just to outreach work, but also to any type of preventive endeavour relating to drugs or HIV. As with data collection, one of

the main obstacles to outreach evaluation lies in establishing what objectives it will serve and what method(s) will be suitable for carrying it out.

Three types of project evaluation can be distinguished (Armstrong and Grace, 1994):

- structural evaluation;
- process evaluation; and
- outcome evaluation.

Structural evaluation focuses on the concrete framework of service delivery, including buildings, equipment, staff and record-keeping. In Germany, for example, quality characteristics, quality standards (Schaffranek, 1996) and quality control receive a good deal of attention in outreach projects (Krebs, 1997).

Process evaluation analyses the work process in relation to its results in order to clarify the reasons for particular outcomes. It analyses the context in which interventions occur and the personal, professional and institutional factors that shape and constrain the outreach intervention.

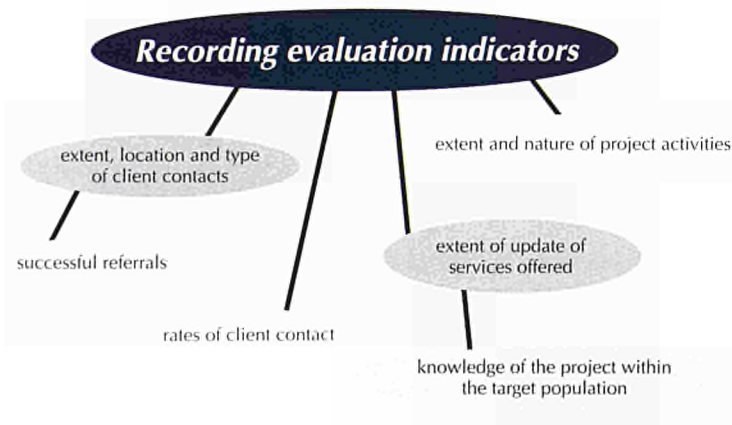
Outcome evaluation is the most difficult type of evaluation, and it is here that evaluation and research often meet, overlap and interrelate. Outcome evaluation measures the results associated with a given outreach intervention, employing cognitive, attitudinal or behavioural measures, and requires the intervention to be clearly delineated and measurable. Generally speaking, outcome evaluations are concerned with distinguishing between the intended or positive consequences of an intervention and its less intended consequences, either negative or positive (Eisner 1979; Rhodes *et al.*, 1991b). Rossi (1978) cites several interrelated questions that should be considered when evaluating an intervention, including:

- whether the treatment is effective;
- whether the treatment can be delivered; and
- whether the treatment is being delivered.

Outcome evaluation, as strictly defined, would be very difficult indeed to perform in outreach work. The scholarly literature confirms that this form of evaluation of outreach interventions is difficult in terms of both design and application. It usually demands considerable resources, and most outreach projects lack the funds and capabilities to conduct it. In addition, a whole series of practical and methodological difficulties present themselves. When it comes to influencing behaviours and reducing the spread of HIV infection, any one geographical area may be exposed to any number of programmes and public-information campaigns. It would be quite unrealistic to conduct an outcome evaluation that tried to assign total responsibility for any changes to one particular programme (Thompson and Jones, 1990).

Process evaluation seems a more realistic option. Carried out in an appropriate manner, process evaluations that combine qualitative and quantitative data could be effective in developing outcome indicators. One possible framework for the process evaluation of outreach work is given in Figure 5.

FIGURE 5: PROCESS EVALUATION INDICATORS



Source: Ian Grant, Centre for HIV/AIDS and Drug Studies (CHADS), Edinburgh

Three general factors may also prompt the evaluation of outreach work:

- evaluation commissioned by external agencies, such as funders or policy-makers;
- evaluation for internal purposes, serving the needs of the organisation itself; and
- evaluation for research purposes, possibly in combination with the first or second points above.

Who is to carry out the evaluation is also an important question – the outreach organisation itself, representatives of the funding body or an independent organisation?

Although not necessarily antithetical to one another, these different motives may require different evaluation procedures and methods. The evaluations may also often serve entirely different purposes:

- funders might use an evaluation to decide about future funding (or to obtain general information about target groups);
- internal evaluations are often motivated by improving service delivery (in relation to either the clients or the working conditions of outreach workers); and
- evaluations with a research motive may serve both purposes, but not by definition.

Independent of the choice of outcome or process evaluation, and whatever the motive for the evaluation, certain decisions should ideally be made, entailing action at different levels:

- What topics will be included in the evaluation and why?
- What methods will be applied?
- What standards should be conformed to?
- How will the outcomes be compared to these standards?
- How will the results be interpreted and used?

Evaluating outreach projects according to such guidelines is still not common practice in Europe. Most of the documents available, however, are either project reports (often internal ones), which evidently are not evaluations in the senses described above, or

policy documents on health care or other issues containing some comments about outreach. Some are even books or articles that merely describe evaluation models. As suggested above, outreach workers tend to collect quantitative data mostly of a descriptive nature, usually for funders and policy-makers.

On closer inspection, it nonetheless emerges that some kind of 'evaluative' work is normally undertaken for internal purposes. Although this does not entirely conform to the prescriptions for outcome or process evaluation, it does resemble process evaluation in many ways. An obvious question is whether formal evaluation is really necessary, given the special nature of outreach work. The outreach workers themselves, however, tend to see the characteristics of process evaluation as potentially very useful. They apply various kinds of qualitative instruments – such as diaries, logbooks, goal-setting procedures and group meetings – to help them reflect on their working practices. They may also use quantitative instruments to keep track of developments in their target groups or to spot other trends (as the Uteseksjon does in Oslo). The transient nature of many contacts and of some sub-populations also makes the formalised methods of random and follow-up evaluation inappropriate.

Outreach workers appear to feel a more pressing need to establish minimum standards or guidelines for outreach teams. Examples of such standards, designed within outreach projects, include:

- The focus should be on teamwork rather than on workers operating individually.
- Teams should include both female and male workers.
- Data about individual clients should not be passed on to the police.
- Teams should include both professionals and volunteers.
- Office facilities should be provided for workers.
- Outreach workers should preferably walk the streets in pairs.

There is a small but growing body of literature on the effectiveness of outreach work. Most of it is US in origin and predominantly concerns itself with the evaluation of HIV outreach interventions. Rhodes *et al.* (1991a) compiled a comprehensive summary of

evaluation findings, which covers the aims, methods, results and conclusions of studies of 8–12 HIV outreach projects in the US. These included:

- the National Institute on Drug Abuse (NIDA) Chicago AIDS Community Outreach Intervention Project;
- the San Francisco Mid-City Project (Watters 1988);
- the New Jersey Community AIDS Program;
- the New York AIDS Outreach Program (Sufian *et al.*, 1989); and
- the Street Outreach AIDS Prevention Project in Baltimore (McAuliffe *et al.*, 1986).

It should be noted that most of these projects are officially ‘research experiments’ which have enabled politically sensitive interventions to be carried out that would otherwise have not been allowed. By definition, research experiments require evaluation, and in Europe such approaches are highly uncommon.

Published literature on the evaluation of European outreach work varies with the type of intervention. Syringe-exchange programmes have been documented relatively well. A nation-wide evaluation of UK syringe-exchange programmes has shown that they are fairly successful at reaching drug injectors and that they facilitate positive behavioural changes among long-term attendees. However, many harder-to-reach and more vulnerable drug injectors have still not been contacted (Stimson *et al.*, 1988; Lart and Stimson, 1990). Evaluations of syringe exchanges in Amsterdam (Buning *et al.*, 1988) and Rotterdam (Grund *et al.*, 1992) have also found less needle-sharing among exchange attendees, with a doubling of the number of drug users entering treatment and rehabilitation programmes.

The more generic outreach interventions in Europe are less likely to have been evaluated. The evaluation of the Central London Action on Street Health (CLASH) outreach project was one of the first HIV outreach interventions to be evaluated in the United Kingdom (Rhodes and Holland, 1992). The evaluation was undertaken as part of a larger research project investigating outreach interventions as a means of preventing HIV infection. The evaluation

combined qualitative and quantitative methods and had three major objectives:

- to describe project development and functioning;
- to monitor project performance and the attainment of objectives; and
- to assess the feasibility and effectiveness of the project as a model of outreaching HIV health education.

The process component of the CLASH evaluation provided an in-depth description of the project's feasibility and effectiveness in management and organisation, as well as in service delivery and working practice (Rhodes and Holland, 1992). In 1996–97, the Centre for HIV/AIDS and Drug Studies (CHADS) in Edinburgh evaluated three projects with major commitments to outreach work, which operate in different but compatible ways (Grant, 1997). This evaluation drew heavily on the CLASH study and focused more on process than on outcome.

Other evaluations have been carried out on minimal outreach interventions that contact large numbers of people, on outreach casework with small numbers of polydrug users, and on outreach training and facilitation in rural settings. Evaluations are increasingly being implemented in the Netherlands and the UK, but less so in other parts of Europe. A process evaluation of a standard peer-education outreach project in schools was recently conducted in Barcelona (Villalbi, 1997).

The monitoring and evaluation frameworks employed by the outreach projects just cited vary widely. Process evaluation currently appears the most feasible type of evaluation for outreach work. The collection and interpretation of quantitative data can be enhanced by qualitative methods of observation and by systematic assessment of the context of service delivery and the observed relationship between programme context and expected outcomes (Booth and Koester, 1996).

Qualitative research methods, which include direct observations and open-ended interviews with outreach workers and clients, can

help answer questions on the success of an outreach intervention in meeting its aims, objectives and strategies. Qualitative methods have the advantage of placing the interventions in the personal, social, political and economic contexts in which they occur, and can help to identify conditions and circumstances that influence the intervention's delivery (Booth and Koester, 1996). These approaches thus not only provide the contextual information for concomitant outcome measures, but are also invaluable for describing the intricate processes involved in giving and receiving health-education messages (Rhodes *et al.*, 1991b).

Rhodes *et al.* (1991b) have suggested a set of intermediate outcome indicators, arguing that the efficacy of an outreach intervention can be measured by the extent to which target populations adopt and sustain risk-reduction practices. If such information is not available, then more immediate measures, such as cognitive or attitudinal outcomes, can be found, although these alone will be insufficient to verify behavioural change. A further measure can be the extent to which target populations were reached. However, the authors acknowledge that this information may also be limited, since the proportions of the target populations contacted may be small. Comparison across outreach projects must also be undertaken with caution, given the local, regional and national diversity of target populations, and of the HIV transmission behaviour occurring among them (Rhodes *et al.*, 1991b).

The design of an evaluation should be tailored to service needs and developments, and should ideally combine qualitative and quantitative methods and incorporate process and outcome measures (see Rhodes *et al.*, 1991b; and the evaluation of the CLASH project in Rhodes and Holland, 1992). Evaluations are most useful when integrated into the overall project design from the outset, in collaboration with outreach workers and managers. Action-oriented research should inform a continuous process of review and implementation of the intervention. Time-trend analysis for the evaluation of community prevention programmes lacking experimental design has both strengths and weaknesses. Qualitative material, while hard to measure, is essential to the success of any outreach project. Because outreach activities are

supposed to occur before individuals receive the goods or services offered by an organisation, evaluations generally do not measure the amount of outreach contact. However, when an organisation encounters resistance from a population of potential consumers, outreach and programme-intervention activities tend to overlap. Richard *et al.* (1996) argue that outreach workers are part of the intervention continuum and have significant effects not only on recruitment, but also on the service delivery itself. Evaluation and measurement issues raised by pre-enrolment outreach contacts can best be addressed by improving quantitative pre-enrolment data collection.

TOWARDS A EUROPEAN INFORMATION SYSTEM

The European Union, and specifically the EMCDDA, recognises the need for evaluative information on drug interventions and programmes, including outreach work, and for sharing information about the efficiency and efficacy of outreach projects. The 'First European Conference on the Evaluation of Drug Prevention', held in Lisbon in March 1997, concluded that standardised instruments should be developed to carry out such evaluations, and that the reliability and validity of such tools are the keys to sound results (EMCDDA, 1998). Outreach work was also discussed at this meeting, specifically in the context of synthetic drugs and peer-oriented youth work (Lewis, personal communication).

The fact that evaluation instruments are often invented *ad hoc* for specific studies makes comparison across projects very difficult. The European Instrument Bank set up by the EMCDDA is meant to help funders, researchers and service providers to address these difficulties. The intimate relationship between epidemiological research and many HIV- and drug-prevention activities has already resulted in some close partnerships, some of which have existed since the mid-1980s. The rapidity of intervention often required of outreach projects leaves them with insufficient time in some cases to establish appropriate outcomes and indicators. The Lisbon

conference emphasised the need to involve all actors in the evaluation of community interventions. Doing so may require continuous negotiation to define goals and processes, but it is almost always necessary in community outreach work.

EDDRA

The EMCDDA, by way of its EDDRA questionnaire, systematically collects information on a broad range of demand-reduction activities in Europe for inclusion in the EDDRA database. The questionnaire is subdivided into eight sections:

- identification;
- background and objectives;
- main characteristics;
- programme evaluation;
- results of the evaluation;
- budget;
- abstract; and
- outputs.

For projects applying for inclusion in the database, some questionnaire sections are mandatory and others are optional. Both quantitative and more qualitative information is recorded.

The full questionnaire is available on the Internet via the EMCDDA web site at <http://www.emcdda.org/>.

CONCLUSION

The EDDRA questionnaire does not include questions on a systematised inventory of outreach projects at national level within Member States and it has emerged that National Focal Points do not necessarily have any such overview of outreach projects in their countries. A further difficulty is that outreach activities have different degrees of importance within organisations: they may be the main focus of a project; a supplementary activity within a wide-ranging service organisation; or an integral part of a more specific service, such as a low-threshold service. Charting existing outreach services could be an important task for the Focal Points in each Member State.

In exploring the acquisition of quantitative and qualitative information on outreach work at European level, the first question would deal with the current practice of outreach work – how outreach projects actually document their activities, what kinds of data they currently collect (if any) and for what purpose. If they perform evaluations, what methods do they apply? In addition, the potential and limitations of the different actors involved in data collection and evaluation should be assessed, including the outreach service as an entity, the individual workers, the target groups, the funders and the relevant policy-makers. Some of these issues are generic – that is, other types of services must also address the growing need for data collection and evaluation in their efforts to monitor the efficiency and effectiveness of their service delivery. However, as has been seen in the foregoing chapters, outreach work is also characterised by a uniquely autonomous practice, and it is from this particular angle that the data collection and evaluation should be approached.

The EMCDDA has established a growing practice of information collection on the prevalence and treatment of drug use, even if the types of information being gathered are still rather quantitative. Although the general framework of the EDDRA questionnaire could be taken as a point of departure, it should be borne in mind that

outreach projects in many countries are still in an exploratory phase. At the level of the National Focal Points, no system has yet been developed for collecting data about outreach projects. Compiling such information on a European scale at this point would require a formidable practical and methodological conversion operation.

An important issue is whether outreach work lends itself to producing the types of information the EMCDDA is looking for. Even if this is the case, the crucial question is inevitably whether these are the types of information most needed and desired by the outreach community itself at present. These questions clearly warrant serious reflection. The findings of the study that informs this book make it clear that outreach workers feel an immense need for information and a forum for exchanging experiences. However, this need is clearly related to improvements in working methods, guidelines, data-collection methods, training and co-operation between different types of workers and agencies, which are probably greater than the need for factual information. Systematic evaluation of outreach projects is still at an early stage in most countries, but not simply because of a lack of awareness or knowledge. It also derives from the specific nature of outreach work, its relationship to other services, its inadequate funding and the political and social contexts in which it has to manoeuvre.

Country overviews and examples of good practice

INTRODUCTION

108

INTRODUCTION

The following national overviews are not equally comprehensive for each EU Member State. Most are based on interviews with key informants, but where this was not feasible they are derived from surveys. Others were written by experts from the country itself. Each overview begins with a summary of the principal characteristics of outreach work at the national level. The countries are presented in alphabetical order.

Austria

- 1 *policy status*: important
- 2 *geographical diffusion*: in most cities with an acknowledged drug problem
- 3 *target groups*: users of 'old' drugs (HIV and other harm reduction); users of 'new' drugs (currently developing)
- 4 *methods*: detached and peripatetic
- 5 *institutionalisation*: structural

OVERVIEW

Outreach work, or *Streetwork*, has a long tradition in Austria, specifically in the field of drugs (Hacker and David, 1996). It first became evident in Vienna in 1979, and is inspired mainly by the Youth Work Model and by *Erlebnispädagogik* (Rinnerbaner, 1995).

Outreach work plays an important role in Austria's national drugs policy. Although such work is not explicitly mentioned in national drug-policy documents, several drug plans exist at federal level in the Länder. There is a trend towards regionalisation, and where health care is concerned the drugs field is already decentralised (ÖBIG, 1997). Reports focusing on health rather than on law

enforcement are submitted annually to the federal Ministry of Labour, Health and Social Affairs and to the EMCDDA.

Currently there are outreach projects in most cities with acknowledged drug problems, including Graz, Innsbruck, Salzburg and Vienna, with the specific aim of contacting hidden populations of drug users. Referral to and contact with other services is an important aspect of this work (ÖBIG, 1997).

Outreach activities are undergoing further development and new areas are being established. In 1995, for example, such activities were extended after an increase in drug overdoses. Vienna's CONTACT organisation contacts drug users who have overdosed, and so far the users seem willing to accept this service. They are referred on to various other drug services and can also get in touch with CONTACT again on their own initiative.

