HARM REDUCTION STRATEGIES & YOUNG PEOPLE IN BLANCHARDSTOWN

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FOREWORD

There has been a real and significant increase in the use and range of drugs by young people in the Blanchardstown area. In addition to the widespread use of alcohol, cannabis and ecstasy, the recent experience of both youth workers and drug projects' staff is that cocaine and benzodiazepine use are on the increase. This is leading to a shift in the local drug culture, characterised by increasing poly-drug use by young people. The use of a wider range of drugs and especially for the combining of drugs is presenting new risks for young people and new challenges those working with them.

As part of its response to this situation, the Blanchardstown Local Drugs Task Force (BLDTF) has been involved in developing a strategy for harm reduction. The harm reduction perspective recognises that it is not possible, at least in the short term, to eliminate drug use by young people, and that young people need information and education to assist them in reducing the harmful effects of drug use.

BLDTF is seeking additional funding to support the development and implementation of a harm reduction strategy. This will involve the employment of a strategic worker who will be responsible for:

- Developing a range of harm reduction measures to minimise the negative consequences of drug use for the individual, the family and the community
- Developing and delivering harm reduction programmes in conjunction with appropriate drugs and youth services
- Establishing three pilot projects, in conjunction with other services, to initiate harm reduction work with specific, identified target groups

The ultimate objective will be to ensure that a harm reduction approach is an integral part of all drug education within the BLDTF area, which is targeted at young drug users or those at risk.

In developing this proposal the BLDTF would like to acknowledge;

- the contribution of all those who participated in the research
- the guidance from the working group (made up of representatives from the Education & Prevention/ Treatment & Rehabilitation Subgroups)
- the direction of the Education & Prevention Subgroup.

Phillip Keegan (Chairperson, Blanchardstown Local Drugs Task Force)

INTRODUCTION – THE PURPOSE OF THE REPORT

The purpose of this report is to assess the potential of harm reduction measures to have a positive effect on drug use among young people in the Blanchardstown area and to outline the elements of a harm reduction strategy, which might be adopted and promoted by the Blanchardstown Local Drugs Task Force (BLDTF).

The exploration of this subject contained in the report was prompted by an application to the Emerging Needs Fund, which was submitted to BLDTF for approval. Whilst the proposal had considerable merits and the specific project in question is likely to secure the support of BLDTF, the application prompted wider discussion about the needs of young drug users and how to respond to them.

This report was therefore commissioned with a view to providing the basis for a harm reduction strategy for BLDTF. The report has the following objectives:

- To explore the meaning of harm reduction and to propose a definition of harm reduction
- To explore the general issues arising from the harm reduction perspective and its relationship to other drug prevention, education and treatment interventions
- To identify and explore the specific issues arising from the harm reduction perspective in relation to interventions with young people, including young drug users
- To identify the elements of a harm reduction strategy, in general and particularly in relation to drug education programmes for young people
- To recommend actions which would provide for effective and practical harm reduction measures targeted at young people

It should be noted that whilst reference is made to harm reduction strategies in drug treatment, the primary focus of the report is on drug education and awareness programmes.

The report is based on three main sources of information:

- **A questionnaire circulated to staff in all drug and youth services funded by or otherwise associated with BLDTF**

- **A series of individual and group discussions with representatives of these agencies and key personnel in BLDTF**

- **A review of literature relating to harm reduction**

DEFINING HARM REDUCTION

The concept of harm reduction can be understood in both a general and a specific sense. If it is accepted that all types of drug use entail at least the potential for causing harm, to individual drug users, their families, the community and society as a whole, then all interventions aimed at reducing or eliminating non-medical drug use can be described as being concerned with harm reduction, in the literal sense that they are concerned with reducing the harm caused by drug use. Some attempts to define harm reduction have approached it from this general perspective. Thus, for example, the National Youth Health Programme defined harm reduction as

> *"any activity which aims to reduce the harm caused by drug use."*
>
> (The Youth Work Support Pack for Dealing With The Drugs Issue 1996)

This type of definition, however, ignores the more specific meaning usually associated with the concept of harm reduction. In its more specific usage the concept of harm reduction is understood to reflect approaches to drug use which seek to reduce the harm caused by drug use, without necessarily reducing drug use itself. Thus whilst traditional approaches to drug use have proposed abstinence as the only means of avoiding drug related harm, the harm reduction approach aims, at least in the first instance, to identify and promote ways of reducing harm while drug use continues.

According to this view of harm reduction, the key characteristic of harm reduction strategies is:

> *"whether they attempt to reduce the harmful consequences of drug use while users continue to use."*
>
> (Single, 1995)

A similar definition, proposes that a harm reduction strategy:

> *"attempts to minimise the potential hazards associated with drug use rather than the use itself."*
>
> (Duncan, et al, 1994)

The more general definitions of harm reduction are problematic in that they obscure some significant differences in approaches to drug use between traditional, abstinence-oriented approaches, and those harm reduction strategies which acknowledge a certain level of drug use (by some individuals and/or within society) as inevitable, at least in the short-term, and seek to reduce the negative effects of such use to a minimum. Watson (1991) defines harm reduction as:

> *"the philosophical and practical development of strategies so that the outcomes of drug use are as safe as is situationally possible. It involves the provision of factual information, resources, education, skills and the development of attitude change, in order, that the consequences of drug use for the users, the community and the culture have minimal negative impact."*

This report is therefore concerned with harm reduction strategies, which have the following features:

1. They aim to reduce the harmful effects of drug use without necessarily reducing the level of drug use.
2. They are aimed primarily at groups or individuals who have already started using drugs or who are considered likely to do so in the immediate future.

As discussed below, harm reduction strategies have tended to provoke a certain level of controversy. Nevertheless, whilst certain aspects of the harm reduction perspective remain contentious, in many countries, including Ireland, significant harm reduction measures have been accepted and integrated into national policies on drugs.

ISSUES IN HARM REDUCTION

The issues involved in the debate on harm reduction strategies are worth exploring for at least three reasons. First, because they raise broader issues about our attitudes towards and beliefs about drugs, which all who wish to engage in drugs work have a responsibility to clarify for themselves. Second, because they may contribute to a better understanding of the advantages and disadvantages of interventions informed by different perspectives. Third, because they may create an awareness of the potential concerns, and even hostility, which those drugs workers implementing a harm reduction strategy may encounter and will need to respond to.

The following quotations, all taken from the EURAD (Europe Against Drugs) website, reflect the position of some of the more vigorous opponents of harm reduction strategies:

> *1. “The term "harm reduction" was coined in Great Britain by a group of individuals attempting to make use of illicit drugs acceptable to society.*
>
> *2. ‘Harm Reduction’ interpretations range from the legalisation of some drugs, to decriminalisation, to the legalisation of all drugs.*
>
> *3. ’Harm reduction’ proponents consider that legalising drugs would be the ultimate 'harm reduction' for the drug user. For them, the right to the personal use of psychoactive and addictive drugs supersedes what is beneficial and healthy for the rest of society*
>
> *4. There is now a well-funded international conspiracy with the aim of ultimately legalising all drugs, starting with cannabis.*
>
> *5. They (proponents of harm reduction) dismiss the concept of a drug-free society and are pursuing policies called "harm reduction".*
>
> *6. The fallacy of ‘Harm Reduction’ is that dangerous and addictive drugs can safely be used if "properly" managed by the user or regulated by government.*

7. "Harm reduction" ignores the proven physiological effects of drug use. 'Harm reduction' is counterproductive to individuals with addictive behaviour. The most successful treatment programmes are abstinence-based.

The main point of the first four quotations, and one which some opponents of harm reduction repeatedly emphasise, is that advocates of harm reduction are also advocates of the legalisation of drugs. It is even suggested that harm reduction strategies are nothing but a clever ploy in the "conspiracy" to legalise drugs. There is, of course, no evidence to support this proposition, other than the fact that some, and probably a small minority, of those advocating harm reduction, do favour some changes to the legal status of some drugs. This is a long way from demonstrating any necessary, logical connection between advocacy of harm reduction strategies and advocacy of legalisation. If this charge were true, it would, of course imply that, in an Irish context for example, successive Irish governments, the vast majority of medical personnel involved in drug treatment and huge numbers of those managing and working in community-based drug treatment services are party to the alleged conspiracy.

The second point, is that proponents of harm reduction "dismiss" the concept of a drug-free society. This point has rather more substance, although it again distorts the position of many of those advocating harm reduction. The point is that there does not exist a drug-free society to dismiss or reject. The use of legal drugs and some illegal drugs is widespread throughout society, and a great deal of harm occurs as a result for individuals, families, communities and society. No convincing strategy has yet been put forward for achieving a drug-free society. Even if a drug-free society is considered to be a realistic and attainable ideal, it can hardly be considered to be one which is likely to be realised in the near future. Harm reduction addresses the question of what can be done to minimise harm in the meantime.

