Engaging the Hard-to-Reach

An Evaluation of an Outreach Service

by Caroline Corr

(This report was written and compiled in 2001 - 2002).

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Executive Summary

Merchants Quay Ireland is located in Dublin's south-west inner city which has a major heroin problem. During the late 1990s, research reports found that there were increasing numbers of heroin users in the area (McCarthy and McCarthy, 1997). This rise in problematic drug use was having a negative impact on the local community and there was an increase in tensions due to anti-social behaviour and public nuisance. Therefore, Merchants Quay Ireland set up an Outreach Service aimed at reducing drug-related harm to both problematic drug users and the wider community. This report presents the findings of an evaluation of the Outreach Service between the period of 11th December 2000 and 5th October 2001.

Research Objectives

The aims of the evaluation were:

- to assist the outreach workers to assess and reflect on their performance;
- to examine if interventions were having the intended effect;
- to identify strengths and weaknesses in the Outreach Service; and
- to improve the practice of the Outreach Service.

Research Method

Process evaluation was used to evaluate the outreach programme. This is the most common and most feasible method used to evaluate outreach work in Europe (Korf *et ah,* 1999). This evaluation was designed in such a way as to enable the outreach workers to self-evaluate their project. The study employed a combination of qualitative and quantitative methodologies. Quantitative data were collected from 11th December, 2000 to 5th October, 2001 using retrospective 'contact sheets' which were filled out by the outreach workers. The 'contact sheets' collected data on the characteristics of the client population and also information on services provided by the outreach workers. Qualitative in-depth interviews were carried out with two outreach workers to lend context to the quantitative data.

Key Research Findings

The main results were as follows:

- A total of 262 clients were contacted during the 10 months of the evaluation
- 587 separate outreach contacts were made with these clients
- 163 (62%) were contacted once and 99 (38%) were re-contacted, an average of 4 times
- During the 10 month period the outreach workers collected or disposed of 2,741 needles

- 31% of the clients were female and 69% were male
- 52% of clients were under 25 years
- Almost all the clients were Irish (98%)
- # 27% were new contacts[1]
- # 75% of clients were homeless at some point during the year
- # The majority of contact work took place in the morning and afternoon
- ft Clients were met in local residential or commercial areas (53%), at a local church (25%), in local drop-in centres (24%) and in a park (17%).
- # 88% of clients were using drugs other than alcohol and 79% were using heroin
- 29% of clients were polydrug users[2]
- 0 Streets (96%) were the most popular location for drug taking followed by a local church (21%), parks (15%) and at home (11%).
- # Harm reduction strategies used by the outreach workers included advice on safer drug use (39%)[3], motivational interviewing (34%)[4], referral to treatment services (17%)[5] and the collection of used needles (8%).
- Other services offered by the workers were building rapport (84%), giving out information on health issues (23%) and accommodation (12%).
- # During the evaluation period the workers noted that among the 99 clients who were met more than once, almost one-fifth (19%) changed to safer drug using practices,[6] while half (50%) started using more or injecting more.
- # The main barriers identified by the outreach workers to sustaining positive behavioural change were a shortage of treatment places, long waiting lists, lack of treatment options and an absence of effective aftercare services.
- The majority of clients (87%) were in contact with at least one service, other than the Outreach Service. Therefore, 13% had no contact with other support services. Almost two-thirds of the clients were in contact with needle exchanges (64%) and homeless services (63%). Almost half the clients were in contact with drug treatment services (41%) while only 10% were in contact with health services.
- Female clients were significantly younger, more difficult to contact and significantly more likely to be staying in a B&B. In relation to drug use, they were more likely to be using benzodiazepines or prescribed methadone. Moreover, they were significantly more likely to be in contact with health services and drug treatment services compared with their male counterparts.

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1 i.e. clients not met by the outreach team before

2 However, this could be an underestimate as the outreach workers may not have been aware of clients' secondary drug of choice.