The main target group of outreach activities are users of 'old' drugs. They are regularly contacted from both HIV-prevention and other harm-reduction perspectives. Various initiatives aimed at users of 'new' drugs are also now being developed, such as 'No Drugs' (1996) in the federal state of Vorarlberg, and peer leaders are recruited to spread preventive messages ('music is enough for a real raver'). In 1996, outreach activities were also aimed at marginalised youth.

Local governments were the first to promote outreach work in Austria. No single model, theory or prime source of inspiration is considered predominant, but the detached method is applied most frequently, and the peripatetic method occasionally. Outreach services are commonly provided by drug agencies, youth work organisations and social care agencies (mostly NGOs), and most obtain funding on a structural rather than *ad hoc* basis.

Funding is generally from the regional level directly to agencies and projects, but direct local-level funding to agencies also exists. National-level funding is rare.

EXAMPLE OF GOOD PRACTICE: *STREETWORK WIEN*

Setting

Streetwork Wien is part of the Verein Wiener Sozialprojekte, a non-profit, government-subsidised organisation founded in 1990. In addition to outreach work, it includes a counselling centre, a mobile bus with needle-exchange facilities and a drop-in centre. The outreach work is conducted by 13 workers, all of them professional social workers. A doctor can also be visited anonymously and free of charge.

Methods

Outreach workers visit the areas where drug users congregate, according to a monthly plan. Approximately 50 users are contacted monthly. Examples of locations visited by outreach workers are:

- Karlsplatz (an underground station in the heart of Vienna), home to the oldest and most enduring drugs scene where some 20–50 people ‘hang out’. The drugs used are predominantly pharmaceuticals, but users can be infected by heating and filtering them.
- Westbahnhof (West Station), a scene that is smaller than at Karlsplatz and frequently shifts location. The drugs used are heroin and cocaine, both consumed intravenously.

Outreach workers carry an ‘outreach backpack’ containing an artificial respiration bag, first-aid gear, examination gloves, mobile phone, condoms, information materials, a directory of social welfare institutions and needles for exchange.

Special projects

Since autumn 1996, special projects have been targeting male and female prostitutes. Male prostitutes are contacted at public lavatories in the transport system and at gay hangouts, and female prostitutes are contacted at their known places of work. Condoms and safe sex information are handed out, and protection against violence is a major issue.

Another new target group is the alternative youth scene – not specifically a drug scene, but one where young people, including

many second-generation ethnic-minority youngsters meet. When outreach work in this scene began in 1996 there were up to 200 people targeted, but in 1998 this had dropped to about 50. Outreach work in this context mainly involves talking with groups of young people, and the work is very different from that in the 'real' drug scenes.

One further new project tests ecstasy tablets and provides information about the risks of ecstasy use about twice a year at major 'rave' events.

Funding

The project receives government funding and has an annual budget of approximately Euro 17,380.

Belgium

French-speaking Community

- 1 *policy status*: developing
- 2 *geographical diffusion*: in all cities with an acknowledged drug problem
- 3 *target groups*: users of 'old' drugs and users of 'new' drugs (demand and harm reduction)
- 4 *methods*: detached and peripatetic
- 5 *institutionalisation*: structural

Flemish-speaking Community

- 1 *policy status*: developing
- 2 *geographical diffusion*: in all cities with an acknowledged drug problem
- 3 *target groups*: users of 'old' drugs (HIV and other harm reduction)
- 4 *methods*: detached
- 5 *institutionalisation*: experimental

OVERVIEW

In the mid-1970s, a new legal framework was created in Belgium for social work and prevention activities, with voluntary organisations assigned a prominent role. Funds were made available to develop social work methods, particularly for youth work. At the same time, street work among young people with social problems was extended to the realm of primary prevention. A law to combat substance abuse and provide care was adopted in 1975, and the voluntary sector absorbed this type of intervention into its core activities. This method of intervention was also influenced by alternative policies being pursued in the Netherlands.

A radical change in the way the authorities operated occurred in the 1980s with a new emphasis on local-level activities. The sectoral, top-down approach was replaced by one stressing horizontality and participation. A new approach was instituted at municipal level, leading to a reappraisal of the relationship between private and public forms of intervention, and the decentralisation was accompanied by a substantial reduction in funding. This political mode of operation resulted in the first 'public-safety covenants' (*veiligheidscontracten*, *convenants de sécurité*). Towards the end of the decade, under the influence of the AIDS epidemic, several risk-reduction projects were launched in the voluntary sector on an experimental basis (Jacques and Goosdeel, 1990).

With the implementation of the 'public-safety covenants', social problems were analysed in terms of their law-and-order aspects in an attempt to reduce the general feeling of insecurity, to protect ordinary citizens and to restore their faith in the authorities. The Brussels riots of 1991 and the increase in the extreme-right vote in parliamentary elections greatly influenced these changes in attitude. Local-level intervention and the philosophy of covenants resurfaced as public-safety covenants were implemented in those urban areas that applied for them.

By 1992, 'public-safety covenants' were being implemented experimentally. These covenants have two components: one involves reorganising the policing approach; the other entails

creating preventive measures. The aim is to decompartmentalise the various levels of action and to pursue cross-sector policies to reduce health risks and drug crime. The whole is co-ordinated by the person responsible for prevention at municipal level, who also formulates policy proposals on security-related issues.

This new policy met with growing success and was implemented throughout the country – though in most cases without participation by those working at grassroots level. This resulted in a weakening of the voluntary sector and new prominence for a law-and-order type of network. At the same time, social work was redefined, making care for substance abuse a shared task of the federal government (Social Affairs and Interior Ministries) and the regions (Wallonia, Flanders and Brussels), which are responsible for rehabilitation and the secondary and tertiary levels of prevention. The Communities (French- and Flemish-speaking) are charged with primary prevention.

Substance abuse, with its links to petty crime and feelings of insecurity, fast became a major issue in Belgium. In 1995, an addiction and drugs policy package was launched. Local authorities already operating a safety covenant were directed to set up new substance-abuse-related schemes, consisting specifically of shelters designed to reach the most marginalised drug users, and ‘transit centres’ to strengthen the link between the judicial authorities and the social and medical care providers. Once the objectives had been defined and substantial funds made available, a street-level (‘proximity’) approach to drug users focusing on risk reduction could be implemented.

Parallel with, and independent of, these developments, the voluntary sector was taking innovative steps in street-level (‘proximity’) work, notably the ‘snowball’ (*boule de neige*) schemes set up as early as 1989. The idea was to stimulate peer-based prevention by educating drug users in health and self-preservation. They were then to pass on the message to fellow drug users who could not otherwise be reached. In 1994, needle exchanges were opened. Other initiatives were taken at music festivals or large dance clubs. Casualty departments, chemist’s shops and ‘snowball’

schemes were all used to distribute information to drug users, and methadone-substitution schemes were also initiated.

Because they were branded as an instrument of law and order and control, the implementation of safety covenants has helped create a rift in the substance-abuse care field, and more generally in that of social work itself. By encroaching on the traditional voluntary sector's field of action, the law-and-order approach has created competition between actors, with public health and police officials sharing the same turf and ostensibly pursuing the same policies. Actors in the voluntary sector experience increasing difficulties in safeguarding drug users' rights, in a context of tightening controls over their activities.

EXAMPLE OF GOOD PRACTICE: *BOULE DE NEIGE*

Setting

In 1989, the Harm Reduction Agency for the French Community of Belgium set up the *Boule de Neige* project in Brussels, Charleroi and Liège, and similar projects are now being started in about ten municipalities each year. The project is an official public-health programme, and is funded by the French Community in Belgium. In September 1997, it was expanded into a European network with support from the European Commission. The project identifies and contacts injecting drug users to increase their health awareness, to give them a range of alternatives to high-risk behaviour and to reinforce risk-reduction measures.

Boule de Neige has about seven professional outreach workers on part-time secondment. These professionals then recruit and train about 150 current or former drug users to contact their peers and relay information. These former users are paid for their job and are called *jobistes*, as French-speaking Belgians commonly call work-placement students. The *jobistes* make a total of about 1,000 contacts in the field.

Methods

The professional workers are recruited first, which takes about six months. They then recruit the *jobistes* (2–4 months) and give them

4–6 training sessions. The peers then go out into the field and hand out information, materials and a questionnaire (1 month). An evaluation is made, data are analysed and a new campaign begins. The peers are invited to bring in candidates for the next operation. Drug users are actively recruited to help develop educational materials like the comic strip *Info un tox*.

Although the questionnaire yields information on the target group, this is not the main objective, which is instead to reach people and to encourage an exchange of knowledge between drug users and the street workers. Some advantages of working with peers are:

- they establish relations more easily with target groups;
- they increase the project's legitimacy in the eyes of the users;
- they can access difficult-to-reach populations; and
- they provide an opportunity for professionals and former users to exchange knowledge and experiences.

Special projects

Since its inception, *Boule de Neige* has conducted more than 90 campaigns in Belgium, all launched in co-operation with a low-threshold organisation. Some spontaneous initiatives evolving from the project include stands at rock concerts, producing leaflets, creating working groups and contacts with pharmacists and general practitioners.

This 'participant prevention' method has proved a unique and outstanding way to learn from users what factors make it easier (or more difficult) to avoid risk-taking behaviours. In this way, *Boule de Neige* has planned and published leaflets in co-operation with drug users, and set up programmes like needle exchanges, prevention programmes in prisons, needle exchanges, 'bad trip rooms' and ecstasy testing.

Funding

The project receives annual funding in accordance with an annual funding convention with the French Community. Its annual budget is approximately Euro 40,000.

Denmark

- 1 *policy status*: important and developing
- 2 *geographical diffusion*: most cities with an acknowledged drug problem
- 3 *target groups*: users of 'new' drugs (demand reduction)
- 4 *methods*: detached and domiciliary
- 5 *institutionalisation*: structural within general services

OVERVIEW

Although outreach work is becoming an important concept in Denmark's national drugs policy, it is still at a developmental stage and is not mentioned in national drug-policy documents.

Local agencies, local governments and NGOs were the first to stimulate outreach work in Denmark, although no one model or theory has greatly influenced its development. However, the Centre for Misuse in Esbjerg and Steen Bach were key sources of inspiration for outreach work.

Nationally defined aims for outreach work include:

- identifying and contacting hard-to-reach populations;
- improving access and service uptake; and
- promoting adequate services and ensuring the accurate targeting of prevention and demand-reduction initiatives.

There are outreach projects in most cities with an acknowledged drug problem targeting mainly users of 'new' drugs from a demand-reduction perspective. Users of 'old' drugs in Denmark are rarely targeted by outreach activities.

Detached and domiciliary outreach methods are frequently applied, while peripatetic methods are rarely used. Outreach services are commonly delivered by drug agencies, health

agencies and youth work institutions, and are of a structural, established nature.

Many funding models exist for outreach work in Denmark, and it is directly and indirectly financed at national, regional and local level. The most common route is direct state funding to agencies and projects, followed by state funding to these projects through a regional-level body. Both governmental agencies and NGOs receive funding for outreach services. Some outreach services have been evaluated, but no documentation is available.

Finland

- 1 *policy status*: developing
- 2 *geographical diffusion*: in some cities
- 3 *target groups*: users of 'new' drugs (demand reduction)
- 4 *methods*: detached, experimental
- 5 *institutionalisation*: incorporated into health, youth and social-care organisations

OVERVIEW

Local agencies and NGOs were the first to stimulate outreach work in Finland. Gunnel Eribom (A-Clinic Foundation) is recognised as an important source of inspiration. No particular models or theories have had a great historical influence on the evolution of outreach work in Finland.

Outreach work does not yet have a firm place in national policy in Finland, although it has been mentioned in several national drug-policy documents, including the 1997 Proposal for a National Drug Strategy (under the designation 'early problem detection and early intervention') and in the 1993 National Project to Prevent Substance Abuse among Youth (in which outreach work is referred to mainly as 'professional' outreach work).

Defined national-level aims include:

- promoting adequate services;
- accurately targeting prevention and demand-reduction initiatives; and
- developing methods for contacting hard-to-reach populations (primarily to prevent infectious diseases and to develop early intervention methods).

Although Finnish drug abuse is much lower than in many other countries – with alcohol still the most attractive drug, even among young people – the desire to experiment with drugs is growing.

Outreach projects can be found in some cities with acknowledged drug problems, although most projects are still at the experimental stage. To date, the target groups occasionally contacted are users of ‘new’ drugs from a demand-reduction perspective. Users of ‘old’ drugs are generally not contacted, nor are users of ‘new’ drugs from a harm-reduction perspective. The agencies most commonly offering outreach work are health agencies, youth-work organisations and social-work agencies. Detached outreach methods are applied occasionally, peripatetic outreach methods rarely and domiciliary methods not at all. One difficulty with detached outreach work on the streets of Finland is the cold climate, which makes working out of doors unpleasant.

There are two main funding models for outreach work. The most important channels funds from the local level directly to agencies and projects. The other funnels budgets from regional to local to agency level. Within both models, governmental and non-governmental organisations are funded for outreach services. Most outreach projects have produced reports on their activities.

EXAMPLE OF GOOD PRACTICE:

NUORTENTURVAVERKKO (NTV – SAFETY NET FOR YOUTH)

Setting

The NTV outreach project was created in 1996 by the A-Clinic Foundation, an umbrella organisation providing services related to

alcohol, drugs and other forms of dependence throughout Finland. Approximately 350 of the foundation's staff work in local units and the national office is in Helsinki.

Methods

NTV applies a holistic approach to young people with social or addiction problems in their natural environments. An average of 10–20 users are contacted monthly.

The central aims of the NTV project are to develop and apply new models and methods of outreach work for marginal and at-risk youths who are not able or willing to use the existing social support and service network. NTV focuses on both demand and harm reduction and co-operates with other organisations and authorities in carrying out their tasks. The two professional workers in the project fulfil a variety of roles, ranging from consultant, to 'think tank' to project co-ordinator.

Special projects

• Shopping Mall Experiment

NTV's first activity in 1996–97 was to organise outreach activities at shopping malls targeted at the parents of teenagers who have little time for their children and who do not attend activities such as parents' evenings at school, to give them a chance to talk about the joys and problems of parenthood. A shopping mall known to be visited by families was chosen as a venue and a booklet with information on teenagers' problems was distributed.

• Network

The network project targeted young people who rely heavily on computers and Internet contacts. A team of young people and professionals designed a youth web site which contained issues of interest to young people.

• One Thing

This project began in late 1997, targeting young people with social and/or addiction problems. This target group is difficult to reach and is contacted in places such as the streets, amusement arcades

and dance clubs. One method is to work with peers who then introduce the outreach workers to new young people.

Funding

NTV receives regular funding on a three-year basis.

France

- 1 *policy status*: developing
- 2 *geographical diffusion*: in some cities with an acknowledged drug problem
- 3 *target groups*: users of 'old' drugs (HIV- and other harm reduction-oriented); users of 'new' drugs (developing)
- 4 *methods*: detached and peripatetic
- 5 *institutionalisation*: experimental, initiated by drug users' self-help groups and AIDS organisations

OVERVIEW

Outreach work in France first arose as a private initiative just after the Second World War to provide specialised preventive help to young people with problems. This type of social work was officially recognised and funded by the authorities from 1963 onwards. A decree passed in 1972 officially confirmed this recognition, and defined the tasks, organisational structure and funding of outreach work. It aims to meet the young people in their own environment, without the intervention of the judicial or administrative authorities. The approach should respect the young people's anonymity and occur only with their free consent (Monier, 1982). Preventive-action clubs are now emerging in all so-called 'difficult areas' in France. Thanks to their mandate and mode of operation, youth workers in such clubs can observe local or more general trends, particularly in the mass consumption of psychotropic substances.

In 1982, following the government's move towards decentralisation, social work and prevention were delegated to regional, departmental or municipal levels of government while drug abuse remained the task of the central state. In its initial stages, this decentralisation had disastrous effects on the prevention and treatment intake for the various forms of substance abuse, and the new division of labour prompted youth-club workers to divest themselves of these problems. Since drug abuse was the responsibility of the state and the prevention clubs were run by the regions, addicts were henceforth systematically referred on to specialised health centres. Even though a few legislative attempts were made to involve local officials in drug-abuse prevention policy, the first clear step was not taken until Direction Générale de la Santé (DGS) decree no. 92-520 of 29 June 1992.

This decree directed state-financed specialised health centres to concentrate on in-house treatment, thereby forcing lower-level authorities to develop their own substance-abuse prevention schemes. Confronted with the massive spread of AIDS among drug users, many municipalities saw themselves compelled to invest in such types of intervention. Many innovative approaches, which had hitherto been stifled by the state domination of policy-making, began to develop. The involvement of lower-level authorities thus marked the end of the state monopoly in dealing with drug problems and the emergence of competing initiatives at local level.

The first innovative approaches were introduced by voluntary organisations. In 1984, Relais Médical aux Délaisés (REMEDE), backed by the medical profession, set up mobile aid points for deeply marginalised people, and Médecins sans Frontières took similar initiatives in 1987. In the same year, Espoir Goutte d'Or, a voluntary organisation helping drug users, attempted to introduce community-based social work in a lower-class district of Paris. As a result of the massive occurrence of AIDS amongst intravenous drug users, the French government decided to make hypodermic needles freely available in chemists' shops, thereby reversing a 1972 anti-addiction policy which had made them available on prescription only. In 1989, Médecins du Monde started a mobile

needle-exchange clinic for drug users (Vidal-Naquet, 1989), and the same year Action Recherche sur les Comportements Adictifs, Déviants et sur la Sociabilité (ARCADES), began researching into AIDS and substance abuse with former drug users collecting the data.