The third point is that advocates of harm reduction suggest that drugs can be used safely. It is true that a fundamental premise of harm reduction strategies is that some types of drug use are more harmful than others. It follows that if a drug user cannot be persuaded to give up the use of drugs entirely, avoidance of the most harmful types of drug use will result in less harm, both to the drug user and to others. This is not at all the same thing as suggesting that drug use is harmless or that it can ever be made so. Even the most well established and thoroughly tested of medicinal drugs all have potentially harmful side-effects, at least for some individuals. It would

be ludicrous to suggest that illegal drugs do not have at least a similar, and probably a far greater, potential to cause harm. It would, however, be equally ludicrous to suggest that regardless of the drug in question, the level of use, the circumstances of use, the characteristics of the user, or the mode of administration, the risks from all illegal drugs are the same. Nevertheless, it is incumbent on advocates of harm reduction strategies to ensure that they refer to *safer* drug use rather than *safe* drug use. This is not primarily to avoid allegations of the type noted, but to ensure that harm reduction messages are truthful and accurate. Particular care needs to be taken to ensure that those who are especially vulnerable, as a result of youth or for other reasons, are not misled into believing that any type of drug use is completely safe.

Finally, it is argued that abstinence-based treatment programmes are "most successful" and that harm reduction strategies are "counter-productive" for those who are drug dependent. Abstinence-based treatment programmes are demonstrably successful for some drug users and less so for others. It is irrelevant whether they are most successful or not: if they are not successful for even a minority of drug users, then for those people an alternative must be found. Furthermore, in most abstinence-based approaches to treatment, as in other approaches, it is often emphasised that the client must be ready to enter treatment. For many people there is a considerable lapse in time between the development of a drug problem or drug dependence and their readiness for any type of treatment, particularly one based on abstinence. In this interval it is surely in everyone's interest that the level of harm resulting from continuing drug use is minimised. The only logical basis for arguing that a harm reduction approach is counter-productive is if it is considered necessary for the drug user to reach "rock bottom" before being ready to enter treatment. From this perspective it may appear that the drug user who is protected from the worst consequences of drug use by the adoption of harm reduction measures may never be ready to attain abstinence. To withhold such protection as may be afforded by harm reduction approaches on this basis, however, suggests a disregard for both the drug user and those around him or her, and amounts to what might be described as a harm maximisation approach.

The fact that some critics of harm reduction use arguments which are dishonest, dogmatic, inflammatory or exaggerated, does not, however, mean that an uncritical approach can be taken to the development and implementation of harm reduction

strategies. It is possible for interventions informed by any perspective to be either ineffective, or even counter-productive.

Abstention-based programmes most often risk being ineffective or counter-productive when they are perceived to exaggerate the risks of drug use. Many cannabis users or even associates of cannabis users might, for example, find it hard to identify with what the “Coalition Against Cannabis” describe as “the extreme dangers of cannabis”. There is a danger that those who find such messages lacking in credibility, will tend to reject all drug awareness messages, however balanced and accurate they may be.

It has been argued above that the view which sees harm reduction programmes as being concerned with the promotion of drug use is untenable. This does not, however, mean that the possibility that such programmes may unintentionally give the impression that drug use is acceptable or harmless, can be discounted. Clearly, no harm reduction strategy which had the effect of promoting or encouraging drug use, particularly among young people, could be considered to be justified.

It is necessary to ensure, as a matter of principle, that harm reduction strategies are effective in that they do actually lead to a net reduction in the harm caused by drug use. From a more pragmatic perspective it is also necessary to ensure that they are socially and politically acceptable. Obviously what is socially and politically acceptable changes over time: strategies in drug treatment such as substitution treatments, needle exchange and the provision of condoms, would have been highly controversial in Ireland twenty years ago, but are now commonplace and widely accepted. On the other hand there is probably little political or public support for measures such as the legalisation of drugs, the prescription of heroin or the provision of injecting rooms.

The following parameters are proposed as a basis on which some of the issues involved in harm reduction can be resolved in a manner which permits the development of effective harm reduction strategies whilst avoiding the provocation of unnecessary controversy.

1. Legalisation of Drugs

As noted above, the advocacy of harm reduction strategies is sometimes represented as being synonymous with the advocacy of legalisation of drugs. Although there may be a perceived link, it is quite feasible to favour harm reduction whilst holding a wide range of views on the legalisation of drugs, from support for the present legal situation in regard to drugs, to support for the legalisation of all drugs. The fact that some advocates of harm reduction may favour changes in the legal status of some or all drugs does not invalidate the approach.

Harm reduction is regarded by most of its advocates as a pragmatic and moderate approach to the problems caused by drugs. Single (1995), for example, argues that:

> *"Harm reduction should be viewed as a middle ground where people with widely differing views on drugs policy can agree with one another regarding practical, immediate ways to reduce drug-related harm."*

The moderate character of the harm reduction approach is also emphasised by Kay (1994):

> *"Harm minimisation strategies are feasible, modest, responsible and relevant in a world where increasing numbers of young people are experimenting with an ever wider range of substances."*

The case for the legalisation of drugs is, of course, sometimes presented as a harm reduction measure in itself. Among the arguments put forward are: that some illegal drugs are no more harmful than drugs which are legal; that the illegal status of drugs leads to criminal involvement in the supply of drugs; that drugs available illegally are more dangerous than pharmaceutically prepared drugs; that the illegality of drugs enhances their appeal to rebellious young people; and so on. Whatever about the merits of these arguments, there are persuasive counter-arguments. In any case, in the present social and political climate a harm reduction strategy based on legalisation would be strongly opposed in many quarters and would almost certainly be unacceptable in many of the settings (such as schools and youth services) in which drug awareness programmes need to be delivered.

As there is no necessary or logical connection between support for legalisation and support for harm reduction the charge that harm reduction proponents favour legalisation should rejected, as should objections based on this argument, to harm

reduction strategies. The harm reduction strategy should therefore adopt a neutral position on legalisation and advocacy of legalisation should not constitute a part of the strategy.

2. Legal and Illegal Drugs

All drugs are potentially harmful. The level of harm associated with particular drugs depends on the level of use, the qualities of the drug, the characteristics of the user, the context of use, and many other factors. It is facile to argue in general terms, that one drug causes more harm than another (for example, that alcohol causes more harm than cannabis) because it is not comparing like with like. If cannabis was as widely used as alcohol, the levels of harm resulting would be more directly comparable. What is true, however, is that the legal status of various drugs probably has more to do with historical accident, than with an objective appraisal of their potential for harm. If tobacco, for example, was only now being introduced to Ireland, it is unlikely that it would enjoy even the restricted legality which it currently does.

Harm reduction strategies should therefore focus on the real and identifiable harm associated with particular drugs, whether legal or illegal. Indeed the essence of harm reduction strategies can be demonstrated with reference to the various efforts at reducing the harm caused by alcohol and tobacco. “Never, ever, drink and drive” (rather than “Never, ever, drink”) is clearly a harm reduction message, and substitution treatments such as patches, chewing gum, inhalers, etc., are accepted methods of treating nicotine dependence. If these approaches are appropriate in the case of legal drugs, there is no logical reason why they should be considered inappropriate in the case of illegal drugs. The only distinction which should be made is that the legal and social sanctions for the use of different drugs varies, and that those using illegal or socially unacceptable drugs are likely to suffer more serious consequences as a result.

3. Abstinence and Harm Reduction

Advocacy of harm reduction does not imply abandoning the goal of abstinence. In the case of individuals, setting abstinence as an ultimate goal is compatible with a wide range of harm reduction measures aimed at minimising the harm resulting in the period before abstinence is achieved. In the treatment of heroin dependence, for example, methadone substitution is intended to reduce the risks of overdose, viral

and other infections, and criminal activity, whilst at the same time promoting stability in the user's life and encouraging engagement with treatment services. Although abstinence from both heroin and methadone is not always attained, it is almost invariably the ultimate objective of treatment, or at the very least, the preferred outcome.

As all drug use is potentially harmful, strategies which effectively reduce the level and extent of drug use at a communal or societal level would clearly contribute most to reducing drug related harm. If no-one used drugs, no-one would be harmed by them. The case for harm reduction, however, is based on the fact that measures to prevent the use of drugs are, at best, only partially effective. The adoption of harm reduction strategies does not therefore mean that efforts to reduce or eliminate drug use in society should be rejected, but that where these are less than fully effective, other measures are required.

Drug awareness programmes should therefore, in general and in the first instance, advise of the benefits of abstaining from drug use. Strategies for safer drug use are secondary, and are only appropriate where the principal message either has been or is likely to be rejected by the target group.