3 This includes advice on better injecting techniques, better preparation procedures and on the importance of utilising multiple injecting sites.

4 Motivational Interviewing is an effective therapeutic tool often used with problematic drug users. It is particularly effective as part of a low threshold approach (Whitehead, 1997).

5 However, positive referral outcomes are unknown.

6 Changes to safer using practices refer to cleaning used injecting equipment, not sharing equipment, less frequent injecting or stopping injecting. It also refers to clients who started methadone maintenance or detoxification programmes.

- Male clients were more likely to have slept rough and been in prison. They were also more likely to be street drinkers.
- Younger clients were more likely to have stayed in a squat or emergency hostel and to have been in prison. In relation to drug use, they were more likely to be on prescribed methadone.
- Older clients were significantly more likely to be using alcohol.
- New clients were more likely to be sleeping rough, less likely to be re-contacted and significantly more likely to be polydrug users. Furthermore, they were significantly less likely to be in contact with any other services.
- Developments the outreach workers would like to see include introducing a peer-based approach to outreach and using influential drug users to distribute harm reduction information in their social networks. They would also like to operate beyond the designated boundaries, expand their team and offer the service later in the evenings and at the weekend. They also identified a client need for street-based needle exchanges when other services are closed. Furthermore they would like to co-work with other outreach teams as well as co-ordinating with, but working independently of, the low threshold service at Merchants Quay.
- The outreach workers felt that policy makers should consider offering treatment options other than methadone, opening a respite house for chaotic drug users and approving the establishment of a safe injecting room.

Conclusions and Recommendations

Despite constraints placed on the outreach workers by time and resources, they succeeded in reducing levels of public nuisance as well as reaching out to many chaotic drug users. Although Merchants Quay Ireland's Outreach Service is still in a developmental stage, it has the potential to develop into an innovative and proactive response to problematic drug use in local communities in Dublin. To this end, the following recommendations should be implemented.

Development of Outreach Service

- Merchants Quay Ireland's Outreach Service should extend its hours to the evenings and weekends and carry out street-based needle exchanges.
- MQI's Outreach Service should co-ordinate with other outreach services to ensure that drug users in Dublin's inner-city and Dublin 8 are reached.
- The outreach workers should target networks of drug users rather than individuals and develop a peer-based approach by using drug users to distribute harm reduction information among their social networks.
- The outreach team should work towards expanding their team and aiming for managerial independence.
- There is a need to continue to mediate with the local community and police and build on the relationship of mutual trust that has developed.
- It is unrealistic to expect one outreach service to cater for all their clients' needs. The outreach workers should liaise with other outreach projects working with homeless people, and ex-prisoners, in order to set up a network of integrated services.
- Finally the Outreach Service needs to remain flexible and responsive to clients' needs.

Drug Services

- Specific training programmes should be designed to target outreach workers.
- Injecting equipment should be more readily available and consideration should be given to establishing a safe injecting room.
- There is also a need to expand the number of places on methadone maintenance programmes, eliminate waiting lists and develop referral protocols.
- Consideration should be given to piloting other treatment options. For instance the government should implement the recommendation of the NACD (2002) report of piloting buprenorphine as an effective treatment option.
- Given the lack of treatment places and treatment options in Dublin there is an urgent need for a respite house in the city.
- There is also a need for more co-ordinated aftercare programmes for those leaving treatment programmes, prisons and maternity hospitals.

Homeless Services

- Staff in homeless services need to be trained to deal with this client group.
- ft Homeless hostels which refuse accommodation to homeless drug users should review their policies and take a more inclusive approach.
- In addition to emergency accommodation, there is a need for long-term stable housing for homeless drug users.

Policy

- The government needs to commit itself to introducing a wider range of harm reduction strategies targeted at hard-to-reach populations such as greater access to clean injecting equipment, a safe injecting room, improved access to treatment and a wider range of treatment options.