All these initiatives aimed to establish contact with a group usually out of the reach of the traditional care system, to curb the risks inherent in the use of illicit substances, and to help drug users claim their rights to social services and benefits. These initiatives tried to give drug users ready access to facilities by introducing low-threshold services outside office hours, by lowering social barriers (hiring social workers close to the target group) and distancing themselves from social hierarchies and moral judgements. While state-run services continued to focus on achieving abstinence, the new initiatives mainly helped those who were still taking drugs. In so doing, they demonstrated that preventive and curative work was possible among these groups (Jacob, 1997).

These experiences are occurring outside the traditional care system in France, and are helping to shed light on the gulf separating society at large from a growing marginalised population. The realisation has dawned that an ever-larger number of people, drug users in particular, no longer have access to the most elementary health or social services. In 1992, a collective known as *Limiter la Casse* (Control the Damage) was launched in which actors from AIDS campaigns, general practitioners, community-health specialists and drug users joined forces to get the new approaches recognised and develop risk-prevention policies (Coppel, 1996). This collective came to an end in 1997 following a disagreement between professional associations and the self-help group of drug users. A new association, the *Association Française de Réduction des Risques* (AFRR), was launched in June 1998. By indirectly exposing the inadequacy of the traditional system, their lobbying work and achievements soon forced decision-makers and politicians to become involved in these problems. In response, the Ministry of Health directed one of the

specialised health centres to open a low-threshold outlet as an experiment, and since 1993–94, risk prevention has been official policy at the Ministry of Health.

In sum, outreach practice in France has been influenced by developments in the public-health field as well as by youth work. The Youth Work Model (see Chapter 4) has had great impact on French outreach practice. The focus on delinquent youth in the late 1940s has gradually shifted as a result of the changing problems faced by young people, one of which is drugs. The importance of voluntary participation, respect for anonymity and building relationships of trust with drug users in the daily practice of outreach work has been stressed (Barraud 1994). While outreach work among drug users is of increasing importance, the use of drugs is not automatically the principal approach because drug users suffer not just from their addiction, but also from more general problems of marginalisation, similar to those of prostitutes, petty criminals and down-and-outs (Barraud, 1994). As a result, the problems of minority youth have also come under the scope of outreach work.

EXAMPLE OF GOOD PRACTICE: *CHILL-OUT*

Setting

Chill-out was founded by the Harm Reduction Association in 1992. It is a private, state-subsidised, non-profit organisation with a staff of approximately 12 professionals and volunteers.

Methods

Chill-out, as its name suggests, targets predominately young people at 'raves' and 'techno' music festivals. It also uses a low-threshold meeting place. Approximately 200–300 'ravers' are contacted monthly.

Funding

Chill-out receives regular state funding and has an annual budget of Euro 45,220.

Germany

- 1 *policy status*: important
- 2 *geographical diffusion*: in most cities with an acknowledged drug problem
- 3 *target groups*: users of 'old' drugs (harm reduction)
- 4 *methods*: peripatetic and detached
- 5 *institutionalisation*: structural and experimental

OVERVIEW

Unlike most other European countries, Germany has relatively detailed documentation on outreach work, although there is little mention of the concept of outreach work itself. The English term 'street work' predominates, also designated as *Straßensozialarbeit* and *aufsuchende Sozialarbeit*. Another, less common, term is *zugehende Sozialarbeit* (AIDS-Hilfe, 1997). Unique in Europe is the professional journal *Streetcorner*, *Fachzeitschrift für aufsuchende soziale Arbeit*, which appears several times a year. Each issue contains descriptions of several outreach projects as well as theoretical discussions, and more recently the journal has also been addressing topics such as efficacy and efficiency (Bassarak, 1995), quality characteristics and quality standards (Schaffranek, 1996) and quality control (Krebs, 1997). Also unique in Europe is the fact that the theory and practice of outreach work for drug users is taught in professional training courses, for example in higher professional schools for social work (see Schmidt and Visser, 1997).

Outreach work is an important concept in national-level drugs policy. Its aims are nationally defined, and are oriented to both demand and harm reduction. They include:

- identifying and contacting hard-to-reach populations;
- improving access to services and service uptake;
- promoting adequate services and ensuring the accurate targeting of prevention and demand-reduction initiatives; and
- promoting safer drug use and safer sexual behaviour.

Local agencies and self-help groups for drug users were the first to promote outreach work in Germany. Most cities with acknowledged drug problems have outreach projects chiefly targeting users of 'old' drugs from a harm-reduction perspective. Users of 'new' drugs are occasionally also targeted from a harm-reduction perspective.

Peripatetic outreach methods are regularly applied, detached outreach occasionally and domiciliary rarely. At local level, however, the ratio may be very different. In Frankfurt am Main, for example, detached work is the most common method. Outreach services are commonly offered by drug agencies, and occasionally by AIDS agencies or self-help groups, and both government agencies and NGOs are financed for outreach services, whether structural or experimental. The predominant funding model is from the regional level to outreach projects with or without local-level intermediaries. Some of these outreach services have been evaluated.

EXAMPLE OF GOOD PRACTICE: CRACK STREET PROJECT

Setting

The Crack Street Project in Frankfurt am Main was initiated in 1997 by La Strada, an agency for drug users with AIDS. La Strada, which has six employees, operates a low-threshold meeting place with counselling services and a needle-exchange service, a users' room and an emergency shelter for homeless drug users. The Crack Street Project is a co-operative venture involving AIDS care from La Strada, youth work from Walkman and the medical services of the NGO Malteser Hilfsdienst.

Methods

In recent years, a separate crack cocaine scene has sprung up in Frankfurt am Main alongside the existing heroin scene, consisting of 300–500 crack users with no services available to them. What makes this outreach project so unique is this specific target group and the integrated method used that combines different institutions and disciplines. An initial three-month pilot phase beginning in

September 1997 showed that working with an interdisciplinary team was very effective.

In early 1998, the hard core of the scene comprised about 200 crack users living mainly on the streets. The group is very mobile and consists of four subgroups:

- adolescents and young adults;
- heroin users;
- participants in substitution programmes; and
- illegal immigrants.

These groups are the principal targets of the project, which offers them crisis intervention, assistance in finding somewhere to sleep, referral to detoxification or other types of treatment centres, information on HIV and AIDS, acupuncture, help in dealing with official institutions, and referral to youth or drug-care agencies. Approximately 100 users are contacted monthly.

Alongside this hard-core scene there is also a larger number of crack users who buy their drugs on the streets, but who are still integrated socially in the communities where they live, for example in neighbourhood youth clubs. Since these users are more difficult to reach through street work, the project also educates community agencies about crack use, and supports them when necessary in providing individual care to crack users.

Funding

The project receives contingency funding and has an annual budget of Euro 101,260.

Greece

- 1 *policy status*: key, but still developing
- 2 *geographical diffusion*: in some cities with an acknowledged drug problem
- 3 *target groups*: users of 'old' drugs (HIV-oriented)
- 4 *methods*: detached and peripatetic
- 5 *institutionalisation*: experimental

OVERVIEW

The University Mental Health Research Institute (UMHRI), the Greek National Focal Point in the REITOX network, designated outreach work as a key concept in national drugs policy in 1997 (UMHRI, 1997). The Therapy Centre for Dependent Individuals (KETHEA), an NGO providing treatment, vocational training and social rehabilitation for individuals addicted to pharmaceutical substances, was the first to stimulate outreach work in Greece. Its work is informed primarily by self-help and peer-education models.

The nationally defined aims for outreach work incorporate both demand-reduction and harm-reduction initiatives, including:

- identifying and contacting hard-to-reach populations;
- identifying user needs and perceptions of services to inform service responses;
- increasing access and service uptake;
- promoting direct, flexible and responsive services and ensuring the accurate targeting of prevention and demand-reduction initiatives; and
- promoting safer drug use and safer sexual behaviour.

The target groups contacted are predominantly users of 'old' drugs at high risk of HIV infection while users of 'new' drugs are not targeted. Outreach projects exist in some, but not all, cities with an acknowledged drug problem. Detached and peripatetic

outreach methods are applied, although not yet frequently, while domiciliary outreach work is not carried out at all. Outreach projects are funded by the national government as well as by drug agencies themselves, and offered by drug and health agencies and youth organisations.

EXAMPLES OF GOOD PRACTICE: KETHEA

Setting

The Centre for Multiple Interventions, set up in 1995, is part of KETHEA, which was founded in 1987. Since then, KETHEA has developed various activities, including drug-abuse treatment, prevention programmes, relapse prevention, street work, social rehabilitation, family therapy and information services to society at large. It operates seven therapeutic programmes, including six therapeutic communities. In 1997, two new activities were established: programmes in five prisons; and a mobile unit, Pegasus, to provide information.

The Centre for Multiple Interventions was founded to reach marginalised drug users – those who are socially excluded, without social support, homeless, with a criminal record, or without financial resources. The programme tackles the immediate problems facing these people, and the main goal is to respond to the problems of drug users with great flexibility.

The Centre for Multiple Interventions provides a number of services, including:

- a meeting place with psychological support, nutrition and personal-hygiene facilities;
- a dentist;
- help in finding employment and other professional support;
- self-help groups;
- social-skills learning groups;
- an introduction to therapeutic programmes;
- self-help programmes for prisoners; and
- counselling programmes on the streets.

The project has three professional street workers and three volunteers (ex-drug users).

Methods

The street-work programme was designed to approach drug users in the places where they live, 'hang out' or make drug deals. The basic goals are to reduce health damage caused by substance abuse, to improve living standards, to motivate users to make minor changes in their behaviour and to give information and counselling support.

Once a week, at night, the outreach team visits two specific areas in the centre of Athens: a square where large numbers of drug users congregate 24 hours a day; and a street frequented by prostitutes. The teams offer counselling services, permission slips for hospital visits, condoms and simplified information on preventing health damage. Approximately 50 users are contacted monthly. A system of feedback and evaluation has been developed, resulting in guidelines for approaching drug users. These include:

- each street-work team should consist of no more than two people;
- street workers should not discuss topics that have not been put forward as problems by the drug user him or herself; and
- street workers should not approach drug users while they are using drugs.

More than 100 such visits have been carried out since the programme was launched, and 560 different persons have been reached in this way.

Special projects

The project also organises open festivals to coincide with Christmas, Carnival and other holidays in an attempt to provide recreation, to motivate drug users to take action, to create trusting relationships and to promote the street-work programme and philosophy. Five open festivals have been organised with about 750 drug users taking part, as well as six smaller events involving 200 users.

Funding

KETHEA receives regular funding and has an annual budget of Euro 66,898.

Ireland

- 1 *policy status*: important
- 2 *geographical diffusion*: in some cities
- 3 *target groups*: users of 'old' drugs (HIV-oriented); users of 'new' drugs (harm reduction, in development)
- 4 *methods*: detached and peripatetic
- 5 *institutionalisation*: structural

OVERVIEW

Since the identification of a major rise in heroin use in the early 1980s, NGOs have offered a variety of demand-reduction services for drug users. During the 1980s, epidemiologists and drug workers had difficulty obtaining official approval to implement harm-reduction strategies, and early outreach work targeted homeless young people. However, since the outbreak of HIV among drug users and other high-risk groups, outreach work is now being used as a harm-reduction strategy to limit the spread of HIV infection. Dublin has high rates of drug-related HIV infection.

Today, outreach work is seen as an important way of identifying hard-to-reach populations, increasing access and service uptake, promoting direct services and encouraging safer drug use and sexual behaviour. In 1996, a Ministerial Task Force commended outreach work as an important working method (Irish Ministerial Task Force, 1996). It recommended that health boards co-ordinate locally based treatment and outreach services to encourage those that had not yet come forward to do so. Work with older injecting drug users at risk of HIV infection is seen as the main priority, although some effort is made to reach users of

‘new’ synthetic drugs to limit any harm that may be associated with their consumption.

Greater emphasis is placed on detached interventions, with peripatetic and domiciliary work being seen as less of an outreach remit. Outreach work overall tends to be delivered as a component of wider, more general services. Since it was adopted by public bodies in response to HIV and AIDS, outreach programmes have been given the clear aim of identifying and targeting high-risk groups. Much of the inspiration and support for HIV-related outreach work came from within the health service. As in Scotland, infectious-disease specialists saw the advantages of employing harm-reduction methods in limiting HIV and, increasingly, hepatitis C infection. Regional health boards and NGOs were the first bodies to stimulate outreach work, which is commonly conducted by drug agencies, health agencies and youth agencies.

Projects and agencies may receive national funding via regional or local agencies, although some regions fund outreach work directly through their own budgets. The latter arrangement tends to disburse the most funds. Initiatives within treatment clinics tend to focus on specific target populations, such as women at risk of sexual and drug-related HIV infection. The outreach team operates as the eyes and ears of the service, both monitoring trends and identifying needs. The workers offer needle exchange, support for sex workers, and referral for methadone prescriptions. They do not see themselves as caseworkers, but emphasise instead the importance of community presence, which enables them to intervene and ‘fast-track’ individuals to treatment while concentrating on making contacts and increasing service accessibility.

EXAMPLE OF GOOD PRACTICE: EASTERN HEALTH BOARD

Setting

The Eastern Health Board established an outreach team in 1988. In 1989, the first needle-exchange programme began in Dublin, followed by a low-dose methadone programme in 1990. An

outreach clinic for prostitutes was opened in 1991, and in 1992 existing services were expanded to 'satellite' clinics and an HIV/Drugs Service was established.

The Eastern Health Board's Outreach Programme targets intravenous drug users, women in prostitution (especially drug users), and gay or bisexual men. Intravenous drug users (IDUs) remain a specific target group for outreach work. The initial objective is to reduce the spread of HIV infection by:

- reaching IDUs who are not in touch with services and providing them with information on HIV and its prevention. HIV-seropositive drug users are encouraged to attend a clinical follow up;
- encouraging and facilitating referrals to drug-treatment agencies; and
- providing information to community groups about HIV.

Street work, or meeting the drug users in their own community, is a vital part of outreach work, and around 700 drug users are reached each month by 20 professional outreach workers. Approximately 60% of the workers' time is spent meeting users in locations as diverse as shopping centres and billiard halls. The outreach workers also provide Dublin's needle-exchange service.

Methods

Outreach workers have their own target groups: most workers target IDUs, one targets women and one targets gay men. The places that they visit vary, depending on the target groups. Workers targeting IDUs make contact on the streets, in youth clubs and in homes; contact with women is made on the streets and in massage parlours; and men are contacted in saunas and clubs. There is a meeting room with medical services for women and one for men. Peripatetic outreach work is also undertaken in a number of prisons to provide information on HIV and related services to a group that is often at high risk.

Special projects

The Women's Health Project (WHP) was established in 1991 to target women working in all areas of prostitution, because their needs were not being met. The WHP is affiliated to the European Intervention Project's AIDS Prevention for Prostitutes (EUROPAP) and consists of two parts:

- outreach teams, both street- and clinic-based, providing women with a service at their place of work, including advice, support, referrals and condoms; and
- a drop-in clinic, staffed by an all-female team, which aims to promote women's health in a confidential and informal atmosphere.

The project uses a peer-support model, based on the experience that women working in prostitution are often best able to contact other female workers, particularly given the invisibility of female sex workers in Ireland which makes them a form of 'hidden population' that is difficult to reach. In 1995 and 1996, following interviews with prostitutes conducted by trained peers, a report was drawn up which made recommendations in the fields of health, law, peer support and awareness (O'Connor, 1996).

The report was based on interviews with 84 women ranging in age from 18–54 years. Over one-third of the women had left school before the legal age (16 years) and had few or no educational qualifications. Almost all had started working in prostitution for financial reasons, although the length of time women had been doing this work varied enormously. Both the sex workers and the service providers noted an increase in the number of women working the streets to finance a drug habit. Many of these women were not always practising safe sex with their clients, due to drug-related financial constraints or poor awareness of the health risks. The women tend to relate education of safer sexual practices only to their work lives, and many women put themselves at risk in their private relationships. The project clearly showed that outreach work can be carried out most effectively by women who are themselves engaged in prostitution, especially because they can access women working in its more hidden forms.

Funding

The Eastern Health Board's AIDS and Drugs Service has an annual budget of Euro 17.9 million, although there is no specific outreach budget.

Italy

- 1 *policy status*: important
- 2 *geographical diffusion*: in some cities with an acknowledged drug problem
- 3 *target groups*: users of 'old' drugs (HIV-oriented and other harm reduction); users of 'new' drugs (harm and demand reduction, developing)
- 4 *methods*: detached
- 5 *institutionalisation*: experimental

OVERVIEW

Outreach work in Italy has no clearly identifiable tradition. A strong social emphasis on pastoral care influenced the activities of some Christian NGOs, and political militancy within the workers' and students' movements in the 1970s found a different form of expression in public services and voluntary organisations. General forms of domiciliary outreach work with young people were detectable within social work during the 1970s and there were also limited forms of self-organisation by advocacy and pressure groups during the same period. While a cultural affinity to ideas of community mobilisation was strong, professionals within statutory services had little concept of detached or street work. Drug outreach initiatives were not formally established until the drug-related HIV epidemic was identified and the need for more innovative responses recognised.

Today, the importance of outreach work is recognised by key drug workers and health professionals in NGOs and public services who are keen to promote its development. OUT, the national drug street

workers' co-ordination project, includes representatives from Bologna, Catania, Como, Genoa, Milan, Naples, Rimini, Rome, Trieste, Turin and a number of other towns and cities.

The main aims of outreach work in Italy are to:

- identify hard-to-reach populations;
- increase access to and use of services;
- promote direct service delivery; and
- encourage safer drug use and sexual behaviour.