4. Target Group

The effectiveness of drug interventions in prevention, education, treatment and rehabilitation, do not only depend on what is said or done, but on the suitability of what is said to or done with those targeted by the interventions and their receptivity to these words or actions. One of basic premises of the harm reduction approach is that there are and will remain individuals and groups who are not, for a variety of reasons, receptive to abstinence-based interventions, whether in education or treatment, or at least who are not receptive to such messages at a particular point in time. These individuals and groups constitute the primary potential target groups for harm reduction strategies.

Whilst the definition of the target group clearly needs to be more precise in practice, the basic point is that harm reduction strategies are appropriate interventions for some individuals and groups, and not for others. In general, those who are not currently engaged in drug use should be supported to continue to abstain from drug

use, and harm reduction strategies should only be targeted at those who are already using drugs or who are likely to do so in the immediate future.

The identification of “at risk” groups should be based on a combination of the knowledge derived from direct work with the target group and awareness of “risk factors” and “protective factors”. The Report of the Working Group on the Treatment of Under 18 Year Olds Presenting to Treatment Services with Serious Drug Problems (2005), makes the point that “the risks of adolescent substance abuse are not spread uniformly through the general population” and identifies the following factors as most relevant in the Irish context:

Risk Factors

- Economic factors: problem drug misuse in Ireland is concentrated mostly on more economically deprived areas
- Behavioural and Environmental factors: in particular early school leaving, early onset of alcohol or drug use and association with substance using peers
- Family factors: including parental substance misuse, poor family management, homelessness
- Psychological factors: especially mental health problems.

Protective Factors:

- Supportive family environment
- Life-skills
- School connection
- Psychological well-being.

Even in these target groups the primary strategy, especially with those who are not regular or dependent users, should be to advocate the benefits of abstinence and where possible to convince them to give up drug use. The principal target group for harm reduction measures should therefore be individuals or groups who have a commitment to a pattern of more or less regular drug use.

In addition to those who are targeted because of their use or potential use of drugs, there are also specific groups whose behaviour may have an impact on the level of risk to drug users. An example would be dance club owners and staff who can reduce levels of risk from drugs such as ecstasy and amphetamines by providing

certain facilities and services within their premises. Another group is the Gardai who, for example, have been advised in the past about the risk of precipitating heart failure in young solvent abusers by chasing them. Other such groups would include, publicans, parents, teachers, youth workers and in fact any group with a role in interacting with people, especially young people, who might be under the influence of drugs.

5.Evidence-based Harm Reduction

The decision to use or continue using drugs, or not, rests ultimately with the individual. In seeking to influence this decision, drug interventions must respect the rights of individuals to make decisions based on accurate information and an informed appreciation of the potential or likely consequences of their decisions.

If it is accepted that messages about drugs, from whatever perspective, should be factual and accurate, then the differences between information about drugs and their effects provided in the context of a harm reduction strategy or in the context of an abstinence-based strategy should be minimal. The main differences will therefore be that some additional information is provided in the context of a harm reduction strategy (for example, about safer methods of use).

The only ethical position in relation to informing or advising people about drugs or drug use is to do from a position of informed, objective and current knowledge. This means that all drug interventions should be informed by the best of current research and expert understanding of drugs, drug use and its effects. There are, of course, areas of dispute, as there are in any scientific field, and where there are no clear indicators as to the most likely correct conclusion, the different views should be presented and explained. At all costs, simplistic, one-sided messages or personal fears and prejudices should be avoided.

In terms of harm reduction strategies, any measure advocated as being safer, should be demonstrably and significantly safer. Drug interventions cannot be based on personal experience, old wives tales or urban myths. The advice, for example, not to mix your drinks, is not a harm reduction message, or is at best a very trivial one. The level of drunkenness results from the total amount of alcohol consumed by an individual. The appropriate harm reduction message in this context is therefore to drink less alcohol.

Harm reduction programmes (or any other drug interventions) should only be delivered by personnel with a comprehensive understanding of drugs and drug-related issues and should be based on the best available current evidence.

6. The Social Context of Harm Reduction

Harm reduction strategies, or any other drug interventions, need to be delivered in the context of an appreciation of other factors which influence drug use in society. There are numerous explanations put forward for the prevalence of drug use in society, which are outside the scope of this discussion. It is, however, possible to say that there is no single factor, which accounts for all drug use. The reasons why people drink alcohol, smoke tobacco, take ecstasy, smoke cannabis or inject heroin, are probably quite different, and the reasons why different individuals use the same drugs are probably equally varied. Nevertheless, there are common factors to social patterns of drug taking which need to be considered. A harm reduction strategy, for example, which does not take account of the correlation between social deprivation and heroin use in Ireland, will have little impact. Similarly, programmes aimed at young people need to reflect an understanding of current youth culture.

HARM REDUCTION AND YOUNG PEOPLE

There are several issues relating to harm reduction which are more difficult in the context of working with young people than with adults. This part of the report seeks to identify some of these issues and suggest how they might be resolved.

Mixed Messages

The belief that simply talking to young people about drugs, may encourage non-users to experiment is less commonly encountered these days than in the past but it does still arise from time to time, especially in settings which have limited previous experience of addressing drug issues. This concern is, however, more likely to arise where the programmes being delivered have a clear harm reduction element. Concerns may reflect the suspicion that drug use is being advocated, that information which would facilitate drug use is being provided or that some young people may misinterpret the message.

Harm reduction programmes offered to young people should clearly not advocate drug use and should promote abstinence from both legal and illegal drugs as the best choice for young people. Provided that this is the case, the first concern can be addressed very clearly. The second concern is not specific to harm reduction programmes, but applies to all drug education: in order to advise on the risks of drug use it is necessary to provide information about the types of drugs and the ways in which they are used. The important point here is to ensure that what is being discussed is appropriate to the age and circumstances of the young people being targeted. This ensures that what is provided relates to the experience of the young people and corrects misinformation rather than introduces a whole new scene which was previously unfamiliar to them.

The concern that young people may misinterpret the intentions of a harm reduction programme is probably the most valid. Not only is there some risk of genuine misunderstanding but there is also the possibility that elements of the programme will be deliberately used by young drug users to validate or justify their drug use either to themselves or to others. Obviously, it is important that the content of the programme is as clear and unambiguous as possible, but this may not in itself be enough to avoid this problem. The best approach is probably to ensure that drug education is

conducted in a context within which the young person is engaged on an ongoing basis, such as a youth project, and ideally where at least one of the workers delivering the programme has an ongoing relationship with the young person. This means that there can be a continuing dialogue within which understanding can be developed and attitudes challenged.

Parental Consent

It is usual practice among schools and youth organisations to seek parental consent prior to providing drug education programmes to young people. For this procedure to be meaningful it is essential that parents understand what it is that they are consenting to and they therefore need to be provided with, or at least offered the opportunity to enquire about, information on the programmes content and methodology. This requirement should not change simply because the programme being offered has a harm reduction element. Parents need to be told that as well as pointing to the benefits of abstinence and highlighting the risks of drug use, the programme will provide advice and information on ways of reducing the risks of drug use for those who are actually using drugs and who may continue to do so.

The concept of harm reduction may be best explained through the use of examples of harm reduction initiatives relating to alcohol which will be familiar from television campaigns such as those aimed at drink driving or binge drinking. Unlike the situation twenty years ago, many parents, especially in urban areas with long-standing drug problems are now well aware of the prevalence of drug use among young people and quite open to the possibility that their own children may be involved or at risk of involvement. Because of this many parents will be willing to accept a harm reduction element to drug education programmes, provided that they are re-assured that it does not advocate drug use. Like the staff delivering the programmes they will almost certainly prefer that their children do not use drugs, but will recognise that if they do, they need to be informed on how to avoid the most serious risks.

The fact that harm reduction programmes will usually be targeted at young people who are known or strongly believed to be using drugs does not need to be explained to parents nor to anyone else. Doing so would run the risk of stigmatising the young people who participate and compromising confidentiality. Parents should, however, have the agency's policy on confidentiality explained to them.

Targeting

Harm reduction programmes are generally considered to be appropriate for young people who are already engaged in or at risk of engaging in some type of drug use, and for the most part inappropriate for those who are not. Whilst the rationale for this is fairly clear, the process of targeting is in practice more complex.

The level of involvement in and awareness of drug use among young people varies considerably. In a school setting, for example, children of similar ages in the same class may have very different experiences of drug use. A class of third year secondary school students, might typically include some children who do not use any drugs at all, others who smoke cigarettes and drink alcohol regularly, and still others who smoke cannabis, a few of whom may also have experimented with a range of other illegal drugs. The level at which a drug education programme should be aimed for such a mixed group is problematic. A simple "Just Say No" approach may be considered irrelevant, patronising and "uncool" by the more experienced drinkers and drug users, and they may be dismissive of the whole programme as a result. On the other hand, a more sophisticated harm reduction approach may risk reinforcing the existing peer pressure on those who do not drink or use drugs by appearing to presume that such behaviour is normal for their age group.