Further Research

- Qualitative research should be conducted to gain insights into the views and opinions of clients using Outreach Services.
- Furthermore, the needs and perceptions of drug users regarding existing drug treatment services should also be examined.
- Finally feasibility studies should be carried out on peer-based approaches to outreach work, alternative treatment options and safe injecting rooms.

1 Introduction

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

(K.ort etal, 1999: 164).

fhis chapter explains why Merchants Quay Ireland set up such an Outreach Service and provides a description if the work carried out by the outreach workers. **Chapter Two** presents a review of literature relating to outreach work. It will be seen that outreach work is an effective strategy in engaging hard-to-reach drug usersatnd in reducing l objectives of the study. **Chapter Four** presents the analysis of data collected from the contact sheets filled out daily by the outreach workers as well as qualitative data from in-depth interviews with the outreach workers. **Chapter** Five discusses the implications of the findings. Finally **Chapter Six** presents some key recommendations.

1.1 Background to the Study

Merchants Quay Ireland is located in Dublin's south-west inner city, which has a major heroin problem. The only large-scale prevalence study on opiate use in Dublin found that there were 13,460 opiate users (Comiskey, 1998). This study found that in the Dublin 8 area surrounding Merchants Quay, 1 in 10 young males, between the ages of 15 and 24, were using opiates (Comiskey, 1998).

Another research project carried out in the locality found that there were increasing numbers of heroin users among the multiply deprived communities (McCarthy and McCarthy, 1997). It found that there were more young people and more women using opiates. This increase in drug use in the locality was attributed to heroin becoming cheaper and more widely available. Furthermore, it was found that the drug culture had a firmer grip with young people growing up as second generation drug users. This research identified an urgent need for outreach and community based work locally (McCarthy and McCarthy, 1997).

This rise in problematic drug use in the area was having a negative impact on the local community and there was an increase in tensions due to anti-social behaviour and public nuisance. Merchants Quay Ireland became aware that there were abandoned needles being found in local flat complexes, on the streets and in parks and that there were substantial numbers of drug users congregating in these areas. Used injecting equipment,

discarded in the community, raises fears about needlestick injuries and risks of transmission of HIV and Hepatitis C (Macalino *et al.,* 1998).[1] There was also concern that these drug users were not adequately linked in with services. Therefore Merchants Quay Ireland established an Outreach Service aimed at reducing levels of public nuisance and targeting chaotic drug users in the locality. This service is funded jointly by the Eastern Regional Health Authority and Dublin City Council.

Merchants Quay Ireland's Outreach Service adopts a multi-strategic approach. The model used is mainly based on the provider-client model (Rhodes, 1996). The aim is to change drug users' behaviour in the community through one-to-one interactions.

The Merchants Quay model also has some of the characteristics of a Community Outreach model in that the team work with networks of drug users as according to Rhodes and Stimson (1998) 'changing peer group norms and practices are an effective method for facilitating individual and collective behaviour change' (160).

Outreach working methods are usually detached, domiciliary or peripatetic. Detached work is the most common in Europe (Korf *et al,* 1999) and this is the method used by Merchants Quay Ireland's Outreach Service. The working method is detached as the outreach workers contact clients in their 'natural' setting (i.e. in the streets and local estates). The Outreach Service is staffed by two workers from the low threshold service operated by Merchants Quay Ireland. The Outreach Team works in pairs to ensure workers' and clients' safety. In order to minimise danger, the outreach workers carry mobile phones and identity cards. They promote harm reduction *directly* in the drug users' social milieu, and also *indirectly* by attracting clients into existing services.

Peripatetic outreach work is carried out to a lesser extent, as the workers also visit a number of clients in prisons, drop-in centres for homeless people and low threshold drug services. This helps broaden the range of people who are reached.

Community Development is an integral part of the outreach work, as the outreach workers also liaise with the local Policing Forum and local community organisations. Furthermore, they link in with two outreach teams working with homeless people and provide them with advice and support on dealing with drugs issues.