Some agencies, such as Gruppo Abele in Turin, place an equal emphasis on re-establishing contact with relapsed individuals who are out of touch with services and family and at high risk of infection as they do on making initial contacts. Although there are no formal national policy documents, the government has sponsored national conferences and the Ministry of Health has commissioned an exhaustive manual on drug-related HIV prevention through street work (Serpelloni and Rossi (eds), 1996) which draws on work conducted in Chicago, London, Milan, Naples, Padua, Parma, Rome, Turin and Verona. The Emilia Romagna region has developed an integrated approach to harm reduction, in which outreach work is an important element.

In the early 1990s, the value of harm reduction gained increasing recognition from the statutory sector, and outreach programmes were developed in some cities with an acknowledged drug problem. Users of 'old' drugs at high risk of HIV infection are the prime targets, although detached, harm-reduction-oriented outreach activities targeting synthetic drug users can also be found along the Adriatic Riviera, in Padua, Turin and at major clubbing venues. Needle-exchange mobile-van projects and street-survival outreach work with drug-using ethnic minorities are conducted in various cities.

Outreach work is primarily detached, most suited to NGOs and some local statutory services. User self-help and advocacy groups are encouraged and produce their own magazine. Funding is derived from national, regional and local government sources, and volunteers also make a valuable contribution. Specialised evalu-

ation models have been developed for preventive outreach work, combining process and summative approaches, including analysing co-operation between organisations (network analysis).

EXAMPLE OF GOOD PRACTICE: *UNITÀ DI STRADA*

Setting

The *Unità di Strada* project was launched in 1995 by Gruppo Abele in Turin in conjunction with the Public Drug Unit. The project targets users who are not in contact with other services in an area known as 'the largest drug market' in Turin, which is frequented by people from all over the region, as well as from other drug scenes.

Methods

Unità di Strada works with five professionals and 12 volunteers, including former or current users. Peers are a cornerstone of the project, whose main focus is harm reduction and which offers social support, counselling, information on safe drug use and safe sex, needle exchange and referral to various other services. The project also provides support to users of non-Italian origin and illegal immigrants who face many added hardships because they lack resources and have no access to the health-care system. The project also collaborates on the publication of a journal, which is produced in co-operation with, and sold by, drug users as a source of income.

Between April 1994 and the end of 1997, almost 1,500 clients had been contacted through the programme. In 1997 alone, the programme reached 668 new clients, 19% of whom were female. The majority of clients were in their twenties or thirties. In 1997, the programme established:

- 3,213 nursing-care appointments;
- 48 emergency referrals to hospitals, mainly due to overdoses or physical symptoms connected with HIV;
- 454 contacts with families of clients;
- 24 parent group meetings with street addicts and their families; and
- 66 referrals to rehabilitation facilities.

Funding

Unità di Strada receives regular three-year funding and has an annual budget of Euro 14,000.

Luxembourg

- 1 *policy status*: developing
- 2 *geographical diffusion*: in a few cities
- 3 *target groups*: users of 'old' drugs (harm reduction)
- 4 *methods*: detached
- 5 *institutionalisation*: structural

In Luxembourg's national drugs policy, the concept of outreach work is still being developed and it is not yet specifically mentioned in drug-policy documents. The nationally defined aims of outreach work are:

- to increase access to and use of services; and
- to promote safer drug use and safer sexual behaviour.

These aims are pursued through harm-reduction measures targeted mainly at users of 'old' drugs. Street-work teams run by the youth and drug agency Jugend- an Drogenhelf (JDH) operate in the cities of Luxembourg and Esch-sur-Alzette, the two largest cities in the country with acknowledged drug problems.

Outreach work is commonly offered by drug agencies, and detached outreach work is the most common method. Outreach work is also conducted by the *Camionnette* mobile van project, which employs a team of social workers to provide basic medical care, information and injecting equipment to deprived drug users near the central railway station.

Outreach projects are funded directly by the national government on an annual basis and are considered 'para-governmental'.

Netherlands

- 1 *policy status*: important
- 2 *geographical diffusion*: in most cities with an acknowledged drug problem
- 3 *target groups*: users of 'old' drugs (harm reduction and HIV prevention)
- 4 *methods*: detached and peripatetic
- 5 *institutionalisation*: structural

OVERVIEW

The origins of Dutch outreach work can be traced to the late 1960s and early 1970s when a transformation occurred in youth work which can be seen both as a protest by youth workers against traditional youth care and as the result of a critical scholarly discourse on youth and youth work. In the latter case, both German and US literature were influential, particularly German writings on *emanzipatorische Pädagogik* and US reports on the new youth culture. Despite the prevailing anti-US attitude following the Vietnam War, US methods and projects were a source of both ideas and terminology. In protest against traditional youth work institutions, alternative services were established, inspired by (and sometimes even named after) US projects, such as Release.

A new kind of youth worker also evolved, spending most of his or her working time on the streets, in the world of young people. The most influential source of inspiration for Dutch outreach work was Jan Hazekamp (1976) of the Vrije Universiteit Amsterdam who helped familiarise students and outreach workers with the international professional literature on outreaching social-welfare work, and stimulated method development. More recent theoretical inspiration specific to outreach work among drug users has come from Franz Trautman (1996) of the Trimbos-instituut, Utrecht.

The first organisation for outreach workers, the Streetcornerwork Foundation, was founded in Amsterdam some 20 years ago. Many of these 'street-corner workers', who later came to be known under the Dutch name *straathoekwerkers*, were trained youth workers or social workers, but 'experienced experts' without professional education were also engaged. From an early stage, street workers had many contacts with drug users, but their general approach was not drug-specific; instead, drug use was viewed predominantly as just part of a 'different lifestyle'.

The development of street outreach work followed many new trends in general youth work, such as the emergence of drop-in centres. The outreach approach was also adopted within the medical profession to combat the spread of heroin use in the early 1970s, and doctors and nurses began actively contacting drug users on the streets and in other areas where young people congregated.

Currently, most Dutch organisations involved in street work are either general youth-work agencies or drug agencies. Street workers focused initially on heroin and cocaine users, particularly those in certain ethnic groups such as the Surinamese, but as these ethnic groups began ageing, there was a reorientation to new groups, such as homeless youth. Since the spread of HIV and AIDS in the mid-1980s, health promotion and harm reduction have gained prominence, and other initiatives have targeted users of 'new' drugs, such as ecstasy. Outreach workers are predominantly health-promotion or secondary-prevention workers, operating at 'raves and dance clubs. This kind of work often includes pill testing.

Another development is the involvement of peers in outreach work, both for user of 'old' drugs (e.g., as buddies for drug users with AIDS or as promoters of safe sex among street prostitutes) and for users of 'new' drugs. A good illustration of the latter is the Unity Project, a European programme now being conducted by Jellinek Prevention in co-operation with drug agencies in Hamburg and Manchester, which keeps agencies informed about the drug-education needs of synthetic drug users.

For example, peers from the Unity Project discovered that the drug users were eager for information about the long-term effects of ecstasy and the risks of combining different drugs. The peers themselves show a keen sense of involvement and team spirit and actively contribute to the development of up-to-date drug-education materials, which they then hand out to young people in the dance scene. Co-operation with club owners and 'rave' organisers has improved over time (Jamin and Voortman, 1997).

EXAMPLE OF GOOD PRACTICE: MAINLINE, AMSTERDAM

Setting

The Mainline Foundation was established in 1990 to promote health and prevention activities among drug users. The AIDS Fund, the national government and the city of Amsterdam are major contributors and most of the funding is channelled to specific projects. Contact with drug users is of prime importance and Mainline's work is based on the self-help organisation model: it takes the drug users' lifestyle and designs informative materials to match. Mainline is familiar with the drug scene and understands the habits, rituals and interests of its users. It is not an official care agency.

Mainline employs four street workers ('fieldworkers'), an office worker and a co-ordinator. In addition to these street workers, several freelancers are involved as well as volunteers, and Mainline has a network of permanent contacts throughout the country.

Methods

Street workers actively seek contact with drug users on the streets, at the 'methadone bus' (a mobile van providing a low-threshold methadone service) and in drug-dealing areas. They distribute information to individual users and watch for trends in the drug users' world. Since they do not make any demands, the street workers are able to contact groups of users who avoid the mainstream drug-care agencies.

Drug users are offered *Mainline Magazine* free of charge on the streets which gives them information about drugs, health and

AIDS, as well as news about the users' culture and the drug scene. Since summer 1994, *Mainline Magazine* has also been available outside Amsterdam, and is now distributed in 20 Dutch cities and towns. Networks of distributors have been formed, primarily drug users from local users' groups; newly recruited distributors receive a short training course. Mainline occasionally accepts help from non-users, but only on the condition that distribution remains as independent as possible of the official drug-care agencies.

In addition to the magazine, Mainline distributes leaflets about AIDS, drugs and general health issues. Thirty titles are available, among them 'Self-Defence for Women', 'The ABC of Hepatitis' and 'Overdose'. The information – which includes addresses of all Dutch needle-exchange points and comparisons of the price and quality of various types of condoms – is of immediate relevance to drug users. Mainline can also distribute flyers at very short notice to warn users whenever poisonous heroin or unidentified pills have been discovered on the streets.

Special projects

Mainline has also established a prevention project especially for female drug users whose lifestyles make it difficult for fieldworkers to reach them to discuss critical issues like safe sex and safe drug use. Mainline now operates a drop-in centre on a fixed afternoon every week at the premises of the Dutch self-help organisation Junkiebond, which has a trustworthy image and is located near the red-light district. The services provided include hairdressing and massage, theatre, workshops on safe sex and sexually transmitted diseases, overdose training and counselling on contraception. During the first year of operation, 45 sessions were held with a total of 220 women attending (an average of five per week). A total of 95 different women were reached, one-third of whom were not in any methadone programme and had no contact with official drug-care agencies.

Funding

The project receives contingency funding.

Norway

- 1 *policy status*: key
- 2 *geographical diffusion*: in most cities with an acknowledged drug problem
- 3 *target groups*: users of 'old' drugs (HIV-oriented and other harm reduction); users of 'new' drugs (demand reduction)
- 4 *methods*: detached and peripatetic
- 5 *institutionalisation*: structural

OVERVIEW

Outreach work, which first began as youth work in the 1960s, is a key concept in Norwegian national drugs policy, and appeared in national drug-policy documents as far back as 1992 (Norwegian Ministry of Social Affairs, 1992, 1997). The aims of outreach work are defined at national level from both a demand-reduction and a harm-reduction perspective, and include:

- identifying and contacting hard-to-reach populations;
- identifying users' needs and their perceptions of services to improve service response;
- improving access to services and increasing service uptake;
- promoting direct, flexible and responsive services, as well as accurately targeting prevention and demand-reduction initiatives; and
- promoting safer drug use and safer sexual behaviour.

Outreach projects are found in most cities with an acknowledged drug problem and target both users of 'old' and 'new' drugs. Contact with the former is primarily HIV-oriented, but other harm-reduction methods are also applied. Most contacts are with users of 'new' drugs, where the emphasis is mainly on demand reduction, and occasionally on harm reduction. Outreach work in Norway focuses more generally on marginalised youth or on young people, with drug use seen as one of their possible problem behaviours (Hakerud, 1994; Nevermo, 1994).

In practice, outreach work mainly follows the Youth Work Model, especially outside the major cities. Detached methods are most commonly applied, followed by peripatetic methods, while domiciliary outreach work is rarely used. Outreach projects have been initiated by local governments and agencies, and have been influenced by developments in such diverse disciplines as social work, anthropology, ecology and holistic medicine. The central sources of inspiration have been Ketil Bentzen at the Ministry of Social Affairs and Njål Petter Svensson at the National Directorate on Drugs and Alcohol.

A key characteristic of Norwegian health and social services is regionalisation and decentralisation of responsibility. Responsibility for the funding, planning and operation of health and social services lies with the municipal and county authorities. Outreach work is financed by the national government via the regional and local governments, and also indirectly by unpaid volunteers.

EXAMPLE OF GOOD PRACTICE: *UTESEKSJONEN*

Setting

The *Uteseksjon* (outdoor section) of the city of Oslo has a long tradition of outreach work, which began with street youth programmes in 1969. The *Uteseksjon* is part of the *Rusmiddeletat* (narcotics department), the body responsible for most drug-related activities in Oslo, ranging from preventive work with school children to rehabilitation programmes and harm-reduction campaigns for drug addicts. The entire *Rusmiddeletat* has about 500 employees, with the *Uteseksjon* accounting for 38 of them, including 26 street workers. The *Uteseksjon* is divided into three units:

- the outreach section;
- the day-care centre; and
- the crisis hostel.

Methods

The outreach section covers the central parts of Oslo, with workers out on the streets seven days a week. The primary goals are to discourage teenagers and young adults from getting involved with drugs and to deter them from harming themselves or others in any other way. The target group is young people aged 16–25, and although they have diverse problems, most of these are in some way drug-related. Contacts are made at the railway station, dealing locations, 'raves' and clubs and, once contact has been established, a longer-term plan is developed in which the crisis hostel and the day-care centre provide a chain of help.

Special projects

Two special projects were established in 1994, one targeting ethnic minorities and another, called 'Stop the Drugs, not the Dancing', targeting users of 'new' drugs. The minority project is aimed at Somali immigrant youth and its goals are to prevent negative developments and stimulate positive ones within the community and to strengthen family relationships. Open meetings are held each week, attracting between three and 15 participants.

'Stop the Drugs, not the Dancing' was established to inform 'housers' about the drugs they are using, and to convince newcomers that it is possible to be a 'hip houser' without taking drugs. The outreach methods include youth-to-youth communication, disk-jockey and dance courses, one-to-one communication, class presentations for parents and students and distributing information at parties.

Funding

Uteseksjon receives regular funding and has an annual budget of Euro 1,653,5400.

Portugal

- 1 *policy status*: developing
- 2 *geographical diffusion*: in some cities with an acknowledged drug problem
- 3 *target groups*: users of 'old' drugs (HIV-oriented)
- 4 *methods*: peripatetic and detached
- 5 *institutionalisation*: experimental

OVERVIEW

Outreach work in Portugal was initiated by drug workers in the early 1990s and originally targeted young people in an attempt to improve access to them outside the heavily stigmatised context of drug treatment centres. Activities emphasised family networks and resembled the Catching Clients or Youth Work models rather than the harm-reduction approach (Correia-Chitas, 1994). However, the focus has now shifted from young people to street addicts.

Outreach work is currently considered a productive strategy for improving flexible services and assessing perceived needs, but the practice is growing slowly. In national drugs policy, outreach work is still developing, and has recently been recognised in national policy documents.

Local agencies and professionals working in public services were the first to undertake outreach work because they were confronted with the inadequacies of established methods. Community-based intervention pilot projects have begun, and needles and condoms have been made available in pharmacies throughout Portugal. Both these steps have furthered the development of outreach work. The central source of inspiration for outreach work has come from Carlos Fugas at the CAT Restelo in Lisbon.

Nationally defined aims for outreach work include:

- increasing access to services and service uptake;
- promoting safer drug use and safer sexual behaviour; and
- establishing and maintaining contacts with the family networks of drug users.

There are experimental outreach projects in some cities with an acknowledged drug problem which are commonly offered by drug agencies and community care organisations. The target groups are mainly users of 'old' drugs, including sex workers, street addicts and ethnic minorities, and the emphasis is on HIV prevention. Users of 'new' drugs are rarely targeted by outreach activities.

Outreach programmes attempt to overcome the difficulty faced by official service providers in identifying the specific needs of drug users on the streets. Peripatetic outreach work is the most common method applied, although it is only used occasionally, while detached methods are rarely applied, and domiciliary methods not at all.

Funding is mainly from the national level directly to outreach projects, although some funding is provided by the local level directly to agencies. In Lisbon it comes from the regional level. The National Plan for Drugs, Projecto VIDA, and the National Commission for the Fight against AIDS are the principal sources of funding. The organisations financed for outreach services are NGOs. Some outreach services have been evaluated, and showed positive results in increasing the visibility of specific marginalised subgroups of addicted users and in improving access to services.

EXAMPLE OF GOOD PRACTICE: *GABINETE DE APOIO*

Setting

The *Gabinete de Apoio* was established in 1994 by the Centro Social do Casal Ventoso. Nine professionals and volunteers target street addicts from a harm- and demand-reduction perspective.

Methods

Approximately 267 street addicts per month are contacted in deprived areas of Lisbon and the known drug scene. The local communities are involved and are encouraged to participate actively in the project.

Funding

The *Gabinete de Apoio* receives regular funding and has an annual budget of Euro 79,192.

Spain

- 1 *policy status*: marginal
- 2 *geographical diffusion*: in some cities with an acknowledged drug problem
- 3 *target groups*: users of 'old' drugs (HIV-oriented)
- 4 *methods*: detached
- 5 *institutionalisation*: experimental

147

OVERVIEW

It is not easy to describe the status of outreach work in Spain. At first glance it seems that no real outreach work tradition exists at all, but the relative autonomy of the regions makes it difficult to draw any general conclusions. Outreach work is a marginal concept in Spanish drugs policy, and nation-wide aims have yet to be defined. The term 'outreach work' itself is little known and has neither been conceptualised nor have its aims been defined. French concepts, such as *travail bas seuil* and *travail de proximité*, or their Spanish translations, are used instead.

Harm reduction tends to be carried out by NGOs, which have to negotiate funding every year with national, regional or local authorities. Spain has responded slowly to AIDS, and not always in a way that matches the scale of the problem. For example, syringe-

exchange programmes have been set up fairly late and the first national conference on HIV prevention among intravenous drug users was not held until 1994.