A good knowledge of the current, local patterns of drug use among young people is essential to ensuring that the programme is pitched at an appropriate level. Consultation with local drugs workers and projects and access to relevant research will facilitate this. It is also essential to ensure that abstinence is promoted and validated, at the same time as acknowledging that some young people do or might in the future use drugs, and that in that case, certain practices are more risky than others.

This issue is less acute in contexts where groups of young people have been brought together specifically because of their drug use or because they are considered at high risk. Where a similar pattern of behaviour, possibly including drug-using behaviour, is the main common characteristic of the group, harm reduction programmes can be tailored specifically to address the risks likely to be encountered by the group. This type of targeting is probably more feasible in a youth work setting where groups tend to be formed either by self-selection or by workers identifying common needs.

Patterns of Drug Use

Effective drug education depends to a significant degree on its relevance to young people. One key aspect of this is its timeliness. Trends in drug use among young people can change rapidly and young people will typically react against programmes which appear out of date or programme presenters who appear out of touch. Typically a lot of drug education has lagged significantly behind the actual practice of drug use among young people. It is not unusual to find an emphasis within drug education programmes on drugs which are no longer popular among young people. LSD, for example, continued to feature prominently in drug education materials long after it had ceased to interest more than a tiny minority of young people. At the same time the response to new trends, such as the recent upsurge in cocaine use, can be painfully slow. Information and educational materials need to be produced and training for staff needs to be provided in response to such developments as they happen rather than two or three years later.

As well as national trends in drug use, there can be significant local variations in patterns of drug use. This seems especially to be the case with drugs that seem to lack the widespread and enduring popularity of alcohol and cannabis, but which may be used extensively for a period of time within a particular locality or within a particular peer group. Such drugs include solvents and a wide range of "other medicines", especially when used in combination with alcohol. It is important to recognise these trends and in particular to quickly identify the potential harms associated with such patterns of drug use. An outbreak of solvent misuse in a small rural town may last only a few months but may cause considerable harm within that time, including deaths, amongst what is often a very young age group.

The type of responsiveness that is necessary to ensure that drug education has an immediate relevance and resonance for young people is more readily achieved in local areas and regions (such as local drugs task force areas) than at national level. The more closely involved workers engaged in direct work with young people at risk are in the process of planning, designing, implementing and evaluating drug education programmes, the more likely it is that such programmes will address the real needs of young people. Thus whilst ongoing work on harm reduction at national level, especially in research and evaluation is essential, there is a strong case for the type of local unit recommended later in this report, which can develop local responses and pilot these within a short time frame.

Peer Education

Peer education approaches to drug education and prevention are not only used within the harm reduction approach, but they do seem to have a particular value in this context and have been widely used. The benefits of peer education can be exaggerated and claims that young people will only listen to people of their own or similar age, or will only respond to individuals with a history of personal drug use are misguided. Nevertheless, involving young people in the design and delivery of drug education can be extremely valuable in ensuring the kind of relevance referred to above. In addition, where the peer educators are themselves young people engaged in drug use or at risk of becoming involved, the peer education process provides a valuable means of enabling them to engage with services, to explore the risks involved in their own drug use, and to develop as individuals by making a positive contribution to their peers and their community. It is envisaged that a continuation and development of the Word on the Street project will be a priority within the BLDTF harm reduction strategy.

Harm Reduction Objectives

Harm reduction in relation to illegal drugs initially became acceptable and incorporated into the National Drugs Strategy in the context of drug treatment, and specifically in relation to the prevention of HIV infection among and by injecting drug users. Kiely (2000) describes how:

"In Ireland, it was not until the early 1990s, that the AIDS crisis forced the Government to acknowledge a role for harm reduction in the area of treatment and rehabilitation. Intravenous drug users were identified as a "high risk category" in the transmission of the AIDS virus and so there was the discrete introduction of methadone maintenance, outreach programmes and needle exchange schemes, all harm reduction measures designed to curb the transmission of the virus."

Harm reduction in drug education clearly has different objectives to harm reduction in treatment. The objectives of a harm reduction programme should be clearly specified. The following is an attempt to identify some of the objectives which could be incorporated into harm reduction programmes for young people. Examples are given using a range of drugs but most objectives would be relevant in relation to all drugs which are widely used by young people.

HARM REDUCTION OBJECTIVES	
OBJECTIVES	EXAMPLES
To delay the beginning of experimentation with drugs	Highlight risks of early experimentation
To reduce the frequency of drug use	Advice to confine drug use to weekends and promotion of alternative activities
To reduce the amount of drugs consumed on each occasion of use	Advice on safe limits for alcohol and consequences of binge drinking
To reduce the use of combinations of drugs	Education about increased risks of combinations of drugs e.g. alcohol and cocaine
To prevent the escalation of drug use (to other drugs)	Advice to resist progression to more dangerous/addictive drugs e.g. ecstasy to smoking heroin
To prevent the escalation of drug use (to dependent use)	Advice on the development of dependence on drugs and early referral to services
To promote safer modes of administration of drugs	Advice on safer methods of use e.g. snorting v. injecting cocaine
To reduce drug related accidents	Advice on drink/drug driving or use of drugs at work
To reduce drug related criminality/arrests	Advice on dealing with Gardai whilst under the influence/in possession
To reduce the physiological risks of drug use	Advice on rest and drinking water whilst using ecstasy
To reduce the use of the most dangerous variants of drugs	Advice on specific risks associated with different solvents
To reduce risks of sexual harm whilst under the influence of drugs	Advice on safer sex and avoidance of sexual assaults
To reduce risks from dangerous environments	Advice to avoid dangerous locations/contexts or using drugs alone
To reduce risks whilst pregnant	Information on effects of drugs on unborn child
To reduce the risk of contaminated or wrongly identified drugs	Advice to purchase from known source

HARM REDUCTION AND YOUNG PEOPLE IN BLANCHARDSTOWN

The purpose of this section of the report is to identify the potential target groups for a harm reduction strategy in Blanchardstown, the main focus of such a strategy and some of the agencies which might be involved in the delivery of the strategy. The information is mainly based on the returns of the questionnaire circulated by the Education and Prevention Sub-Group of the BLDTF.

Table 1 shows the organisations and groups from which questionnaires were returned (the number of questionnaires from each project is in the second column) and the numbers of young people which each group works with. Where there are discrepancies in the numbers provided by different respondents from the same project this has been resolved from other information provided or the lower figure has been used. In one case no information on numbers was provided. The overall figures are not particularly useful as the level of engagement obviously varies from projects providing an intensive service to organisations having occasional contact with large numbers of young people. For this reason the figures for BYS Youth Information Service are excluded in the second total to give a more accurate picture of the numbers of young people engaged on a regular basis. It is clear that the majority of young people engaged by these services are in the 10 to 14 year age group, followed by a somewhat smaller number in the 15 to 18 year age group, and significantly fewer in the 19 to 25 year age group.

The description of the target group (if any) is as provided in the questionnaire. A large number of projects provided no information on their target group beyond the age group and geographical catchment area of the project (these are not included in the description as they are usually evident from the title of the project and the figures provided). A total of twelve projects identified their target group as “at risk” or as being in a known at risk group, such as early school leavers. Clearly there are several other projects which work with these target groups but which did not specify this. Similarly, not all of the young people targeted by some of these projects are considered at risk. The numbers of young people in those projects which identified an at risk target group or are known to be mainly engaged with this target group are detailed in Table 2.