The Outreach Service works on the premise of the Public Health Model, which assigns an important role to professional intervention. This model became popular in the mid-to-late 1980s, notably as a result of the spread of HIV and AIDS. Its primary aim is harm reduction through the promotion of safer drug use and safer sex (Korf *et al,* 1999).

There are a number of drug outreach workers in Dublin working for other organisations. Voluntary organisations, such as Dublin AIDS Alliance, have drugs outreach workers while the different Health Boards have numerous outreach workers attached to Community Drug Teams, needle exchanges, methadone maintenance programmes and in-patient and outpatient detox programmes.

[1] However the likelihood of a person in the community contracting a blood-borne disease as a result of a needlestick injur is considerably lower than 0.3 per 100 incidents (Macalino *et al,* 1998). For instance in a review of 408 people whi attended an A&E in Rome because of a needlestick injury, there were no cases found of HIV seroconversion (Montell *et al,* 1992). Nevertheless, this is not undermining the fact that people in the community who get a needlestick injur suffer from considerable emotional stress because of the fear of possible health consequences (Macalino *et al,* 1998).

1.2 Objectives of the Outreach Service

The overall aims and objectives of the Outreach Service can be divided into two broad categories.

Table 1.1 illustrates that the aims and objectives of the Outreach Service are two-fold as it simultaneously endeavours to reduce harm among injecting drug users as well as the local community.

TABLE 1.1 OBJECTIVES OF THE OUTREACH SERVICE

Promoting harm reduction among injecting drug users	• identify and contact individuals and groups of chaotic drug users • Provide information and advice on safer drug use • Encourage and sustain changes towards safer drug use • Seek to draw those not in contact with services into centre-based services • Discuss health issues • Refer clients to relevant agencies
Promoting harm reduction in the local community	• Collect and dispose of used needles • Liaise with other outreach programmes working with homeless people and provide them with advice and support on dealing with drugs issues • Establish links with other community groups, the local Policing Forum, Dublin City Council and local business interests • Promote good community relations in order to relieve some of the local tensions • Encourage drug users to have greater sensitivity to the concerns of the local community

1.3 Research Objectives

After the first year of the Outreach Service an evaluation was carried out. Evaluations are vital for outreach projects in order to assess whether the target group is benefiting from the intervention (EMCDDA, 2001a). It also ensures adequate accountability to flinders, service users and service providers. The aims of the evaluation were:

- to assist the outreach workers to assess and reflect on their performance;
- to examine if interventions were having the intended effect;
- to identify strengths and weaknesses in the Outreach Service; and
- to improve the practice of the Outreach Service.

2

Literature Review

This literature review looks at the development of outreach work among problematic drug users.[2] It will be seen that outreach work is an effective strategy in engaging hard-to-reach drug users and in reducing levels of risk behaviour. The chapter concludes with examining outreach work in the Irish setting.

2.1 What is Outreach Work?

In the wake of the HIV epidemic in the 1980s, low threshold services[3] were set up in Europe targeted at problematic drug users. However some of these services, like needle exchanges, failed to reach certain groups such as younger injectors, new injectors and women (McKeganey and Bernard, 1991). This was a cause for concern as these groups were likely to be engaging in HIV transmission behaviour (Rhodes *et al.* 1990). Consequently outreach services were set up to target hard-to-reach groups who were not in contact with low-threshold services. Outreach workers differ from workers in mainstream drug services as they go out to areas where drug use occurs (Sterk-Elifson, 1993). Outreach work is 'by its nature, at the front line of drug services, dealing with people at a grassroots level' (EMCDDA, 2001a: 16). Consequently, there is a greater emphasis on services being 'community-based' and 'user-friendly' (Rhodes, 1997a). There is no standard way to carry out outreach work but it is rather a commitment to responding to issues raised by the target group in a holistic way (EMCDDA, 2001a).