Barcelona is estimated to have between 8,000 and 10,000 intravenous drug users, one-quarter of whom are female. Since 1991, there has been a slight decrease in the proportion of IDUs and an increase in those inhaling and smoking, particularly among younger users; but the majority of users are still IDUs. The most commonly used drug is white heroin, and brown heroin is also available at certain times of the year. Heroin is often taken with cocaine, alcohol and benzodiazepines, and an increase in the use of cocaine has also been observed in recent years.

Methadone programmes began on a small scale in 1987 and were expanded after 1992. The first needle-exchange programme was established in the late 1980s and grew between 1993 and 1996. In 1997 alone, over 130,000 syringes and 50,000 condoms were distributed in Barcelona. The city has a health-care network specifically for drug addicts, which offers health services both in governmental and private institutions. This network, as well as the harm-reduction programmes, are integrated in the Pla d'Acció sobre Drogues de Barcelona, which has a budget of Euro 309,000.

Other examples of outreach and related work being practised in Spain include:

- *Instituto Genus*: a street-level group whose activities are closest to the drug scene in Madrid;
- *Isidrobus*: a needle-exchange bus in Madrid;
- *Médicos sin Fronteras*: a bus operating in Barcelona for the benefit of marginal groups, including drug users;
- *Médicos del Mundo*: needle-exchange programmes in several Spanish cities; and
- ABS: outreach work in the ecstasy scene in Barcelona.

EXAMPLE OF GOOD PRACTICE: SAPS

Setting

The *Servei d'Atenció i Prevenció Socio-sanitaria per a drogodependents* (SAPS) is a night shelter for Barcelona's most highly marginalised drug users and is categorised as a *centro de encuentro y acogida* (known as *centres de rencontre et accueil* in France – IGIA, 1996). It was established in April 1993 after a fairly lengthy period of negotiation about its objectives and location with the financial support of the central, regional and municipal governments. It was initially intended as an emergency social centre for marginalised drug addicts with the fundamental objective of reaching out to users who had little contact with the regular social and health-care services. A needle-exchange programme was added later. The centre is located in a wing of an emergency health centre and is accessed via the fire stairs. The premises appear too small for the volume of people who attend the centre. The needle exchange is located in the reception hall through which the other parts of the centre can be accessed.

Methods

The staff consists of nine trained nurses, youth workers and social workers who staff the centre in weekly shifts in small groups. A doctor, gynaecologist and lawyer are also affiliated to the centre. The premises are open nightly from 22.00–6.00 seven days a week, including holidays, and the only rules are 'no dealing, no consuming and no fighting'. The needle-exchange programme is flexible; syringes are dispensed even if used ones are not returned, and there are no limits to the number of needles per day or per visit. Users are asked their name (which may be an alias), so that staff can record the number of different clients visiting the centre.

The centre receives materials directly from the regional government for distribution, including one-piece or separable 1cc insulin syringes, alcohol wipes, 5cc bottles of distilled water and condoms. The condoms are usually given out three at a time, but this number is increased to six for clients working in prostitution. The programme

also offers 2cc syringes and intramuscular needles, aluminium foil and 50cc individual containers for drug users who exchange large numbers of syringes. Apart from prevention material, the centre also offers food, hygiene facilities, clothing, medical services, nursing, social assistance, legal aid and some medicines and medical treatments. Blood samples are analysed for general study and HIV diagnosis. Mantoux tests for tuberculosis, pregnancy tests and vaccinations against influenza, tetanus, pneumonia and hepatitis B are also available. In addition, the centre provides education on safer sex and safer drug use.

Most of the needle-exchange clients live in the neighbourhood, although in the summer the number of visitors doubles, and includes people from other parts of town and even other regions of Spain and Europe. In recent years, considerable numbers of North African clients have visited the centre, mainly for its food and hygiene services.

With the exception of protests from neighbours when the centre was first opened, there have been no conflicts with the broader community, probably because of the centre's low visibility and the fact that it is located in a health-care centre. There have been no major problems with the police, and the centre maintains periodic contacts with the district police station. Nonetheless, some clients have reported that they have been stopped and searched by the police, and that on some occasions their needles have been confiscated. A stronger police presence in the area over recent years may have prompted drug dealers to move to other areas.

The team at the centre keeps a daily register of the number of people who have visited and the types of services used by each client. All clients who have requested a health or social service have an individual file to enable follow-up. Occasionally qualitative and quantitative information is collected about the risk behaviours of users and HIV prevalence, and the centre presents both a quantitative and qualitative summary of activities each year.

Funding

SAPS receives regular funding and has an annual budget of Euro 309,000.

United Kingdom

- 1 *policy status*: important
- 2 *geographical diffusion*: in most cities with an acknowledged drug problem
- 3 *target groups*: users of 'old' drugs (HIV-oriented and other harm reduction); users of 'new' drugs (demand and harm reduction)
- 4 *methods*: detached, domiciliary and peripatetic
- 5 *institutionalisation*: structural

OVERVIEW

Detached outreach work has been conducted with young people in the UK since the 1960s. By the end of that decade, youth-work methodologies were being implemented by street drug projects, which were also influenced by the commitment of user and advocacy groups to user mobilisation. These projects' early origins meant that indigenous workers were less oriented to action research than those reported in the English-language literature on the Chicago model of drug-related HIV prevention. By the late 1970s, clinical workers and medical researchers were beginning to recognise the value of street work and ethnographic research in identifying trends and contacting drug users.

While the British academic literature on outreach work concentrates primarily on HIV prevention, actual practice draws on a longer tradition rooted in youth work, 'scene' work and politico-cultural activism. A divergence in approach in England, Scotland and Wales may be detected in practical issues, reflecting the specific national culture. More relaxed attitudes, evident in much of the voluntary sector, have encouraged pragmatic and flexible interventions, but have sometimes created difficulties for practical management, staff security and evaluation.

In the UK, detached, peripatetic and domiciliary outreach work is delivered by drug, health and youth agencies. It is most frequently seen as detached 'scene' and street work by drug workers, although

services such as needle exchanges, sex-work projects and *in-situ* delivery of primary health care may also fall within all three categories. National policy documents reviewing services for drug users (Polkinghorne Report, 1996) and the purchase of effective care and treatment (Public Health Policy Unit, 1997) stress the importance of effective outreach programmes. Projects are established in most cities with an acknowledged drug problem as part of more general services.

In principle, 'old' and 'new' drugs are accorded equal priority, although HIV and hepatitis C prevention among IDUs tends to receive the most attention. Models for HIV prevention, street and agency outreach work, and harm reduction in 'rave' settings have been developed by the Centre for Research on Drugs and Health Behaviours, the Lifeline Project and the Scottish Drugs Forum. All drug users, ethnic minorities, crack users, female sex workers and drug-using gay men are targeted by different projects, depending on their objectives, context and location.

Funding is provided by national authorities for demonstration projects, and occasionally to local projects. Local funding by health and local authorities is most common, as well as funding by charitable trusts that may provide 'seed' money for new innovative work. In-depth academic evaluations, as well as routine investigations, are conducted (see, for example, Grant, 1997), although establishing effective and appropriate measures for outcomes remains a complex task.

EXAMPLE OF GOOD PRACTICE: SAFE COMMUNITY DRUG AGENCY

Setting

The Safe Community Drug Agency (CDA), founded in 1997, is part of Cranstoun Drug Services which has provided specialist drug services for more than 25 years. Cranstoun's services are developed in partnership with local authorities, health authorities, the probation service and the prison service as well as drug addiction teams. Cranstoun has more than 70 workers and its work is divided into three main sections:

- community services;
- prison services; and
- residential services.

While most drug projects in London have an outreach team, only about three projects focus exclusively on outreach work.

CDA is part of Cranstoun's community services section and employs five outreach workers and one administrator, as well as ten peer educators.

Methods

CDA aims to contact users who are not in touch with other care services. It focuses on community provisions for the young, women, people from black communities, and those involved with the criminal-justice system.

CDA operates in South London, where outreach teams visit a variety of locations including the streets, housing estates, youth clubs, flats, escort agencies, massage parlours and police custody suites. More than 100 people are reached each month. Generally, contacts are maintained for no longer than three months, after which clients are referred to other drug services.

The services offered include sexual-health advice, criminal-justice arrest referrals, peer education for young people and counselling. An integral part of CDA's development has been the open

discussion and negotiation between the parties involved in drug-related services, including the Drug Addiction Team, the Drug Reference Group, the local authority, the health authority, the South London Drug Prevention Team, the Inner London Probation Service and local treatment providers.

Funding

CDA receives core and contingency funding and has an annual budget of Euro 296,790.

Summary and conclusions

THE DEVELOPMENT OF OUTREACH WORK	156
GOALS AND TARGET POPULATIONS	156
ORGANISATIONAL STRUCTURES	158
MODELS OF OUTREACH WORK	160
OUTREACH WORK AND NATIONAL POLICIES	163
PRACTICE AND CONCEPTS	164
DOCUMENTATION AND EVALUATION	164
RECOMMENDATIONS	167

THE DEVELOPMENT OF OUTREACH WORK

The practice of outreach work has altered considerably over time. Outreach work in general has its longest tradition in the United States, while the Netherlands and the United Kingdom have, within the rather brief span of three decades, established an outreach tradition specifically tailored to drug users. A similar pattern can be seen in academic practice where there has been a gradual shift in focus from the poor in general, to the youthful poor, to 'flower-power' youth, to drug users, and subsequently on to 'hidden' drug users in the wake of the HIV epidemic. The most recent shift can be observed in the targeting of users of the so-called 'new' drugs in the 'rave' and party scene, which has broadened yet again the scope and contact methods of outreach work. Despite these similarities, many differences are also evident between countries, for example in the points and the pace at which outreach workers intervene. In both Europe and the United States, outreach interventions have been influenced or initiated by research projects that also involve direct action.

GOALS AND TARGET POPULATIONS

Outreach work still focuses predominantly on users of 'old' drugs, such as heroin and cocaine. Outreach work for users of 'new' drugs, such as ecstasy, with an emphasis on demand reduction, appears to be more common in the Nordic countries than in other parts of Europe. Harm-reduction outreach initiatives among users of 'new' drugs in Europe have so far been most common in Austria, Germany, the Netherlands and the UK. Throughout the EU, four overall aims of outreach work have been defined at national level:

- identifying and contacting hidden populations;
- referring these populations to existing care services;

- initiating activities aimed at prevention and demand reduction; and
- promoting safer sex and safer drug use.

A further aim, defined nation-wide in only a few countries, is to identify the needs and perceptions that drug users have with respect to existing drug-care services and, subsequently, to relay this information to the services as feedback. Such information could greatly enhance the effectiveness and co-ordination of drug-care services.

Of the three working methods distinguished – detached, domiciliary and peripatetic – detached outreach work is the most common in the EU, followed by peripatetic and lastly domiciliary outreach work, which is not widely practised.

In outreach work for users of ‘old’ drugs, debate centres around two questions. Is it more effective to contact hidden populations to try and improve their access to existing centre-based treatment and care services? Or is it better to contact them directly within the social environments and localities frequented by drug injectors, where the drug taking and risk behaviour actually occur?

With regard to the users of ‘new’ drugs, the aims of outreach interventions are little different from those involving ‘old’ drugs. However, the target group characteristics and the settings differ profoundly, necessitating radically different working methods. Compared to the efforts for users of ‘old’ drugs, outreach work with users of ‘new’ drugs is still in its infancy.

One of the most intractable aspects of behaviour confronted by outreach work targeted at both types of user is the prevention of unsafe sex. In part, this is because sexual behaviour often transcends the boundaries of the target groups. Promotion of safer sex in the general population, although also not easy, is therefore still urgently needed to slow or stop the spread of AIDS.

ORGANISATIONAL STRUCTURES

Most outreach services operating in the EU emanate from drug agencies or youth-work organisations. Stand-alone outreach organisations are rare, as are outreach activities 'self-organised' by current or former drug users (either independently or as part of a broader self-help organisation). In north-western Europe, outreach services are more commonly part of health agencies, while in southern regions they are often part of community services.

Outreach services include both internal and external organisational structures, and both aspects should be assessed in light of the main aims of outreach work – obtaining a clear picture of the target groups, accessing them, and identifying and appropriately supporting drug-users' needs. Both literature studies and observations of outreach practice show that most such services still lack sufficient financial, legal and human resources to perform their tasks well. Practically nowhere in the EU do adequate training facilities exist with a specific focus on outreach work, and there is a consequent lack of professional accreditation and coherent job profiles. Much could also be done to improve the terms of employment and career opportunities of outreach workers. Experience shows that when welfare agencies are under threat, their outreach activities are often the first to be cut back.

The external relations of outreach services involve contacts with other drug agencies as well as interaction with a still-wider organisational context. Such relationships are of critical importance. Outreach workers may initiate many fruitful activities to promote safer drug use, but if the drug users then face a host of obstacles to putting the new techniques into practice (such as being arrested by police after having exchanged syringes), outreach activities are condemned to failure at the outset. Networking and co-operation between agencies is important, but practical problems abound. Scarce resources, different or opposing aims, and divergent professional backgrounds and cultures all hinder effective networking. It should be noted that these types of networking problems occur not just in outreach work, but also throughout the drug field.

The major organisational problems that can arise in outreach projects include the structural isolation of workers, difficult relations with host organisations, over-involvement with clients, disagreements over methodology and objectives, duplication and overlaps with other services, and the lack of an adequate career structure. In the light of such difficulties, it would seem advisable to allow outreach services enough autonomy to develop working methods that are responsive to the needs and situations they encounter. A fundamental aim in developing future services for drug users should be to make them more accessible to clients. Outreach work has an important part to play in this process.

Three types of outreach workers can be distinguished:

- professionals;
- indigenous workers or peers; and
- volunteers.

Given the ongoing process of professionalisation in outreach work, the involvement of peers and volunteers is perceived as very valuable indeed. However, the inclusion of peers (current or former drug users) is often a source of controversy, not so much in theory, but in operational practice. Disagreements also arise about the validity and legality of the methods used and the position of workers within the wider organisation. Such conflicts are more likely to occur in the 'old' drugs than in the 'new' drugs sphere, partly because of the different characteristics of their target groups. The composition of outreach teams and the degree of involvement of 'indigenous' workers and volunteers vary from country to country according to the status of the work in the countries in question or to pragmatic considerations.

With regard to 'new' drugs, the peer approach is gaining popularity. A viewpoint is developing in some countries that it may be more efficient and effective to train generic youth workers in drug prevention and demand reduction, thus integrating such themes into the totality of their work, which also requires a multiplicity of other skills.

MODELS OF OUTREACH WORK

Outreach work can vary with regard to:

- the people that practise outreach work and their target groups (*who*);
- the objectives of outreach workers (*what*);
- the methods applied (*how*); and
- the settings in which these methods are put into practice (*where*).

Based on the literature and on discussions with experts, four models of outreach work have been constructed, each with its own 'who', 'what', 'how' and 'where'. Not all have found practical expression in every EU Member State, nor have they always succeeded one another chronologically. In the field, working practices classifiable according to one model will usually contain characteristics of other models as well. Nevertheless, there is wide agreement among outreach workers and international experts as to the practical value of the models and their authenticity as representations of current outreach practice.

The Youth Work Model is the oldest in Europe. In the 1960s, youth workers began emerging from their offices and actively seeking contact with 'problem youth'. Characteristically, the goal they set for themselves was to find a solution with the young people themselves, instead of deciding from an office what they thought best. This model is mainly followed by professionals, but also by some former drug users who have undergone specific educational or on-the-job training. They are generally referred to as 'mobile' or 'outreaching' youth workers or street workers. Their target groups are not necessarily defined as drug users, nor is drug use as such the primary focus; instead, it is regarded as one of the problems of marginalised young people. The aim is to prevent any further marginalisation and to encourage social integration. The approach is usually detached outreach work, and involves making contact with marginalised youth, including drug users, in their 'natural environments', encouraging them to make use of their 'natural networks', and guiding them in their contacts with traditional institutions.

The Catching Clients Model first emerged in the early-to-mid-1970s in therapeutic communities. The original practitioners were predominantly therapists and former patients, or professionals and volunteers working from religious organisations. The primary task of this type of outreach worker was, and still is, to draw drug users into care programmes, and in particular into drug-free, inpatient treatment. Abstinence, followed by social reintegration, is the foremost goal. Originally, detached outreach work predominated, but today the work is mainly peripatetic in places like police stations, prisons and hospitals. Although other models also furnish information about treatment facilities and refer drug users to them, outreach work does not automatically qualify for the Catching Clients Model. A necessary condition is that drug-free treatment be the primary aim of the outreach work. The Catching Clients Model is currently practised most extensively in the Nordic countries, particularly in Sweden and Norway, with the users of 'old' drugs as the chief target group. Although outreach work in Greece is generally defined as a harm-reduction activity, in practice it still bears a close resemblance to the Catching Clients Model.

The Self-help Model, like the original Youth Work Model, responds to the wishes and possibilities of the drug users themselves. Two major differences in this third model are that it focuses much more explicitly on drugs, and that its actions are based more on the perceived interests of the group than on those of the individual. Originating in the late 1970s, it has clear links to the drug users' self-organisations, as well as to the notion of acceptance – that is, acceptance of drug taking as a social reality, as opposed to the abstinence paradigm. More than any other model, this one is grounded in the drug scene itself, and is practised predominantly by current or former drug users (peers), community workers and volunteers. It aims mainly at harm reduction, encouraging safer drug use and safer sex by providing information, distributing syringes and condoms, organising community-based activities, and setting up or promoting user-friendly facilities, including places where users can take drugs. Nowadays there are few truly independent self-organisations, since most of them have found accommodation in drug-care agencies.