Table 1: Target Groups by Age and Other Characteristics

Project	Qs	0-10	10-14	15-18	19-25	Target groups
Blakers Foroige	1	-	-	-	-	
Blakestown & Mountview NYP	4	0	45	0	0	
Blakestown & Mountview Youth Initiative	5	0	20	50	15	Young people and their families
Blakestown Mountview CDT	2	0	0	4	10	Drug users and their families
Blakestown Youth Project	1	0	40	20	0	Young people considered to be at risk
Blanchardstown Youth Information Centre*	1	0	0	5000	4000	
Blanchardstown Youth Service (BYS)**	3	0	0	0	0	
BYS Computer Clubhouse	1	0	40	60	0	
BYS Direct Work	1	5	1187	1123	362	Early school leavers, Travellers, young mothers
BYS ESL Programme	1	0	2	13	0	Young early school leavers
Corduff Community Resource Centre YC	1	60	40	10	0	
Corduff Community Youth Project	2	0	50	35	0	
Hartstown Den	1	0	0	0	0	
Hartstown Huntstown CDT	3	0	80	20	51	Affected by/at risk from drug use
HSE Education	1	0	0	24	20	Youth, schools, workplaces, community
HSE Outreach	1	0	0	6	41	
Huntstown Community Youth Project	1	0	40	20	0	Young people considered to be at risk
Mulhuddart Community Youth Project	4	0	134	45	0	Young people including those most at risk
Mulhuddart Corduff CDT	5	20	20	10	50	Drug users and their families
Oasis	1	0	158	35	0	Potential early school leavers
Peer Education Programme	2	0	336	40	0	
Tolka River Project	3	0	0	0	4	People in recovery
WEB Project	3	0	15	17	0	Young people at risk/in trouble with the law
Word on the Street	1	0	1	20	0	
Youthreach	6	0	0	50	30	Early school leavers
Zone Youth Health Café	1	0	20	15	0	
Totals	**56**	**85**	**2228**	**6617**	**4583**	
Totals (excluding BYS Youth Information Centre)	**55**	**85**	**2228**	**1617**	**583**	

* These figures are excluded from the second total, as the figures do not imply direct work with young people

** The figures provided in this questionnaire are excluded, to avoid double counting, as they are included under BYS direct work

Table 2: Numbers of Young People in Projects Targeting Those At Risk

Project	0-10	10-14	15-18	19-25	Total
Blakestown & Mountview NYP	0	45	0	0	45
Blakestown & Mountview Youth Initiative	0	20	50	15	85
Blakestown Mountview CDT	0	0	4	10	14
Blakestown Youth Project	0	40	20	0	60
BYS ESL Programme	0	2	13	0	15
Hartstown Huntstown CDT	0	80	20	51	151
HSE Outreach	0	0	6	41	47
Huntstown Community Youth Project	0	40	20	0	60
Mulhuddart Community Youth Project	0	134	45	0	179
Mulhuddart Corduff CDT	20	20	10	50	100
Oasis	0	158	35	0	193
Tolka River Project	0	0	0	4	4
Word on the Street	0	1	20	0	21
Total	**20**	**540**	**243**	**171**	**974**

In addition BYS Direct Work targets at risk groups but no figures separate to the overall BYS figures were provided

According to the table above there are approximately one thousand young people in the Blanchardstown area engaged with projects which are wholly or mainly targeted at young people at risk, of whom just over half are in the 10 to 14 year age group and approximately one quarter are in the 15 to 18 year age group. It is these young people who would, in the first instance, provide the primary target group for harm reduction measures. In addition there are likely to be other young people at risk who have not engaged with existing services, who might be targeted through an outreach programme. It is not possible to estimate the numbers in this group but it could easily exceed this figure, as participation rates in youth services rarely reach fifty per cent.

In Table 3 below, the projects responding to the questionnaire are analysed in terms of the programmes which they deliver in the area of drug education and four closely related fields: health education; sex education; peer education; and harm reduction. Over three-quarters of the projects provide some sort of health education, and over two-thirds are involved in the provision of drug education. Just under half provide sex education and a similar number are involved in peer education. Harm reduction

programmes are the least widely provided, with under one third of the projects providing such programmes. Furthermore, of the eight projects which provide harm reduction programmes, six are either drug-specific programmes, or statutory services

Table 3: The Delivery of Drug Education and Related Programmes provided by the Health Service Executive.

Project	Drug Ed	Health Ed	Sex Ed	Peer Ed	Harm Reduction
Blakers Foroige	-	-	-	-	-
Blakestown & Mountview NYP	✔	✔	✔	✔	-
Blakestown & Mountview Youth Initiative	✔	✔	✔	✔	-
Blakestown Mountview CDT	✔	✔	✔	-	✔
Blakestown Youth Project	-	-	-	-	-
Blanchardstown Youth Info Centre	✔	✔	-	✔	-
Blanchardstown Youth Service (BYS)	✔	✔	✔	✔	-
BYS Computer Clubhouse	-	-	-	✔	-
BYS Direct Work	-	✔	-	✔	-
BYS ESL Programme	✔	✔	-	✔	-
Corduff Community Resource Centre YC	-	-	-	-	-
Corduff Community Youth Project	-	-	-	✔	-
Hartstown Den	-	-	-	-	-
Hartstown Huntstown CDT	✔	✔	✔	✔	✔
HSE Education	✔	✔	✔	-	✔
HSE Outreach	✔	✔	✔	✔	✔
Huntstown Community Youth Project	-	✔	-	-	-
Mulhuddart Community Youth Project	✔	✔	-	-	-
Mulhuddart Corduff CDT	✔	✔	✔	-	✔
Oasis	✔	✔	✔	-	-
Peer Education Programme	✔	✔	✔	✔	✔
Tolka River Project	✔	✔	-	-	✔
WEB Project	✔	✔	-	-	-
Word on the Street	✔	✔	✔	✔	✔
Youthreach	✔	✔	-	-	-
Zone Youth Health Café	✔	✔	✔	-	-
Totals	**18**	**20**	**12**	**12**	**8**
Percentage of Projects Providing Programmes	**69%**	**77%**	**46%**	**46%**	**31%**

Only two youth projects, the Peer Education Programme and the Word on the Street Project state that they provide harm reduction programmes, and these two projects are closely linked in carrying out this work. It is clear that there is currently little drug education being carried out within the youth sector based on a harm reduction perspective. It was evident from discussion with youth sector personnel that there were a number of factors involved in this, including a lack of understanding of the approach, insufficient knowledge, lack of training and the effects of guidelines, including child protection guidelines, within the sector. There is a need to undertake a review of the guidelines for practice within the youth sector to ensure that they do not unnecessarily impede the implementation of effective harm reduction programmes in relation to drugs (and other issues).

The youth projects in Blanchardstown, particularly those explicitly targeting young people at risk or operating in areas with high levels of disadvantage, have contact with many of the young people who could benefit from effective harm reduction programmes. At present, however, with a few exceptions, it appears that they are not well equipped to deliver such programmes. In this situation a partnership between the youth service and some of the drug-specific projects would appear to be the most effective means of delivery.

Respondents to the questionnaire were asked to rank a list of drugs in order of prevalence among the target groups they worked with. Table 4 below shows the frequency with which drugs on the list were ranked as being in the five most prevalent. It should be noted that tobacco was not included in the list of drugs, but was mentioned by some respondents under the “other” category: had it been listed it would no doubt have featured more prominently.

Although the table does not represent a scientific finding in relation to prevalence, it does seem to represent a reasonably accurate picture of the likely extent of the use of different drugs among young people. According to the table the drugs most widely perceived to be prevalent among the (mainly) young target groups of the projects are, in order: alcohol, cannabis, ecstasy, cocaine, solvents and benzodiazepines. The next most prevalent drug was thought to be heroin, although this was predictably mentioned far more by the drug-specific projects than by the youth projects. It would seem reasonable that the harm reduction strategy should focus initially on developing harm reduction policies and information in relation to these six drugs and tobacco.

RECOMMENDATIONS

1. Harm reduction is A range of strategies for reducing the negative consequences of drug use for the individual, the family, the community and society, involving interventions in prevention, education, treatment and rehabilitation.

2. Harm reduction strategies should be targeted primarily at individuals and groups who are already engaged in drug use or who are identified as at risk of becoming involved. In addition, harm reduction measures may be aimed at personnel whose policies and/or behaviour may impact on the well-being of drug users (such as Gardai, teachers, pub and nightclub staff, parents, etc.)

3. The harm reduction strategy should be compatible with other approaches which seek to promote abstinence in individuals and to reduce the level of drug use in society. The harm reduction strategy is secondary to efforts to promote abstinence and is used only where those strategies have proven or are likely to prove ineffective.

4. The harm reduction strategy should promote “safer” drug use. It should avoid any suggestion that drug use is or can be safe or harmless.

5. The harm reduction strategy should be neutral on the question of the legalisation of drugs.

6. The harm reduction strategy should be directed at reducing the harm caused by both legal and illegal drugs.

7. The harm reduction strategy should be based on accurate, up to date and reliable evidence about the harms resulting from drug use.

8. The harm reduction strategy should only advocate safer approaches to drug use which are demonstrably safer.

9. Harm reduction programmes should be delivered by suitably trained and experienced staff with a thorough understanding of the approach. Training should be provided for staff involved in the design and delivery of harm reduction programmes.

10. The harm reduction strategy should be directed at carefully identified groups of young people engaged in projects for young people at risk or involved in drug use but not currently engaged in such provision.

11. The harm reduction strategy should be tailored to the needs of the group. The strategy should:

a. be suited to the age and developmental level of group members

b. be focussed on three distinct age groups: twelve to fifteen, sixteen to eighteen, and nineteen to twenty-five

c. take account of factors such as gender and the social and cultural context of drug use

d. be relevant to the young people taking into account the group's knowledge, attitudes and experiences of drugs

12. The harm reduction strategy should be delivered initially in and by projects with a record of work in drug education and related fields of health and social education, and should draw on the expertise of the drug-specific projects.