Although outreach work varies among different European countries, there are four general aims that are common across all countries. These are:

- €# 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 (Korf *et al.*, 1999: 8).

Research has found that outreach services 'reduce the physical and ideological gap between the user and the service, and as such are likely to improve service uptake' (Rhodes *et al,* 1990: 12). Outreach projects have also been found to reduce risk behaviour (Friedman *et al.,* 1992). Successful outreach work usually depends on certain values and principles such as respect, hope and kindness and on personal staff characteristics such as commitment, altruism, and creativity (Tommasello *et al,* 1999).

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2 Outreach work is also carried out with users of 'new' drugs (e.g. ecstasy) in clubs and raves but this type of outreach work will not be examined here.

3 Low threshold services are easily accessible by clients, and abstinence is not a prerequisite for service provision. Often, such services work with clients on an anonymous basis. They are designed to attract future clients by offering, besides drug-related services, other services that respond to the immediate needs of clients. Examples of low threshold services include needle exchanges and low dosage methadone programmes.

2.2 Outreach Working Models

Models of outreach work have been developing since the late nineteenth century and have been influenced by a number of perspectives including philanthropy, social and political reform, youth and community work, ethnography and public health (Rhodes *et al,* 1991). The earliest outreach work was carried out by the Salvation Army in America targeted at poor people, in particular immigrants (Korf *et al,* 1999). There are also examples of philanthropic projects in deprived areas of London during the 1860s (Stimson *et al.,* 1994).

Following the Second World War, outreach workers began to target young people because of concerns that their deviant behaviour was a 'major social problem' (Korf *et al.,* 1999: 18). In America the focus was on street gangs, and youth workers followed these gangs into their 'subterranean world' in order to 'contact them and ultimately control them' (Gilman, 1992: 6). While outreach workers and social workers acknowledged that these 'deviants' were from socially deprived backgrounds, they focused their interventions on individual rather than structural change (Korf *et al.,* 1999). During the 1960s in Europe (in particular the UK and France), this style of outreach was developed into the **Youth Work Model** which targeted the post-war adolescent generation, especially the working-class young. Initially youth workers provided drop-in centres for 'young rebels' (Gilman, 1992) but the gap between 'traditional youth services and young people themselves was seen as a potential source of social instability' (Korf *et al,* 1999: 18). Therefore, outreach workers went out to youths in their local environment in order to prevent further marginalisation and to encourage social integration (Korf *et al,* 1999). The aim was to steer youths in the direction of traditional services (e.g. probation services) and much emphasis was placed on education, training and leisure activities. Today this model is frequently used in the Nordic countries, Austria, France, Germany, Portugal and Finland.

Outreach work did not occur in Belgium, Germany, Norway and the Netherlands until the mid-1960s as a result of the 'flower-power' era (Korf *et al,* 1999). The main change in the 1960s was that drug use was transcending all social classes as experimentation with cannabis and LSD became widespread (Korf *et al,* 1999). Accordingly, youth workers and outreach workers moved their focus from deviant youths to drug-using youths (Korf *et al,* 1999). Outreach workers continued to advocate abstinence from drugs, concurring with government policy, and it was the non-governmental organisations (NGOs) which were more accessible and adaptable during this time (Korf *et al,* 1999).

It was not until the 1970s that outreach workers had to address the rapid spread of heroin use in many European countries and the corresponding emergence of 'problem drug addicts' (Korf *et al,* 1999). The **Catching Client Model** was introduced, based on the experience of youth workers, aimed at drawing drug users into drug-free and in-patient treatment (Korf *et al,* 1999). The prevailing view at the time was the criminalisation of users, drug-care services based on abstinence and a medical model for treating drug users (Gilman, 1992; Korf *et al,* 1999). While outreach work in the UK concentrated on drawing drug users into drug-free services, outreach services in the Netherlands were more unconventional and unconditional (Korf *et al,* 1999). The Catching Client Model is still practiced extensively in the Nordic countries and to a lesser extent in Italy and the UK.