The Public Health Model is built upon the Self-help Model, the main difference being that it assigns a more important role to professionals (nurses, doctors, fieldworkers). The Public Health Model came into its own in the mid-to-late 1980s, notably under the influence of HIV and AIDS, and later of other diseases such as hepatitis. The primary aim is harm reduction through safer drug use and safer sex, achieved by providing information and distributing syringes and condoms. Outreach workers often operate from low-threshold facilities, such as methadone-maintenance programmes and drop-in centres.

More recently, outreach work along the lines of the Public Health Model is also being practised among users of 'new' drugs. More than in the case of 'old' drugs, peers are recruited for such initiatives, both for peer support and for peer education. There is also greater emphasis on detached outreach work, performed mainly at 'raves' or in and around clubs. Still newer is outreach work among crack cocaine users.

Historically speaking, these models emerged one after the other. This does not mean, however, that all models have been practised in every EU Member State, nor that the most recent model – the Public Health Model – now predominates in all countries. In countries with longer traditions of outreach work, the first methods proceeded according to the Youth Work Model, sometimes with problem drug users as a specific target group, but more often with a general focus on youth in socially deprived groups.

Now, however, outreach work targeting drug addicts seldom conforms to the Youth Work Model, although it is still commonly performed amongst young people who are experimenting with drugs, particularly in Nordic countries. The Catching Clients Model is no longer common, although it, too, is relatively more prevalent in Nordic countries and in Greece. The Self-help Model has flourished most productively in the Netherlands as well as in the United Kingdom. The Public Health Model is the one most widely practised today, but *de facto* it is less common in northern and southern Europe. It is the most strongly developed in

Germany, the Netherlands and the United Kingdom, and there is clear evidence of its growing acceptance in southern European countries.

OUTREACH WORK AND NATIONAL POLICIES

Outreach work in the drugs field is an activity of growing importance in Europe. In most of the countries reviewed in this book, outreach work plays a significant part in national drug policies. However, it seems that such work is at a more developmental stage in Belgium, France, Luxembourg and Portugal, while in Spain it is still of marginal importance as far as national-level drug policies are concerned. Most countries have nationally defined aims for outreach work, although the activity is not always referred to in national-level drug-policy documents.

The degree of diffusion of outreach work varies among the countries surveyed, being the greatest in north-western countries, where it is practised in all or most cities and towns with acknowledged drug problems. It is lowest in southern European countries, apparently reflecting the experimental nature of most outreach projects in this region.

A great deal of variation exists between countries in the funding of outreach work, with different models applied concurrently. The most common sources are direct state funding and direct municipal funding of outreach agencies. Not all Member States apply these two models, however. Most, but not all, generate additional funding from drug-care agencies, trusts or charities, or work with unpaid volunteers. Although patterns are difficult to discern, Denmark and the UK appear to work the most with non-public sources of funding.

PRACTICE AND CONCEPTS

The country overviews in Chapter 7 reveal many similarities, as well as differences, in national policies and practices. There are also differences and similarities in terminology. One crucial difficulty today is that the term 'outreach work' itself is hardly known, much less used, in most countries among the people who carry it out. People outside the UK normally use terms such as 'street work' or 'fieldwork'. After a brief explanation, however, they readily recognise what is understood by the concept of outreach. Chapter 5 examines the terminology of European outreach work in some detail, and an international glossary of terms appears at the end of the book.

Even though some effort will be necessary to make 'outreach work' a universally accepted term for this widely practised and cross-culturally recognisable activity, this has not discouraged the present authors from proposing a new definition:

Outreach work in the drug field is a proactive method used by professionals and trained volunteers or peers to contact drug users. Its aims are to inform them about the risks associated with drug-taking, to support them in reducing or eliminating such risks, and/or to help them improve their physical and psychosocial circumstances through individual or collective means.

DOCUMENTATION AND EVALUATION

Outreach projects report on their aims and their work activities using different formats depending on the audiences they are addressing. Reports are usually designed for funding agencies, policy-makers or the larger organisations of which the outreach work is a part. Documents are either regular or irregular reports providing background information on the project and general profiles of the target groups and services provided.

They often also include some descriptive quantitative figures. Another target audience, and obviously the most important one, is the potential users of the outreach services. Many different kinds of materials are produced for this audience, mostly in pamphlet form, providing, in lay terms and sometimes also in foreign languages spoken by immigrant target groups, information about available services and where these services can be obtained. They often contain prevention messages as well.

It appears to be common practice for outreach projects to collect at least some basic data about their activities and their target groups. Four different types of data have been identified:

- general characteristics and drug behaviour of individual clients;
- aggregated client data, often organised according to target subgroups;
- individual and aggregated employee data; and
- material data (e.g., number of syringes and condoms supplied).

These general types of data collection are common to most outreach projects. However, the indicators applied, as well as the time frame used, vary greatly between projects. In other words, few standardised guidelines exist, even at local or regional level, let alone at national or European level. Meanwhile, in practice such quantitative types of data collection are regarded by many workers as far from ideal, for a number of reasons.

- Given the nature of outreach contacts on the streets (or at parties and 'raves'), it is not always easy to collect the quantitative data required, and it can interfere with the principal activity of outreach work. To avoid this problem, data-gathering instruments should be 'casually unobtrusive'.
- Workers are not always convinced about the usefulness of the questions asked.
- Since most information is based on clients' self-reported behaviour, the issue of reliability has to be dealt with.
- Many outreach workers would prefer to have more time available to collect and reflect on data they perceive as useful (for example, diaries or systematised field observations).

- Some projects are funded by two or more different agencies, which require different types of data collection and presentation. This can complicate the data-collection procedures.
- Data collection is sometimes demanded, but then no use is subsequently made of the information. It seems a mere bureaucratic prescription.

The need for evaluation, although often intended for very different purposes, is recognised at various levels, ranging from individual outreach projects to regional, national or European bodies. Three types of evaluation methods have been discussed here – structural, process and outcome evaluation. Outcome evaluations of outreach interventions are difficult to design and apply, require considerable resources and are prone to a range of practical and methodological difficulties. Process evaluation appears the most widely applied method in outreach projects. However, much of the documentation is internal reports about outreach projects, making it unclear whether these are true evaluations or merely policy documents containing some remarks about outreach work. Systematic evaluation of outreach projects thus appears to be at an early stage in many countries. Outreach workers themselves are known to perceive process evaluation as the most beneficial, and express an urgent need for qualitative information and for establishing minimum standards or guidelines for outreach teams. Data collection and evaluation instruments are often invented *ad hoc* and are specifically geared to certain projects, making comparison with other projects on a nation-wide or European scale very difficult.

Outreach practice is characterised by uniquely autonomous methods of practice from which angle the need for data collection and evaluation should be approached. A more in-depth study of some of the issues addressed here is recommended, in order to ascertain whether European data collection on outreach work is feasible. The EMCDDA's current EDDRA questionnaire could serve as a prototype, but it should preferably be revised in a number of ways to make it more suitable for evaluating outreach practice.

In the final analysis, however, given the unique nature of outreach work and the widely divergent state of the art, the most urgent needs of the outreach projects themselves at present seem to lie in improving the actual practice of outreach work itself. Some ways to achieve this would be to formulate working standards and methods, to create training facilities, to strengthen inter-organisational working relations, and to develop methods for recruiting peers and volunteers.

RECOMMENDATIONS

On the basis of the findings presented in this book, seven recommendations for future action in support of outreach work among drug users can be made.

Since drugs outreach work is now practised in all European Union Member States, there is an urgent need for cross-national collaboration. A major prerequisite is that the conceptual framework surrounding outreach work be universally understood. A major obstacle to this is that the English concept of 'outreach work', which embraces all the specific tasks performed in this type of activity, is not commonly applied – or even widely known – outside Ireland and the UK. It is particularly unfamiliar to the continental outreach workers themselves, who use a variety of other terms to refer to it. This confusion of tongues may impede cross-national communication. As a result:

- concrete steps should be taken to ensure that people in all European Union Member States, particularly those who work in outreach or related fields, become familiar with the term and concept of outreach work.

Outreach workers generally learn their trade in operational practice and professional training courses that deal with drugs usually focus on more traditional types of interventions, such as residential or ambulatory treatment. Little attention is devoted to outreach work.

Although some outreach training courses are available, and outreach work is treated sporadically at colleges and universities, little is known about the quality of such courses or the curricula they work with. As a result:

- training course to professionalise outreach work, and ways to integrate outreach work into more general professional training curricula, should be identified.

In order to safeguard the quality of outreach work, people in several European countries are now developing basic criteria ('standards') for outreach infrastructure, methods, professional qualifications and related issues. Most such initiatives are local in nature and independent of one another, even within the same country. As a result:

- a project should be established to enable experts from different Member States to exchange experiences and explore the possibilities and limitations of European standards.

An essential precondition for the integration of outreach programmes into a European information system is the availability of systematic data on such programmes at national levels. So far it has proved very difficult to obtain systematised national overviews, which is quite a complex task, even for National Focal Points. Different outreach projects use widely varying methods of registration and documentation, ranging from qualitative data (such as diaries and logbooks) to quantitative statistics (derived from intake forms, checklists or questionnaires). The decision to use a particular method is based on considerations such as the organisational aims of a project, its target groups and its internal or external organisational obligations. As a result:

- a simple format for data collection which is consistent with the practical work of outreach activities should be created. This should allow for the full range of possible objectives of outreach activities, and for the different target groups and range of problems they may be facing. A standardised data-collection

format would enable systematic, national-level data to be gathered for use in a European information system.

In view of the loosely structured nature of outreach work as compared with other types of interventions, outcome evaluation is not generally advisable as a method of assessment. It is not usually possible to isolate the specific effects of outreach interventions from those of other influential factors. In most cases, process evaluation will be the most feasible method for evaluating outreach work. As a result:

- research should be undertaken into the experiences that have been gained during process evaluations of outreach work. The findings of such evaluations should be documented, making a clear distinction between outreach activities for 'old' and for 'new' drugs. The indicators and models applied in the evaluations should be assessed, and the possibility of creating 'prototype' process-evaluation models which would be suitable for cross-national application studied. This would greatly enhance comparability among countries.

The organisational structures in which outreach work is embedded vary widely. Most often they are health, youth or drug services. More rarely, they are relatively autonomous, small organisations which deal exclusively or primarily with outreach work. Little is known about what organisational forms can best guarantee the quality of outreach work. As a result:

- the influence of organisational structures on the quality of outreach work should be discussed, again distinguishing between outreach work for 'old' and for 'new' drugs.

The methods for disseminating information on outreach work depend in large part on the group being targeted. When this target group is the outreach workers themselves, dissemination through existing institutional channels is an insufficient guarantee that the information will actually reach them. A regular, active exchange of experiences amongst outreach workers would seem a more

effective method. This would also give more experienced projects an opportunity to communicate their knowledge and skills to less experienced projects. As a result:

- European exchange platforms in the form of workshops should be set up at which outreach workers themselves can meet, actively exchange experiences, and learn from one another. They could also take the form of a European outreach newsletter or an outreach Internet web site. Given the fact that information exchange among outreach workers is still in its infancy and that outreach workers spend most of their time on the 'street', face-to-face meetings at this stage would appear the most beneficial.

Glossary

Glossary

This glossary provides short descriptions of terms related to outreach work. Key concepts discussed in previous chapters are briefly explained, and some less commonly used concepts are also given. Most descriptions are in English, with the exception of several French terms which, because of their specific meaning, are explained in French for terminological clarity. Terms in languages other than English have entries that refer to the English equivalent. Unless otherwise indicated, terms in French are also used in Wallonia, and terms in German in Austria and the German-speaking parts of Switzerland.

The entries provided here are based on the study that informs this book. The list is therefore not exhaustive for all languages concerned. The symbol → indicates that the term is also in the Glossary.

TERM	DEFINITION
<i>Acercamiento</i>	Spanish for →outreach; not very common
<i>Aufsuchende Arbeit</i>	German for →outreach work
<i>Bas seuil</i>	French for →low-threshold. Also, <i>bas seuil d'exigence</i> or <i>structure à bas seuil d'exigence</i> Structure où les usagers de drogues peuvent avoir accès à des services de bases (café, espace de repas, seringues stériles, kits, douche, aide pour faire leurs démarches) sans que des contreparties ou

des exigences soient demandées, hormis le respect des règles minimales de la vie sociale (non acceptation des violences), et de la loi (pas d'usage et de deal de drogues dans les locaux). Le terme de bas seuil est assez controversé dans la mesure où il peut être péjoratif (travail à bas seuil des prestation)

Bassa soglia Italian for →low-threshold

Boule de French for →snowballing

neige Influenced by the Belgian *Boule de Neige* project, the French term is also known in border regions of Germany and the Netherlands, and increasingly in other EU countries too

Centro de acogida Spanish for →drop-in centre. To some extent it is comparable to a low-threshold centre, an equivalent of which does not exist in Spanish

Chill-out room Room at a →'rave' without music or with less loud and fast music than in the 'rave' or party itself. Drug users can relax, drink and 'cool down', and outreach workers can contact them, offer help and give information. Internationally used term

Cold contact Person (drug user, client) not previously known to the agency or outreach organisation (opposite of warm contact). The term is used in UK and Ireland, but is not common in other countries

Community change Change in the norms of communities (populations, groups) of drug users as a whole, rather than change restricted to individual members of that community

Crisis intervention Action aiming to solve the most important acute problem at the moment

Detached outreach Outreach work outside any service contact, such as on the streets, in pubs, clubs or squats. Concept often unknown in the practice of outreach work outside the UK. Similar to →street work

Dispositif mobile French for →mobile bus or van

Bus aménagé pour aller au devant des personnes et leur délivrer des services de bases, soins, seringues, informations, etc.

Domiciliary outreach	Outreach work in the homes of target populations, through regular home visits to drug users or the homes of dealers. Not a common concept in the practice of outreach work outside UK. Commonly included as 'home visits' under the more general term →street work
Drop-in centre	A user-friendly centre where drug users or street sex workers can go, stay for a while, have simple food or drink, and obtain information, condoms, syringes, etc. Quite common international term for a fixed →low-threshold facility
<i>Druckraum</i>	German: facility where users can take drugs under better hygienic circumstances than on the streets, usually with nurses and sometimes also social workers present. Originally for intravenous users in particular, but increasingly for crack users as well, hence, the term → <i>Konsumraum</i> is becoming more common
<i>Echange de seringues</i>	French for needle exchange Donner des seringues stériles pour les injections. Certains intervenants en contre partie les seringues usagées, mais ce n'est pas systématique compte-tenu des difficultés que rencontre les usagers de drogues pour ramener leurs seringues, du fait de l'interdit qui frappe l'usage de drogue dans la législation française, le port d'une seringue peut alors être une suspicion d'usage en cas d'interpellation par la police. L'échange de seringues peut se faire dans un lieu fixe ou dans le cadre d'un travail de rue
<i>Educazione tra pari</i>	Italian for →peer education
Empathy	Ability of outreach workers to have confidential, informal or friendly relationships with drug users
Empowerment	Helping people gain power to take action to control and enhance their own lives, and the processes of enabling them to do so. In the context of outreach work, not a very common concept outside the UK
<i>Equipa de rua</i>	Portuguese for →street-work team

<i>Equipa mista</i>	Portuguese for mixed teams. Representatives from the target populations are included as partners in the project team
<i>Esimotivointi</i>	Finnish: literally 'premotivation'. First step in an outreach method by which to begin motivating a client to become aware of his or her problems
<i>Elsivä sosiaalityö</i>	Finnish for →outreach work
<i>Formidling</i>	Norwegian for →referral
<i>Gassenarbeit</i>	Swiss German and to a lesser extent Austrian for → <i>Straßensozialarbeit</i> , →street work. Today the terms → <i>Streetwork</i> and → <i>Straßensozialarbeit</i> are more common in Austria
<i>Groupe de pairs</i>	French for →peer group Des personnes qui font partie du monde social des usagers de drogues et sur lesquels les intervenants s'appuient pour qu'ils servent de relais, transmettent des informations et des messages de prévention au sein de leur milieu
<i>Grupo de iguales</i>	Spanish for →peer group
<i>Harm reduction</i>	Active efforts to reduce the harm that drugs can cause rather than trying to prevent drug use as such
<i>Intercambio de jeringuillas</i>	Spanish for needle exchange
<i>Intervenção comunitária</i>	Portuguese: community intervention, involving local populations in dealing with the local drug problem
<i>Intervenção de rede</i>	Portuguese for →networking
<i>Katutyö</i>	Finnish for →street work, in particular among the young
<i>Konsumraum</i>	German: facility where drug users can take drugs under better hygienic circumstances than on the streets. See also → <i>Druckraum</i> . The term <i>Konsumraum</i> is gaining popularity
<i>Krisen-intervention</i>	German for →crisis intervention
<i>Laagdrempelig</i>	Dutch for →low threshold
<i>Lavoro di rete</i>	Italian for →networking