13. The harm reduction strategy should focus on those drugs identified as most prevalent among young people: tobacco, alcohol, cannabis, ecstasy, cocaine, solvents and benzodiazepines, and should collate and develop educational materials relating to these drugs. (Harm reduction advice, education and treatment related to the use of heroin and other opiates should continue to be carried out primarily by the drug-specific projects).

14. The BLDTF should seek additional funding to support the development and implementation of the harm reduction strategy. The strategy will involve the establishment of three pilot projects in conjunction with other services to initiate harm reduction work with specific identified target groups

15. Staff employed or allocated to work on the harm reduction strategy should have an appropriate level of skill and knowledge in both youth work and drugs work. To ensure an appropriate balance of skills at least two staff should be jointly responsible for this work.

16. The management structure for the strategy should be designed to ensure that the expertise of existing services, including the Task Force, the CDTs and the youth sector, is fully utilised.

17. The initial work plan for the selected initiative should include the following tasks:

- To further research the extent and nature of young people's drug usage
- To further research approaches to harm reduction
- To critique existing harm reduction literature and programmes
- To acquire and/or develop appropriate harm reduction materials
- To further explore the use of peer education as part of a harm reduction strategy and to enhance and develop the Word on the Street programme
- To design, deliver and evaluate two new models of harm reduction in other areas of Blanchardstown
- To educate and inform drugs and youth project staff about harm reduction strategies

APPENDIX

The following examples of drug education literature each include content reflecting a harm reduction perspective. They illustrate not only the harm reduction messages themselves, but also the various styles of presentation adopted by different agencies for their target audience. The notes below highlight some of the main features of each example.

1. Cocaine…What You Need to Know (Nursing Health Promotion Initiative, Addiction Services, South Western Area Health Board, 2005)

This is the final page of a small booklet on cocaine which explains what cocaine is, how it is taken, its effects, and the risks associated with the use of cocaine in general and specifically with different methods of use. The style of the booklet is straightforward with the use of photographic images and clear factual text.

In terms of the harm reduction messages, six points are made on this page, four of which relate to risks associated with sharing equipment such as pipes or injecting equipment. A point is also made about the risk of buying cocaine contaminated with other drugs or chemicals, although there is no suggestion as to how this can be avoided. There is also a warning to keep all drugs away from children, a point reinforced by the presence of a baby's soother in the photograph of lines of cocaine being cut. On the back cover of the booklet, three further points are made under the heading "Be Safe": Don't mix your drugs; If using after a break, go easy; Tell a friend where you'll be.

This production of this booklet is a positive move by the SWAHB in that it is a timely response to the increasing prevalence of cocaine use. It contains useful information and is well-presented. The harm reduction message could, however, have been more clearly and fully presented. Of the six points listed in the section on harm reduction, four are essentially the same point (about the risk of viral infection) whilst the other two (about contaminated drugs and keeping drugs away from children) are general points with no specific relevance to cocaine users. This latter comment also applies to the three further points made on the back cover. Furthermore, the use of the heading "Be Safe" above these three points is open to criticism as it might seem to suggest that cocaine use is safe provided these points are complied with.

SNORTED

straws or banknotes can leave you open to infection with HIV and Hepatitis

COCAINE

AKA – Snow, Charlie, Coke, Freebase, Crack, Rock.

Cocaine is a powerful stimulant drug, it comes from the South American Coca Plant. Crack is cocaine that has been chemically treated to produce crystals or rocks which are smoked.

HOW IS IT TAKEN?

Snorted: Up the nose, this is the most common way to take cocaine. It can lead to loss of smell, nose bleeds and as cocaine is acidic it can damage the lining and septum of the nose.

Sharing any equipment used to snort cocaine e.g. straws, banknotes, cutters or cutting boards may leave you open to infection with HIV and Hepatitis. Just think it may only take one small drop of infected blood (so small you can't see it) to infect you or your friends!!

2. Information about Hash (Word on the Street, 2004)

This is an extract from a leaflet on cannabis produced by the Word on the Street group, a peer education project run by Mountview/Blakestown Community Drugs Team and the Blanchardstown Youth Service's Peer Education Project. The leaflet packs a lot into a small leaflet, including information on the effects of cannabis, the legal status of the drug and the possible reasons that young people use it. The harm reduction perspective is clearly stated in the leaflet's introduction:

" We are not saying do this or don't do that but what we know is young people are smoking hash and that's the reality of it. What we are saying is just be careful."

The leaflet is a good illustration of both the strengths and potential weaknesses of a peer education approach to harm reduction.

The leaflet is clearly written by young people with a good, if incomplete, knowledge of cannabis. This section of the leaflet reproduced here (Advice) puts a lot of emphasis on the practical difficulties associated with the process of buying and using cannabis. Although it is not explicitly stated there is an underlying awareness of the ways in which the cannabis is associated with criminality and the dealing of other drugs in the community. The warnings not to buy hash "on tick" and not to buy other drugs when buying hash are particularly useful, and have rarely if ever previously appeared in Irish literature on cannabis. The warning on nicotine addiction is also an interesting perspective, as most literature regards smoking tobacco as a "gateway" to cannabis use, and it is worth noting that the opposite effect can and does sometimes apply. The overall strength of the advice here is that it is likely to seem relevant to young people and to impact on them in ways that more traditional advice on cannabis, produced by adult experts, has often failed to do.

The leaflet does not, however, include any advice in relation to the option to abstain from smoking cannabis, or even to defer starting to use, other than a vague reference to not starting "if too young". There is also very little information on the potential physiological and psychological harms which may result from cannabis use, especially among young users. The advice in relation to the costs of smoking cannabis and the possible legal consequences is valid and relevant, but the overall message seems to be that if you can afford it and avoid getting caught, the only real problems you are likely to encounter are a few holes burnt in your tracksuit.

Your Rights

* Chldren under 7 may not be detained in a Garda station.
* The Gardai must inform parents if they arrest someone over 7 and up to 18 years old.
* A child under 15 can't be imprisoned
* A child under 16 can be sent to a special school.
* You can be stopped by a Garda anywhere.
* If you are told that you are being arrested, ask what for and under what power.
* If you are arrested make sure that you tell a friend or relative and tell them what Garda station you are being taken to.
* You have the right to a phone call and a Solicitor.

Drawbacks

* Use or possession of hash is against the Law. You can be arrested and charged.
* If you have a conviction for having or using hash you will not be allowed to emigrate to the United States, Canada or Australia.
* Many jobs now do drugs testing on job applicants. They may not employ anyone who uses hash or any other illegal drugs. If you smoke hash regularly it can remain in your system for thirty days.

The law

* The misuse of Drugs Act 1997 and 1984 prohibits the sale, possession, supply or use of "controlled drugs". This includes hash.
* Having hash for your own use can get you a fine anywhere between €380 and €1200 approx. You can get up to 12 months in prison for a second offence.
* Sale or supply of hash can carry a ten year sentence or more depending on the amount.
* A Garda can search you without consent if he or she has a fair idea that you have drugs on you.

Word on the Street are:
Emer, Tom, Jenny, Tracey, Karl, Stephen, Peter, Brian and Sean

If you or a family member need help, advice or support contact Mountview / Blakestown Community Drugs Team at 01-8219140

Word on the Street is funded by Blanchardstown Local Drugs Task Force and facilitated by Mountview / Blakestown Community Drugs Team.

Views expressed in this leaflet do not necessarily reflect the views of either agency

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Word on the Street

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Information about Hash

Word on the Street

We are a Peer Education Group from Mountview and Blakestown. We are a group of 16 to 18 year olds from Whitechapel, Sheepmore, Fortlawn and Whitestown. Our mission is to find out facts about drugs and to pass this on to our peers. This info leaflet about Hash is our first to be published and will be followed by more leaflets about different types of drugs as time goes on.

We hope you find this leaflet useful.