The **Self-help Model** originated in the late 1970s and was quite similar to the Youth Work Model although it worked with drug users' self-help organisations, and accepted drug-taking as a social reality (Korf *et al,* 1999). Therefore, the emphasis shifted to harm reduction activities (including information on safer drug use and safer sex; distributing syringes and condoms etc.) and user-friendly facilities (such as settings where drug users could take drugs in a controlled environment). This model is popular in the Netherlands where user organisations produce magazines promoting the dignity of drug users and emphasising the responsibility they have for their own lives (Korf *et al,* 1999).

By the early 1990s outreach work had been established in most EU countries (Korf *et al,* 1999). The most recent development in outreach work is based on the **Public Health Model** which, although similar to the Self-Help Model, assigns a greater role to professional intervention (carried out by nurses, doctors, drug workers, field workers and peers). The primary aim is harm reduction through the promotion of safer drug use and safer sex. Thus harm reduction has become the main philosophy underpinning outreach work. Harm reduction refers to 'a policy or programme directed towards decreasing adverse health, social and economic

adverse consequences of drug use even though the user continues to use psychoactive drugs at the present time'(Single, 1995: 289).

A fifth model of outreach work is the **Service Network Model.** This comprises 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' (Korf *et al,* 1999: 80). The main aim is to encourage drug users to use youth, drug and health care services. The intention is that by using a network of professionals, resources can be pooled and interventions will be more effective. In practice, however, it is difficult to co-ordinate all the different disciplines (Korf *et al,* 1999).

The 1990s also saw the development of community outreach work which involves targeting social networks of drug users (Korf *et al,* 1999). There has been much academic debate over the merits of this approach compared to the **provider-client model.** This model involves one-to-one interactions carried out by a small number of professionally trained outreach workers who 'reach out' to individual drug users with the aim of providing health education and prevention materials in the community (Rhodes and Stimson, 1998). The provider-client model has been shown to be effective in reaching injecting drug users who are not in contact with services, in distributing condoms, needles, syringes and bleach and encouraging reduction in levels of injecting risk behaviour (Rhodes, 1997a). Furthermore, some controlled evaluations associate such reduction with a levelling in HIV incidence among injecting drug users (Rhodes, 1997b). This approach, however, is also criticised for relying too much on individualistic methods of behaviour change (Rhodes, 1997a) and for only facilitating *arithmetic* progression into the target population (Stimson *et al,* 1994). Furthermore, Rhodes *et al.* (1991) suggested that 'easier to reach' IDUs are most likely to be contacted while those most in need of services often remain uncontacted. It is also generally considered that individual outreach work is limited in its ability to sustain behavioural change, compared to community outreach, because of its over-reliance on individual beliefs and intentions (Rhodes, 1993).

The **community outreach model** is often favoured as it acknowledges that individual behaviour change depends on social relationships and situations in which such behaviour occurs and also relies on the values of peer groups and social networks (Korf *et al,* 1999; Rhodes, 1997a). It allows for *geometric* progression through communities by seeking 'to engender changes in social norms within social communities of drug injectors, regardless of the service contact' (Stimson, *et al,* 1994: 1601). Furthermore, community approaches do not just focus on networks of drug users but also on the broader 'community' such as the family, extended social networks and the local community (Korf *et al,* 1999).