Low threshold	Originally from the Dutch → <i>laagdrempelig</i> . Easily accessible facilities for drug users with user-friendly services with a greater emphasis on harm reduction than on abstinence. Visitors can have something to eat and drink, hygienic facilities are often provided, needles can usually be exchanged and methadone is sometimes dispensed. Has been translated into several other languages
Mapping	Making a geographical and social 'map' showing at what points groups of drug users can be found in a region, city or neighbourhood, including information on their characteristics and/or problems. The purpose is to set goals and priorities with regard to target groups, theoretically the first stage of an outreach project. Also used to map new trends in drug use (trend mapping or trend spotting)
<i>Meccanismi autoregolativi</i>	Italian: self-changing processes, behavioural change through collective or group processes, e.g., changing subcultural norms and values
Mobile bus or van	A bus or van providing services to drug users at certain times on a regular basis (e.g., daily or every weekend). Services may include needle exchange, elementary medical care, food and drink, methadone provision. Normally in neighbourhoods where many drug users live or congregate. Does not apply to buses and vans with a fixed location
<i>Προγραμμα προεγγιξης χρηστών στο δρόμο</i>	Greek for →street work. Literally a counselling programme for support on the streets
<i>Nachlaufende Sozialarbeit</i>	German: to go after, try to find the client again
Networking	Working together with other services in the interest of clients, but in different fields or at different levels. Also called network mobilisation
<i>Niedrigschwellig</i>	German for →low-threshold. For example, <i>niedrigschwellige Drogenarbeit</i>
<i>Offene Szene</i>	German for →open scene

Open scene	Originates from German → <i>offene Szene</i> . A stationary gathering of drug users in public where drug use and trafficking is visible, even to an outsider, for example in or near train stations. Term not used in UK, but not uncommon in other countries
Oppsukende arbeid	Norwegian for → outreach work
Peer	From 'peer group'. Trained volunteer who belongs to the target population (drug user, prostitute) or previously did (ex-drug user, ex-prostitute). Usually involved in peer support or peer education projects. Internationally applied term
Peer education	Peers educating drug users by communicating preventive messages, in particular on safe drug use and safe sex, to their peers in their own language within a common subculture. Most important for outreach work among users of 'new' drugs
Peer outreach	Outreach work undertaken by → peers
Peripatetic outreach	Organisationally rather than individually focused. Work undertaken and services delivered in agencies and institutions such as hostels, youth clubs and prisons. Although outreach workers are not unfamiliar with this kind of work, it is not a common term in practice outside UK. In France the term 'peripatetic' is associated with prostitution
Prévention participative	French: 'shared prevention', working together with the target group in preparing, conceptualising and realising prevention and prevention materials. Based on equality of partners. Practised in <i>Boule de Neige</i> project. Not a common concept
Rave	Gathering of a large group of predominantly young people, originally in the open air or at a partly open venue, at which amplified and very fast music is played, mostly at night. Today the setting is often indoors. Often associated with the use of synthetic drugs such as ecstasy, although usually not all visitors are under the influence of such substances

<i>Reducción de daños</i>	Spanish for →harm reduction
<i>Reducción de riesgos</i>	Spanish for risk reduction
<i>Redução de riscos</i>	Portuguese for →harm reduction and risk reduction
Referral	Informing drug users where they can get adequate help, bringing them into contact with other agencies and institutions
<i>Relasjons bygging</i>	Norwegian for relationship building. A very common concept in the daily practice of outreach work in Norway, meaning contacting people in the streets to build a more trusting relationship to facilitate further work. Similar to Finnish concept of → <i>esimotivointi</i>
ΣΤΕΚΙ ΤΙΑ ΧΡΗΓΕΤΕΞ ΗΑΡΟ ΤΙΚΜΗ ΟΓΞΙΟΗ Safe sex	Greek for →drop-in centre. Literally 'drug users' meeting point'
Safe use	Also 'safer sex'. Practising sex with lower risk of infections. In the context of outreach work, mainly the promotion of condom use and the distribution of condoms. In many countries known mainly by the English term
Satellite	Also 'safer use'. Using drugs in ways that carry a lower risk of infection or other harmful consequences. In the context of outreach work, mainly the promotion of non-intravenous modes of administration, or, in the event of intravenous use, the consistent use of new syringes or needles or the thorough sterilisation of used ones. In many countries known mainly by the English term. Many outreach workers are actively involved in needle exchange
	Outreach provision in special locations (e.g., formal in probation offices, informal in community centres) in partnership with other agencies. See →peripatetic outreach

<i>Schadens- minimierung</i>	German for →harm reduction
<i>Schneeball- verfahren</i>	German for →snowballing. Also <i>Schneeball- methode</i> or <i>Schneeballtechnik</i>
<i>Skadereduser ende tiltak</i>	Norwegian for →harm reduction
<i>Sneeuwbal- methode</i>	Dutch for →snowballing. In Flanders (Belgium) better known as → <i>boule de neige</i>
Snowballing	Contacting new persons (drug users, clients) through the network of already known persons (drug users, clients). A technique applied in quali- tative research (snowball sampling) and a term increasingly used in outreach work, in particular in peer support and peer education projects
Social work	An educational background common amongst outreach workers. However, ‘social worker’ can have rather different official and unofficial meanings. In some countries, social workers are likely to be perceived by drug users as state officials or repre- sentatives of institutions. More neutral term in Germany → <i>Sozialarbeit</i>
Solution- focused brief intervention	Provision of short-term intervention to client (maximum of several months). Problem-solving focus on the basis of client’s needs
<i>Sozialarbeit</i>	German for →social work
<i>Sozialarbeiter</i>	German for person who practises <i>Sozialarbeit</i>
Spotting	See →mapping
<i>Spritzentausch</i>	German for needle exchange
<i>Spuitenruil</i>	Dutch for needle exchange. Also <i>spuitenomruil</i>
<i>Straathoeck- werk</i>	Dutch for →street work. In the Netherlands also known by the English term ‘street-corner work’. Also <i>veldwerk</i>
<i>Straßensozial- arbeit</i>	German for →street work. More common term in Germany and Austria is <i>Streetwork</i>
Street work	Internationally the most common term for →outreach work. Refers primarily, though not exclusively, to detached outreach work

<i>Trabajadores de acercamiento</i>	Spanish for →outreach workers. More common term → <i>trabajadores de calle</i>
<i>Trabajadores de calle</i>	Spanish for →street workers
<i>Travail de rue</i>	French for →street work Il s'agit d'aller au devant des usagers de drogues, dans la rue, les squats, à pied, dans un bus ou dans des voitures banalisées pour leur délivrer des messages de prévention, leur donner des informations (adresses où ils peuvent obtenir des services, risques liés à l'injection) de distribuer des seringues stériles, etc.
<i>Überlebenshilfe</i>	German: survival help. In particular, the provision of food, drink and clothing
<i>Utekontakt</i>	Norwegian for →street work
Warm contact	Person (drug user, client) already known to agency or outreach organisation. Used in UK and Ireland, not common in other countries. Opposite of cold contact

References

References

- Adler, P.A.** (1985) *Wheeling and dealing: An ethnography of an upper-level drug dealing and smuggling community* (New York: Columbia University Press).
- AIDS-Hilfe** (1997) *Zugehende Sozialarbeit für drogengebrauchende Frauen und Männer. Ein Handbuch* (Berlin: Deutsche AIDS-Hilfe).
- Armstrong, D., Grace, J.** (1994) *Research methods and audit in general practice* (Oxford: Oxford University Press).
- Auge, M.** (1995) *Non-places: Introduction to an anthropology of super-modernity* (London: Verso).
- Barraud, D.** (1994) 'Taking the first step: Outreach work with drug users', in Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs, *Outreach* (Strasbourg: Council of Europe Publishing), 85–91.
- Barrow, S.M., et al.** (1991). 'Evaluating outreach services: Lessons from a study of five programs', *New directions for mental health services*, 2, 29–45.
- Bassarak, H.** (1995) 'Thesen zur Strassensozialarbeit/Mobilen Jugendarbeit zwischen selbstgestellten Leistungsanspruch und von aussen determinierten Effektivitäts- und Effizienzkontrolle', *Streetcorner*, 8(2), 53–71.
- Becker, H.S.** (1963) *Outsiders: Studies in the sociology of deviance* (New York: Free Press).
- Blanken, P., Barendregt, C.** (1998) *Het roken van cocaine-base in Rotterdam* (Rotterdam: Instituut voor Verslavingsonderzoek).
- Bolton, K., Walling, A.** (1993) 'User to user', *Druglink*, 8(4), 14–15.
- Booth, R.E., Koester, S.K.** (1996) 'Issues and approaches to evaluating HIV outreach interventions', *Journal of drug issues*, 26(3), 525–39.
- Boullenger, N., Weinberger, M., Coppel, A.** (1992) 'Les recherches françaises de terrain sur les toxico-

manies', in Ehrenberg, A. (ed.) *Penser la drogue, penser les drogues. I – Etat des lieux* (Paris: Editions Descartes).

Bravo, M.J. (1994) 'Reaching special target groups: Some lessons learned', in Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs, *Outreach* (Strasbourg: Council of Europe Publishing), 33–43.

Broadhead, R., Margolis, E. (1993) 'Drug policy in the time of AIDS: The development of outreach in San Francisco', *Sociological quarterly*, 34(3), 497–522.

Buning, E., Van Brussel, G., Van Santen, G. (1988) 'Amsterdam's drug policy and its implications for controlling needle sharing', in Battjes, R., Pickens, R. (eds) *Needle sharing among intravenous drug abusers: National and international perspectives*, NIDA Research Monograph 80 (Rockville, MD: National Institute on Drug Abuse).

Cohen, A.P. (1985) *The synthetic construction of community* (London: Routledge).

Coles, P., Pates, R. (1993) 'More than just a number', *Druglink*, 8(4), 16–17.

Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (1994) *Outreach* (Strasbourg: Council of Europe Publishing).

Coppel, A. (1996) 'Les intervenants en toxicomanie, le sida et la réduction des risques en France', *Communication: Vivre avec les drogues*, No. 62 (Paris: Seuil), 75–104.

Correia-Chitas, V. (1994) 'Intervention in networks, an experience in a town in the Greater Lisbon area', in Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs, *Outreach* (Strasbourg: Council of Europe Publishing), 59–63.

Cranstoun Drug Services (1997) *Annual review 1996/1997: Tackling drug use in our communities* (London: Cranstoun Drug Services).

Debord, G. (1983) *The society of the spectacle* (Detroit, MI: Black and Red).

Demange, J. (1996) 'The French situation', in Nizzoli, U. (ed.) *The way things are* (Modena: Mucchi), 209–13.

Ehrenberg, A. (ed.) (1992) *Penser la drogue, penser les drogues. I – Etat des lieux* (Paris: Editions Descartes).

Eisenbach-Stangl, I. (1994) 'Die neue Nuechternheit. Epidemiologie des legalen und illegalen Drogengebrauchs von Kindern, Jugendlichen und jungen Erwachsenen in Oesterreich', in Janig, H.R. (ed.) *Wartezeit. Studien zu den Lebensverhaeltnissen Jugendlicher in Oesterreich* (Innsbruck: Oesterreichischer Studien Verlag).

Eisner, E. (1979) *The educational imagination: On the design and evaluation of school programs* (New York: Macmillan).

Elwood, W.N., Dayton, C.A., Richard, A.J. (1995) 'Ethnography and illegal drug users: The efficacy of outreach as HIV prevention',

Communication Studies, 46(3/4), 261–75.

EMCDDA (1998) *Evaluating drug prevention in the European Union*, Scientific Monograph No. 2 (Lisbon: European Monitoring Centre for Drugs and Drug Addiction).

EMCDDA (1997) *New trends in synthetic drugs in the European Union: Epidemiology and demand-reduction responses*, Insights series No. 1 (Lisbon: European Monitoring Centre for Drugs and Drug Addiction).

Fontana, T. (1997) 'Ach wie gut... dass es bald eine BAG Street-work/Mobile Jugendarbeit in Deutschland gibt', *Streetcorner*, 10(2), 19–21.

Foote, W. (1943) *Street corner society* (Chicago, IL: University of Chicago Press).

Franken, I.H.A., Meulders, W.A.J. (1994) *Evaluatie-rapport Aids-preventie-project Boule de Neige* (Limburg: Consultatiebureau voor Alcohol en andere Drugs).

Fromberg, E. (1996) 'Harm reduction and XTC', Paper presented at the 'Conferenza Internazionale: Ecstasy e sostanze psichedeliche', Bologna, 18–19 November.

Fromberg, E. (1995) 'The ideologies behind harm reduction', Paper presented at the 6th International Conference on the Reduction of Drug-related Harm, Florence, 26–30 March.

Gamella, J.F., Roldán, A.A. (1997) 'The content of ecstasy in Spain', in

Korf, D.J., Riper, H. (eds) *Illicit Drugs in Europe* (Amsterdam: SISWO), 130–40.

Gilman, M. (1992) *Outreach – drugs work* (London: Institute for the Study of Drug Dependence).

Glaser, B., Strauss, A. (1967) *The discovery of grounded theory* (Chicago, IL: Aldine).

Grant, I. (1997) *An evaluation of outreach work in Lothian* (Edinburgh: Centre for HIV/AIDS Studies).

Gregory, J. (ed.) (1995) *Youth at risk. Community education responses to the needs of disadvantaged and excluded young people across Europe* (Edinburgh: International Community Education Association).

Grund, J., et al. (1992) 'Reaching the unreached: An outreach model for "on-the-spot" AIDS prevention among active, out-of-treatment addicts', in O'Hare, P. (ed.) *The reduction of drug-related harm* (London: Routledge), 172–80.

Hacker, P., David, A. (1996) *Vienna Drogenbericht 1996* (Vienna: Magistrat der Stadt Wien).

Hakerud, E. (1994) 'Effective factors in early intervention. Experience from work with streetgangs', in Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs, *Outreach* (Strasbourg: Council of Europe Publishing), 55–58.

Hartnoll, R.L., Rhodes, T.J., Jones, S., et al. (1990) *A survey of HIV*

outreach intervention in the United Kingdom (London: University of London, Birkbeck College).

Hazekamp, J.L. (1976) 'Streetcorner-work: een plaatsbepaling', *Jeugd en Samenleving*, 6, 503–18.

Hibell, B., et al. (1997) *The 1995 European School Survey Project on Alcohol and Other Drugs (ESPAD) Report. Alcohol and other drug use among students in 26 countries* (Stockholm: Swedish Council for Information on Alcohol and Other Drugs (CAN)/Pompidou Group of the Council of Europe).

IGIA (1996) *Centros de encuentro y acogida. Documento de referencia* (Barcelona: Grup Igia).

Ingold, F. (1991) 'Les toxicomanes en Europe: Epidemiologie et ethnographie', in Ehrenberg, A. (ed.) *Individus sous influence* (Paris: Editions Esprit).

Irish Ministerial Task Force (1996) *First report of the Ministerial Task Force on measures to reduce the demand for drugs* (Dublin: Department of Tourism, Sport and Recreation).

ISDD (1997) *Drug misuse in Britain* (London: Institute for the Study of Drug Dependence).

Jacob, E. (1997) 'Les structures à "bas seuil", nouvelle appréhension des phénomènes de toxicomanie ou gestion à minima des "populations à risques"?', *Revue Prevenir*, 32(1), 103–13.

Jacques, J.P., Goosdeel, A. (1990) 'Operation Boule de Neige', Paper presented to an international expert meeting on 'Aids, drugs and mass migration', Berlin, 17–20 November.

Jamin, J., Voortman, G.J. (1997) 'Three European cities united in prevention project', *Jellinek quarterly*, 4(3), 10–11.

Johnson, J., (1990) 'Ethnopharmacology', *Contemporary ethnography*, 19(3), 349–69.

Kaminsky, D. (1996) *Nouvelles politiques fédérales dans un Etat trirégional* (Paris: Colloque du Groupe de Recherche Psychotropes, Politique et Société).

Kinable, R. (1994) *Druggebruikers en AIDS. AIDS-risicogedrag by injecterende druggebruikers en evaluatie van een preventief project* (Antwerp: Verenigin voor Alcohol en andere Drugproblemen, Katholieke Universiteit Leuven, Free Clinic).

Klose, A., Steffan, W. (eds) (1996) *Streetwork und Mobile Jugendarbeit in Europa* (Münster: Votum).

Knoke, D., Kulinski, J.H. (1982) *Network analysis* (Newbury Park, CA: Sage).

Korf, D.J. (1995) *Dutch treat: Formal control and illicit drug use in the Netherlands* (Amsterdam: Thesis).

Korf, D.J., Blanken, P., Nabben, T. (1991) *Een nieuwe wonderpil? Verspreiding, effecten en risico's an*

ecstasy-gebruik in Amsterdam (Amsterdam: Jellinekcentrum).

Korf, D.J., Riper, H. (eds) (1997) *Illicit drugs in Europe* (Amsterdam: SISWO).

Krebs, W. (1997) 'Qualitätsniveau und betriebswirtschaftliche Orientierung in der Strassen- sozialarbeit – Ökonomisierung von Streetwork?', *Streetcorner*, 10(2), 3–18.

Lart, R., Stimson, G. (1990) 'National survey of syringe exchange schemes in England', *British journal of addiction*, 85(11), 1433–44.

Leqaurré, F., Jacques, J.P., Pauwels, C., Goosdeel, A. (1993) 'Snowballs still on the run', Paper presented at the 4th International Conference on the Reduction of Drug-related Harm, Rotterdam, 14–18 March.

Lewis, R. (1997) 'An overview of injecting drug use and HIV infection in Edinburgh, Scotland, maximising benefit and minimising harm', *Journal of drug issues*, 27(1), 43–56.

Lifeline Project (1991) 'Reaching out could be copping out: Outreach services for drug users', *Druglink*, 6(1), 12–14.

Longshore, D. (1992) 'AIDS education for drug users: Existing research and new directions', *Journal of drug issues*, 22(1), 1–16.

Majoer, B. (1994) 'Helping the helpers, a plea for structural support of "heart" workers', Paper presented at the 5th International Conference

on the Reduction of Drug-related Harm, Toronto, 6–10 March.