Reasons young people give for smoking Hash

* there is very little else to do
* the buzz is great
* just to chill out
* it relieves the boredom
* peer pressure

We are not saying do this or don't do that but what we do know is young people are smoking hash and that's the reality of it. What we are saying is just be careful

The Chronic Story

Billie Mash had some cash
So he thought he would buy some hash
He bought the hash
And then got bashed
And got it all took off him
He thought he was having a session
When all he got was a lesson
Not to buy hash again

OH WELL!!
by Brian Gunnery

Some of the effects hash has on individuals

* some people go green
* other people get sick
* some people get real dizzy
* other people get the giggles
* some people get paranoid
* some people get the munchies
* it can cause loss of memory
* some people get clumsy or stupid over smoking

Advice

* Don't buy from a stranger or you might be ripped off
* Don't get hash on tick if you can't pay for it
* Don't buy E or Coke or Gear if you were only looking for Hash
* Don't waste your whole wages on hash
* If you don't smoke cigarettes you might get hooked on nicotine from smoking joints
* Watch out for bombers - lumps of hash fall out of the joint and burn holes in your clothes. The hash has to be spread to avoid 'bombers'

Also

* If you go into your house stoned your parents MAY notice.
* Not a good idea to get arrested while carrying hash.
* Don't involve kids by smoking or building joints in front of them
* When you buy hash you're going to need money for smokes and skins too.
* Make sure it's good hash by asking around
* Don't start smoking if too young

FOR ADVICE AND INFORMATION

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THE KING OF ECSTASY ISLAND, KING PEANUT THE THIRD OUT FOR A STROLL.

BUT AS KING PEANUT THE THIRD, IS ABOUT TO EAT FRUIT FROM THE 'E' TREE ...

MEANWHILE INSIDE PETE'S HEAD, HIS BRAIN IS FALLING FROM ITS CHEMICAL HIGH TO ...

A MAN TOO LONG WITHOUT SLEEP

PETE HAD NOT SLEPT OR EATEN ALL WEEKEND THIS MADE HIS MOOD WORSE, BUT COULD HE SLEEP NOW?............ COULD HE FUCK!

THE e WEEKEND

PETE'S FEELINGS AND MOOD HAD GONE FROM NORMAL, TO THE HIGH BROUGHT ON BY THE 'E'. HE NOW FELT BAD AS THE 'E' WORE OFF AND HIS MIND, BODY AND SOUL TOOK THE WEEK TO RECOVER FROM THE WEEKEND'S FUN!

OVER A PERIOD OF A YEAR OR SO THE HIGHS WERE NOT SO HIGH

AND THE LOWS WERE MUCH LOWER AND IT TOOK LONGER TO GET OVER THEM

PETE FELT SO BAD THAT WHEN HE WENT TO THE TOILET, HE WASN'T SURE IF IT WAS HIM OR THE TURD THAT SLIPPED DOWN THE BOWL.

THAT'S BETTER!, AS MY COUSIN FLOYD ALWAYS SAYS. "WHAT'S THE USE IN COMING DOWN, WHEN YOU'LL ONLY GET HIGH AGAIN?"

LIKE IT REG!

Ecstacy

My name is X
I love the effects
When I start trippin
People start flippin
Rushes come to me
Like XTC
I'm in my own world
No time for a bird
When I start scaggin'
I feel like getting a rope and hangin'
When my friend comes with more E
Then I'm happy as Larry!

Composed by
Andrew, David and Sean

Where to get Information or Help

Thunderdome 7.8 x 5.2 mm 43 mg MDMA
Triangle 10.2 x 4.1 mm 98 mg MDEA
Lips 8.1 x 5.4 mm 61 mg MDMA
Killers 9.1 x 4.3 mm 136 mg MDMA + caffeine
Number One 8.2 x 4.8 mm 56 mg MDMA
Blue Star 8.7 x 5.4 mm 11 mg amphetamine + trace caffeine
Clover Leaf 7 x 6 x 4.8 mm 46 mg MDMA + 19 mg MDEA
Sunrise 9.1 x 4.6 mm 129 mg MDEA
Diamond 12.7 x 7.3 x x 4.5 mm 102 mg MDEA
Twins 9.2 x 4.2 mm 79 mg MDMA
Mercedes 8.6 x 5.2 mm 12 mg amphetamine + trace caffeine
Micro 3.8 x 1.7 mm LSD
Dove 9.2 x 3.0 mm 67 mg MDMA + 31 mg MDEA
Euro 9.2 x x 2.8 mm 57 mg MDMA
Red Playboy 9.1 x 3.2 mm 27 mg amphetamine + trace caffeine
Dolphin 9.2 x 3.6 mm 26 mg MDEA + 5 mg MDMA
TNT 10.1 x 3.4 mm 55 mg MBDB
Triangle 10.1 x 4.3 mm 107 mg MDEA
Pyramid 10.1 x 4.6 mm medicine called Neo Cibalgin
CD 8.1 x 4.0 mm 9 mg amphetamine + trace caffeine
Apple 9.2 x 5.7 mm 42 mg MDMA trace caffeine
E-mail 4.5 x 8.5 mm 71 mg MDMA
One Two Five 9.1 x 2.6 mm 41 mg MDMA
Dove 9.1 x 3.0 mm 18 mg amphetamine + trace caffeine
Adidas 8.7 x 9.3 mm 8 mg amphetamine + trace caffeine

Try:

- Your own local drug agency
- The Internet - www.dap.ie
- Drugs/ Aids Helpline at 1800-459449
- Friends
- Parents
- School Counsellers
- Youth Leaders

Word on the Street are Emer, Tom, Jenny, Sean, Andrew, Jade, Brian, Gavin, Keith, Mark, David, Shane, Caroline and Holly

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Word On The Street

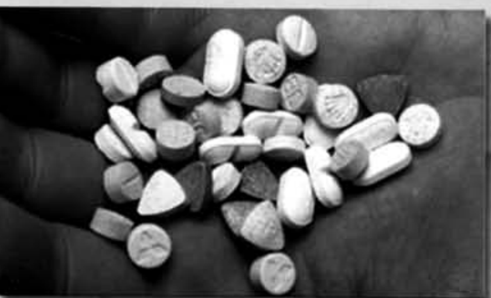
Information about Ecstasy

Word on the Street

We are a Peer Education Group from Mountview and Blakestown in Blanchardstown. We are a group of 16 to 18 year olds from Whitestown, Sheepmoor, Fortlawn and Whitechapel. The aim of our group is to find out facts about drugs and to pass them on to our peers. This is the follow up leaflet to the one we did about hash.

What is Ecstasy (E)?

The full name for ecstasy is methyl-enedioxyamphetamine. It is called MDMA for short. It is usually taken in tablet form. It was first made in 1910, and was later used to treat Parkinson's disease in the 1940s. In the 60s, ecstasy was used in marriage guidance counselling - counsellers thought it helped couples to empathise with each other (see each other's point of view). In the 1980s, people started taking 'E' for the buzz as a dance drug. It is now illegal to make, sell, or have Ecstasy in your possesion



What Happens when you take 'E'?

- Your mouth goes dry
- Your heart beats faster
- You get a tingly feeling
- It can get hard to swallow
- Your body heats up
- Music and lights feel different, stronger and more powerful
- You get 'high'
- You can hallucinate
- You get a burst of energy
- You can get rushes through your body
- You can get head rushed
- You go on a love buzz. You love everyone

Why People take 'E'?

- Boredom
- For a buzz
- Because their friends are taking it
- Makes you feel good
- Makes you forget your problems for a while
- To get "mad out of it"
- It takes you into another world
- Gives you energy to dance all night
- It is easy to get
- They are cheap (as little as 3 euro)

The Risks of taking 'E'?

- Your jaws get stiff and you grind your teeth.
- You can overheat
- You can get very depressed
- You could go off with anyone
- You can owe money
- You can lose weight
- You can get sore jaws
- A few people have lost the plot and ended up in mental hospitals
- A few people have died
- You never know what is in an E tablet
- You can get into trouble with your family
- You can get in trouble with the law
- You can overheat or even freeze.

(Your normal body thermometer can shut down.)

The Law

It is against the law to:

- Have ecstasy
- To sell or supply ecstasy
- To make ecstasy
- To drive while on ecstasy

How to Reduce the Risks

- Stay with your friends
- Try not to buy from a stranger
- Wait for the 'E' to take effect - don't top up, it takes time
- If dancing, try to keep your body cool

You can do this by:

- Wearing loose, light clothes
- Not wearing a hat
- Taking breaks to chill out
- Drink water or juice - don't drink alcohol as it will dehaydrate you and make you even hotter
- Sip about a pint of water every hour (It is possible however to drink too much water)

The perspective of young people, and especially young drug users, is a valuable element of a drug awareness programme but it needs to be supplemented by other perspectives. It is unrealistic to expect young people alone to be able to present a comprehensive overview of the risks and benefits of using any drug. The acceptability of this type of literature would not be compromised by reference to a choice to not use whatever the drug is in question, nor by ensuring that a more complete list of potential risks, and how to reduce them, is included.

3. Information about Ecstasy (Word on the Street, 2004)

This leaflet is a follow-up to the leaflet on cannabis discussed above. Whilst it again does not offer any support to a young person trying to resist the temptation to take ecstasy or considering giving it up, it does present a more comprehensive and better- organised overview of both the positive and negative effects of the drug. It also gives practical advice on how to reduce the risk of heatstroke when using ecstasy in a dance context.

4. Where's Me Slippers? (Release)

This is an extract from Where's Me Slippers, one of a series of leaflets produced by the Manchester based Lifeline project. The leaflets typically use a cartoon format, featuring drug using central characters, sometimes in combination with advice or information in plain text. The style, artwork, language and humour are designed to appeal to young people and young drug users in particular. These features are presumably intended to convey to the target group that the authors are in touch with young people, with the drug scene, and with the real issues which arise from drug use. The overall effect is intended to ensure that the safer use messages in the stories are credible and acceptable to young drug users.

In this extract the message is intended to persuade regular or heavy ecstasy users to "take a break" from using ecstasy from time to time. Whilst this is a reasonable objective and may well reduce the problems experienced by those users who heed the message, this type of literature needs to be carefully targeted. The Lisa character, who represents the advocacy of more moderate use of ecstasy, is clearly a user herself and has no problems with the idea of regular use of drugs like ecstasy and speed. At one point she lectures her friends on the "proper" use of stimulants as follows:
"We use drugs like E and Whizz because we like it, not because we have to, like a bunch of smack heads…I don't do E's every weekend. I give it a miss now and again. It means I enjoy it more."

5. Too Damn Hot (Release)

In another similar leaflet, Too Damn Hot, another story featuring the same characters, ends with Lisa collapsing on the dance floor from heatstroke. The point is made that her friends, Pete and Reg need to call an ambulance. Although this is an obvious point, it does highlight the fact that harm reduction information is not only relevant to those actually using drugs, but also to their friends, who may or may not be users. This leaflet contains more detailed text explaining what to do if someone collapses while dancing under the influence of ecstasy. It also explains why the use of ecstasy in certain settings poses a risk of heatstroke which may be fatal.

Whilst there are clear harm reduction messages in the Release leaflets, there is also an equally clear message that using stimulant drugs is enjoyable, fun and, provided not done to excess, reasonably safe. There are undoubtedly positive aspects to this type of material, but it would need considerable adaptation to make it acceptable in most Irish contexts, with the possible exception of those clubs and other venues frequented by young adults where the use of stimulants was commonplace. It is also worth noting that the disparaging references to heroin users, as “smack heads” and “junkies”, would not be considered acceptable by many Irish drugs workers.

Any drug education programme or material is only of value if it is effective in influencing the behaviour of current or potential drug users. In so far as the literature discussed above is effective it is likely to have significant benefits, up to and including the prevention of serious harm and even death. It should, however, be emphasised again that there is a thin line between advocating the safer use of drugs and advocating drug use. This does not mean that the harm reduction perspective should be rejected, but it does mean that the utmost care should be taken in the design and presentation of programmes and material. None of the literature considered here explicitly advocates abstinence as a valid choice. The underlying assumption is presumably that the material is targeted at drug users who by definition have already rejected this choice. There are two important points in relation to this assumption. The first is that even if the target group have chosen to use drugs, they have not necessarily chosen to continue to use drugs indefinitely. The second is that even with the most careful targeting, this material and the messages it contains will inevitably end up in the hands of those who are younger and not currently involved in drugs. It does not seem unreasonable that the starting point for this type of literature should be “If you use drugs…” rather than “When you use drugs…”.

FOR ADVICE AND INFORMATION

Lifeline Publications Guidelines

AIMS
To provide information on the nature and effects of ecstasy. It highlights potential dangers and includes information on how to reduce the risks associated with ecstasy use.

AUDIENCE
Adults and young people engaged in the recreational use of drugs. Use with under 16s with support (see page 3).

CONTENT
Some swearing.

FUNDING
Self-financed.

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TOO DAMN HOT!

UPDATED VERSION

WITH PEANUT PETE

PETE AND LISA ARE 'ON ONE' AT THE CLUB.
WHY IS IT WHEN SHE SWEATS SHE LOOKS SEXY... BUT I JUST LOOK LIKE I'VE PISSED MYSELF?
THROB
WAWAWAH
THUNGAAA

TEMPERATURES RISING....
THE CLUB WAS HOT... RAISING PETE'S BODY TEMPERATURE...
DANCING MADE HIM HOT RAISING HIS BODY TEMPERATURE.....
AND ONE OF THE EFFECTS OF TAKING ECSTASY IS TO RAISE BODY TEMPERATURE
IN OTHER WORDS PETE WAS..
TOO DAMN HOT

I'M NOT PAYING A QUID FOR A FIZZY DRINK, I'LL GET A DRINK IN THE BOGS!

SOME RAVERS CAN LOSE UP TO SIX PINTS OF FLUID, THESE FLUIDS MUST BE REPLACED...SO YOU MUST DRINK, BUT NOT ALCOHOL AS THIS DEHYDRATES YOU.
BASTARDS HAVE TURNED THE WATER OFF!
BOILING BOLLOCKS! GOTTA COOL DOWN!

PETE IS LUCKY ENOUGH TO BUMP INTO HIS MATE REG
HELP ME REG, I'M ROASTING!
WELL, I'LL PISS ON YOU IF YOU LIKE, OR YOU COULD FLUSH YOURSELF DOWN THE BOG LIKE NORMAN!...
HOT

OR YOU COULD POUR THIS BUCKET OF ICE COLD WATER OVER YOU, THAT I JUST HAPPEN TO HAVE!
I TELL YOU WHAT PETE! LET'S POP OUT ON TO THE VERANDAH TO COOL DOWN.

WHAT THE FUCK IS A VERANDAH?
IT'S A SORT OF CHILL OUT ROOM FOR TOFFS!
AH, THERE'S MY GREAT UNCLE BASIL
NO RIF RAF
OH CEDRIC, THIS HEAT.. IT'S SO TEWIBLY, TEWIBLY HOT!
FWIGHTFUL MY DEAR!

I SAY! REG. HOW ARE YOU OLD THING?

YOUR CHUMMY LOOKS A BIT HOT HAVE A SIT DOWN AND A COOL DRINK NOT ALCOHOL.....THAT WILL MAKE THINGS WORSE... AFTER ALL WE DON'T WANT YOU DEVELOPING HEATSTROKE!

HEATSTROKE WHAT'S THAT?
OH IT'S GHASTLY! ABSOLUTELY GHASTLY! I DEVELOPED IT IN THE TROPICS.... I FELT DIZZY AND A BIT SICK, CAME OVER ALL TIRED AND I STOPPED SWEATING, I COULDN'T PISS .... NASTY! HEATSTROKE CAN KILL!
E TYPE PETE

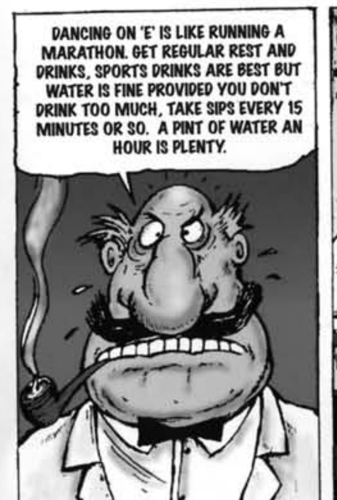
THAT'S THE MAJOR CAUSE OF DEATH ON THE DANCE FLOOR... HEATSTROKE
FUCK ME! I'M DEPRESSED!

YOU'RE TRYING TO TELL ME THAT IT WASN'T THE 'E' THAT KILLED THOSE RAVERS.... IT WAS HEATSTROKE!

PROBABLY. WE DO NOT KNOW EVERYTHING ABOUT ECSTASY. IT MIGHT BE SOME PEOPLE ARE MORE AT RISK THAN OTHERS. WE JUST DON'T KNOW
'IT COULD BE YOU'?

YOU SEE IT'S THE COMBINATION... CLUBS ARE HOT, DANCING MAKES YOU HOT AND ECSTASY MAKES YOU HOT... ADDS UP TO HEATSTROKE

THAT MEANS THAT DEATHS FROM HEATSTROKE ARE AVOIDABLE!


DANCING ON 'E' IS LIKE RUNNING A MARATHON. GET REGULAR REST AND DRINKS, SPORTS DRINKS ARE BEST BUT WATER IS FINE PROVIDED YOU DON'T DRINK TOO MUCH, TAKE SIPS EVERY 15 MINUTES OR SO. A PINT OF WATER AN HOUR IS PLENTY.

LET'S GET BACK AND TELL THE OTHERS!
IT'S TOO DAMN HOT TEMPERATURES RISING IT'S HARDLY SURPRISING WE'RE HAVING A HEATSTROKE!

BUT AS PETE AND REG GO BACK TO THE CLUB..
WHAT DO WE DO NOW?
OH SHIT, IT'S LISA SHE'S COLLAPSED!
IF SOMEBODY COLLAPSES CALL AN AMBULANCE.

NOTES

NOTES

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