McAuliffe, W., Doering, S., et al. (1986) *Evaluation of Street Outreach AIDS Prevention (SOAP) project: Final report* (Boston, MA: Health Education Organisation).

McDermott, P. (1993) 'The personal touch', *Druglink*, 8(4), 13.

McDermott, P., Matthews, A., O'Hare, P., Bennett, A. (1992) 'Ecstasy in the United Kingdom: Recreational drug use and sub-cultural change', in Heather, N., et al. (eds) *Psychiatric drugs and harm reduction: From faith to science* (London: Whurr).

McKeganey, N., Bernard, M. (1996) *See work on the streets: Prostitutes and their clients* (Milton Keynes: Open University).

Milburn, K. (1996) *Peer education. Young people and sexual health: A critical review*, Working Paper No. 2 (Edinburgh: Health Education Board for Scotland).

Moerkerk, H., Aggleton, P. (1990) 'AIDS prevention strategies in Europe: a comparison and critical analysis', in Aggleton, P., Davies, P., Hart, G. (eds) *AIDS: Individual, cultural and policy dimensions* (Bristol: Taylor and Francis).

Monier, B. (1982) 'Réflexion sur la prévention spécialisée', *Le Livre ouvert des clubs et équipes de prévention spécialisée* (Paris: Centre National du Livre).

Morse, M. (1965) *The unattached: A report of the three-year project carried out by the National Association of Youth Clubs* (Gretna, LA: Pelican).

Nabben, T., Korf, D.J. (1997) 'Panel study on new trends in drug use in Amsterdam', in Korf, D.J., Riper, H. (eds) *Illicit drugs in Europe* (Amsterdam: SISWO), 157–63.

Nevermo, K. (1994) 'An example of outreach work in a county of northern Norway', in Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs, *Outreach* (Strasbourg: Council of Europe Publishing), 55–59.

Norwegian Ministry of Social Affairs (1997) *Drug policy*, White Paper 16 (Oslo: Stortinget).

Norwegian Ministry of Social Affairs (1992) *The delivery of services for substance abusers*, White Paper 69 (Oslo: Stortinget).

ÖBIG (1997) *Report on the drug situation in Austria 1997* (Vienna: Österreichisches Bundesinstitut für Gesundheitswesen).

O'Connor, A.M. (1996) *Women working in prostitution: Towards a healthier future. Second report for EUROPAP and the Eastern Health board* (Dublin: University College Dublin).

O'Hare, P.A., (ed.) (1992) *The reduction of drug-related harm* (London: Routledge).

Pearson, G. (1991) 'Varieties of ethnography: Limits and possibilities in the field of illegal drug use', in *Proceedings of the expert meeting on illegal drug use: Research methods of hidden populations* (Rotterdam: NIAD).

Pearson, G., et al. (1991) 'Everything starts with an E: An introduction to ecstasy use by young people in Britain', *Druglink*, 6(6), 10–11.

Podschun, G. (1993) 'Teen peer outreach, streetwork project: HIV prevention for education for runaway and homeless youths', *Public health reports*, 108, 150–55.

Polkinghorne Report (1996) *An independent review of drug treatment services in England* (London: Department of Health).

Power, R. (1994) 'Some methodological and practical implications of employing drug users as indigenous fieldworkers', in Boulton, M. (ed.) *Challenge and innovation: Methodological advances in social research. Research on HIV/AIDS* (London: Taylor and Francis), 97–111.

Power, R., et al. (1992) 'Informal coping strategies of community-based drug users in Britain', in Kozel, N.J. (ed.) *Epidemiologic trends in drug abuse* (Rockville, MD: National Institute on Drug Abuse).

Public Health Policy Unit (1997) *Planning and provision of drug misuse services* (Edinburgh: The Scottish Office).

Rhodes, T. (1994a) *Risk, intervention and change* (London: Health Education Authority).

Rhodes, T. (1994b) 'HIV outreach, peer education and community change: Developments and dilemmas', *Health education journal*, 53(1), 92–99.

Rhodes, T. (1993) 'Time for community change: What has outreach to offer?', *Addiction*, 88(10), 1317–20.

Rhodes, T. (1991) 'HIV outreach in Britain', *Druglink*, 6(3), 12–14.

Rhodes, T., Holland, J. (1992) 'Outreach as a strategy for HIV prevention: Aims and practice', *Health education research*, 7(4), 533–46.

Rhodes T., Hartnoll, R.L., Johnson, A.M. (1991a) *Out of the agency and onto the streets: A review of HIV outreach health education in Europe and the United States*, Research Monograph No. 2 (London: Institute for the Study of Drug Dependence).

Rhodes, T., Holland, J., Hartnoll, R. (1991b) *Hard to reach or out of reach: An evaluation of an innovative model of HIV outreach health education* (London: Tufnell Press).

Richard, A.J., Bell, C., Elwood, W.N., Shotts-Clayton, C. (1996) 'Outreach and program evaluation: Some measurement issues', *Evaluation practice*, 17(3), 237–50.

Rinnerbaner, E. (1995) 'Erlebnispädagogik der Streetwork Wien', *Streetcorner*, 8(2), 3–13.

Riper, H., Berkeley, D., Sanchis, C. (1995) *Study of the knowledge, attitudes and behaviour in respect of AIDS of target groups in the Community. Final report DGV* (Luxembourg: European Communities).

Roldán, A.A., Gamella, J.F., Sánchez, J. (1997) 'Trends and patterns of ecstasy use in Spain', in Korf, D.J., Riper, H. (eds) *Illicit drugs in Europe* (Amsterdam: SISWO), 147–57.

Rossi, P.H. (1978) 'Issues in the evaluation of human services delivery', *Evaluation quarterly*, 2, 573–99.

Schaffranek, J. (1996) 'Standards und Qualitätsmerkmale von Streetwork', *Streetcorner*, 9(1), 31–36.

Schelsky, H. (1958) *Die skeptische Generation, Eine Soziologie der deutsche Jugend* (Düsseldorf/Köln: Diederichs).

Schmidt, T., Visser, F. (1997) 'Ist Streetwork erlernbar? Erste Erfahrungen aus einem Hochschulprojekt', in AIDS-Hilfe, *Zugehende Sozialarbeit für drogengebrauchende Frauen und Männer. Ein Handbuch* (Berlin: Deutsche AIDS-Hilfe), 91–102.

Serpelloni, G., Rossi, A. (eds) (1996) *HIV/AIDS e Droga. Manuale per operation di Prevenzione. L'intervento in strada* (Verona: Leonard Edizioni).

Shiner, M., Newburn, T. (1996) *Young people, drugs and peer education: An evaluation of the Youth Awareness Programme (YAP)* (London: Home Office).

Skinner, H.A. (1992) 'Lifestyle assessment and change: Theory, what theory?', in Tudiver, F., Bass, M.J., Dunn, E.V., Norton, P.G., Swart, M. (eds) *Assessing interventions: Traditional and innovative methods* (Newbury Park, CA: Sage).

Specht, W. (1991) 'Jugendkonflikte als Herausforderung für sozial pädagogisches Handeln', in Specht, W. (ed.) *Die gefährliche Strasse: Jugendkonflikte und Stadtteilarbeit* (Bielefeld: Böllert, KT Verlag).

Spencer, J.C. (1950) 'The unclubbable adolescent', *British journal of delinquency*, 1, 113–24.

Steffan, W. (1988) *Streetwork in der Drogenszene* (Freiburg im Breisgau: Lambertus).

Steffan, W. (ed.) (1989) *Strassensozialarbeit. Eine Methode für heiße Praxisfelder* (Weinheim/Basel: Beltz Verlag).

Stimson, G., Alldritti, L., Dolan, K., et al. (1988) *Injecting equipment exchange schemes: Final report* (London: Goldsmiths College, University of London).

Stimson, V., Eaton, G., Rhodes, T., Power, R. (1994) 'Potential development of community-oriented HIV outreach among drug injectors in the UK', *Addiction*, 89(12), 1601–11.

Strang, J. (1994) 'Why are early intervention and self-help so neglected?', in Co-operation Group to Combat Drug Abuse and Illicit

Trafficking in Drugs, *Outreach* (Strasbourg: Council of Europe Publishing), 25–31.

Sufian, M., Freidaman, S., et al. (1989), 'Risk reduction after intervention among intravenous drug users', Paper presented at the 5th International Conference on AIDS, Montreal, 4–11 June.

Svensson, N.P. (1994) 'General introduction presentation', in Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs, *Outreach* (Strasbourg: Council of Europe Publishing), 9–15.

Thomas, M., Pierson, J. (eds) (1995) *Dictionary of social work* (London: Collins Educational).

Thompson, P.I., Jones, T.S. (1990) 'AIDS prevention for IDUs in the community: Street-based education', *Hygiene*, 9(4), 34–38.

Trautman, F. (1996) 'Strassensozialarbeit in den Niederlanden', in Klose, A., Steffan, W. (eds) *Endberichte zum Forschungsprojekt Europäische Streetwork-Explorationsstudie* (Münster: Votum-Verlag)

Trotter, R.T., Bowen, A.M., Potter, J.M. (1995) *Network models for HIV outreach and prevention programs for drug users*, NIDA Research Monograph No. 151 (Rockville, MD: National Institute on Drug Abuse), 144–80.

UMHRI (1997) *Annual report on the drug situation* (Athens: University Mental Health Research Institute).

Van Brussel, G.H.A., Buster, M.C.A., Woude, D.H. v.d. (1995) *Dovend vuur. Jaarbericht Drugsafdeling GG & GD 94/95* (Amsterdam: Gemeentelijke Geneeskundige en Gezondheidsdienst).

Vidal-Naquet, P. (1989) *Hors les murs, l'action sanitaire et sociale foraine auprès des publics marginalisés* (Aix-en-Provence: Centre d'Étude et de Recherche en Pédagogie de l'Economie, Université de la Méditerranée Aix-Marseille II).

Villalbi, J.R. (1997) 'The prevention of substance abuse in schools: A process evaluation of the adoption of a standardised education module', *Promotion and education*, 4(1), 15-17.

Ward, J., Pearson, G. (1997) 'Recreational drug use and drug dealing in London', in Korf, D.J., Riper, H. (eds) *Illicit drugs in Europe* (Amsterdam: SISWO), 140-47.

Watters, J.K. (1988) 'A street-based outreach model of AIDS prevention for intravenous drug users: Preliminary evaluation', *Contemporary drug problems*, 14, 411-23.

Wiebel, W. (1988) 'Combining ethnographic and epidemiologic methods in targeted AIDS intervention: The Chicago model', in Battjes, R., Picken, R. (eds) *Needle sharing among intravenous drug abusers*, NIDA Research Monograph 80 (Rockville, MD: National Institute on Drug Abuse).

Yates, R., Gilman, M. (1990) *Seeing more drug users: Outreach work and beyond* (Manchester: Lifeline).

Young, J. (1976) *The drugtakers: The social meaning of drug use* (London: Paladin).

P a r t i c i p a n t s

Participants

P a r t i c i p a n t s

Participants

*Participants at the expert meeting on
outreach work, Amsterdam
29-31 March 1998*

INTERNATIONAL EXPERTS

Kitty Enbom

A-Clinic Foundation
Satamakatu 14
SF-20100 Turku
Tel: +358 2 210 4400
Fax: +358 2 234 2785

Prof. Dr Werner Steffan

Austrasse 72A
D-90429 Nürnberg
Tel: + 49 911 263079
Fax: + 49 911 261860

Dr Ana Rodes

Hospital Universitari
Ctra. de Canyet, 5/n
E-08916 Barcelona
Tel: +34 3 465 12 00/465 88 58
Fax: +34 3 465 85 88
e-mail: arodes@ceescat.hugtip.scs.es

EMCDDA

Margareta Nilson

Rua da Cruz de Santa Apolónia,
23-25
P-1149-045 Lisboa
Tel: +351 1 811 30 00
Fax: +351 1 813 17 11
e-mail: margareta.nilson@emcdda.org

LOCAL EXPERTS

AUSTRIA

Christine Pichlhöfer

Verein Wiener Sozialprojekte
Streetwork Wien
Schönbrunner strasse 7/b/1
A-1040 Wien
Tel: +43 1 58 66 209
Fax: +43 1 58 66 209 9

BELGIUM

Alexis Goosdeel

Modus Vivendi
Rue Haerne, 51
B-1040 Bruxelles
Tel: +32 2 644 22 00
Fax: +32 2 644 21 81
e-mail: goosdeel@pscl.ucl.ac.be

GERMANY

Jürgen Klee

Krisenzentrum La Strada
Mainzer Landstrasse 93
D-60320 Frankfurt am Main
Tel: +49 69 23 10 20
Fax: +49 69 23 40 04

GREECE

Epaminondas Prinarakis

Kethea Headquarters
24 Soevolou str.
G-116 36 Athens
Tel: +30 1 38 47 700
Fax: +30 1 33 03 903

IRELAND

Mary O'Neill

Eastern Health Board
Womens Health Project
Baggot Street Clinic 19
Addington Road
IE-Dublin 4
Tel: +353 1 660 2198
Fax: +353 1 668 0050

ITALY

Susanna Ronconi

Gruppe Abele, Centro Studi
Via Giolitti 21
I-10123 Torino
Tel: +39 11 814 27 11
Fax: +39 11 839 55 77
e-mail: abele@arpnet.it

NETHERLANDS

Irene Herzog

Mainline
Postbus 53803
NL-1040 HH Amsterdam
Tel: +31 20 68 22 660
Fax: +31 20 68 13 003
e-mail: info@mainline.org

NORWAY

Christian Skattum

Uteseksjonen i Oslo
Boks 5934 Majorstua
N-0308 Oslo
Tel: +47 22 46 39 10
Fax: +47 22 69 86 30

PORTUGAL

Carlos Fugas

Cat Restelo
Avenida do Restelo
P-1400 Lisbon
Tel: +351 1 303 06 00
Fax: +351 1 301 85 40

UNITED KINGDOM**Linda Reed**

Cranstoun Project
SAFE CDA
132 Wandsworth High Street
UK-London SW18 4JP
Tel: +44 181 944 1116
Fax: +44 181 543 4348

PROJECT TEAM

Dr Dirk J. Korf (project leader)
University of Amsterdam
Faculty of Law
Bonger Institute of Criminology
Postbus 1030
NL-1000 BA Amsterdam
Tel: +31 20 525 3930
Fax: +31 20 525 3495
e-mail: korf@jur.uva.nl

Heleen Ripper

University of Amsterdam
Faculty of Law
Bonger Institute of Criminology
Postbus 1030
NL-1000 BA Amsterdam
Tel: +31 20 525 3930
Fax: +31 20 525 3495
e-mail: ripper@jur.uva.nl

Marielle Freeman

Bureau voor Onderzoek en
Statistiek
Weesperstraat 79
NL-1018 VN Amsterdam
Tel: +31 20 527 9527
Fax: +31 20 527 9595

Ian Grant

Senior Research Officer
Scottish Drug Misuse Information
Strategy Team
Information and Statistics Division
Trinity Park House
South Trinity Road
UK-Edinburgh EH5 3SQ
Tel: +44 0131 551 8652
Fax: +44 0131 551 1392
e-mail: ian.grant@isd.csa.scot.nhs.uk

Roger Lewis

EMCDDA
Rua da Cruz de Santa Apolónia
23-25
P-1149-045 Lisboa
Tel: +351 1 811 30 00
Fax: +351 1 813 17 11
e-mail: roger.lewis@emcdda.org

Elisabeth Jacob

RESSCOM
40, Rue de Malte
F-75011 Paris
Tel: +33 1 43 55 79 48
Fax +33 1 43 55 79 73
e-mail: resscm@wanadoo.fr

Chantal Mougin

Centre National de la Recherche
Scientifique
136 Rue de Bagnolet
F-75020 Paris
Tel: +33 1 43 71 97 16
Fax: +33 1 40 25 12 12

Practical Information

ADDRESS:

EUROPEAN MONITORING CENTRE FOR DRUGS AND DRUG ADDICTION
Rua da Cruz de Santa Apolónia 23-25
P-1149-045 Lisboa, Portugal

TELEPHONE:

+351 1 811 30 00

FAX:

+351 1 813 17 11

E-MAIL: info@emcdda.org

<http://www.emcdda.org>

Reference details:

Outreach work among drug users in Europe: Concepts, practice and terminology

EMCDDA Insights Series, Number 2, 1999

Printed in Portugal

EMCDDA, JUNE 1999

European Monitoring Centre for Drugs and Drug Addiction

Luxembourg: Office for Official Publications of the European Communities

1999 – pp.196 21x 14.85 cm

ISBN 92-9168-062-1

Price (excluding VAT) in Luxembourg: EUR 28.00



The EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is one of 11 decentralised agencies set up by the European Union to carry out specialised technical or scientific work. The Centre's main goal is to provide 'objective, reliable and comparable information at European level concerning drugs, drug addiction and their consequences'. Through the statistical, documentary and technical information it gathers, analyses and disseminates, the Centre provides its audience – whether policy-makers, practitioners in the drugs field or European citizens – with an overall picture of the drug phenomenon in Europe.

The Centre's main tasks are:

- collecting and analysing existing data;
- improving data-comparison methods;
- disseminating information; and
- co-operating with European and international bodies and organisations and with non-EU countries.

The EMCDDA works exclusively in the field of information.

Price (excluding VAT) in Luxembourg EUR 28.00



OFFICE FOR OFFICIAL PUBLICATIONS
OF THE EUROPEAN COMMUNITIES

L-2985 Luxembourg

ISBN 92-9168-062-1



9 789291 680627 >