Community outreach often uses peer education working within the **social diffusion model** (Rhodes, 1997b). This approach assumes that IDUs make effective prevention advocates and secondly that changing peer group behaviour is effective in changing both individual and collective behaviour (Rhodes, 1997b). Evaluations of such models have found that peer outreach is more effective than the provider-client model in reaching hard-to-reach populations (Rhodes, 1997b). In the US two models of peer outreach have become popular. The **indigenous leader model** uses a combination of community ethnography and medical epidemiology. Ethnographic researchers and outreach workers identify key informants or opinion leaders who are trained as indigenous outreach workers. Then they target other key opinion leaders within the target population and encourage them to become indigenous outreach workers. The aim is to generate social responsibility among the IDU community to reduce harm by disseminating harm reduction techniques through their social networks. Evaluations of this approach have found that it reduces risk behaviour and HIV infection in IDU networks (Rhodes, 1997b). The other peer approach used in America is the **peer-driven intervention model.** This approach uses ethnographers and outreach workers to contact any IDU who is then encouraged to act as a peer educator. The aim is 'to *saturate* whole peer groups with an intervention message by encouraging *as many drug users as possible* to act as peer educators' (Rhodes, 1996: 30). All IDUs contacted by the project are given monetary incentives to act as peer educators. Although Rhodes (1997b) points out that this may be inappropriate in some cultural and economic contexts (which is probably the case in Ireland), he does reveal that evaluations of such an approach suggest that more IDUs are contacted than are by provider-client approaches and peers learn more about risk reduction than through contacts made by professional outreach workers.

Rhodes and Stimson (1998) regard peer outreach as one of the first steps towards community change and collective action. However they highlight three factors which often prevent outreach work developing into collective action. Firstly 1DU networks lack organisational infrastructures and a sense of community and political identity. Secondly, because of the 'hustling' culture characteristic of drug users' lifestyles, organisation and management are problematic. Finally, because of the illegal status of injecting drug use, statutory organisations are unlikely to promote the cause of collective action for IDUs. Users' groups have been effectively established in a number of countries, including Ireland. Nevertheless, tensions do arise in trying to work independently and also collaborate with non-drug users and health professionals in order to get funding (Rhodes and Stimson, 1998).

2.3 Who are the Hard-to-Reach ?

The hard-to-reach are marginalised, isolated, socially excluded and highly mobile and are often not in contact with any services (Korf *et al,* 1999). Reasons given for avoiding contact with services are that they are geographically or psychologically inaccessible, hard-to-reach groups fear the consequences of contact and some drug users feel they do not need help or do not perceive that they need it. Furthermore, services are irrelevant to their needs or are not proactive in seeking clients (Power *et al,* 1993). Also, outreach workers often find if difficult to engage with hard-to-reach groups (Erickson and Page, 1998). For instance, outreach workers in London have found that hard-to-reach groups are initially suspicious of them, often see lengthy interventions as interference and occasionally reject the workers altogether (Rhodes *et al,* 1991). The hard-to-reach include young chaotic drug users, homeless drug users, female drug users and drug users from minority ethnic groups.

Young chaotic drug users are considered hard-to-reach, especially early school leavers (Mayock, 2000). The proportion of young people presenting for treatment in Ireland has decreased (O'Brien *et al,* 2000). In a study carried out in a Dublin inner-city community, Mayock (2000) found that young problematic drug users concealed their drug use from their friends and local community and, as a result, were unlikely to seek help. Furthermore, Pain *et al.* (2002) found that hard-to-reach young people did not identify with services and service providers for a number of different reasons. The young people reported that they were rarely listened to, labelled and subject to a high level of control.

Homeless drug users are hard-to-reach as many are unaware of services available or unwilling/unable to access these services. They are excluded from many homeless services and are often refused access to hostels. Homeless drug users find it difficult to access services in Dublin because of long waiting lists, perceived discrimination due to not having an address, programmes based on actual catchment areas, as well as missing stages of programmes due to illness or a prison sentence (Costello and Howley, 2000). Moreover, the task of funding drug use makes it very difficult for homeless people to commit themselves to lengthy assessment procedures involved in accessing drug treatment programmes (Costello and Howley, 2000).

Female drug users, especially those with children, are particularly reluctant to access services and tend to remain a hidden population (Goode, 2000). In Ireland women make up less than a third of those presenting for treatment (O'Brien *et al,* 2000). This may indicate that fewer women than men experience problems with drugs. Conversely, it may also suggest that drug treatment services are less appropriate to women's needs and societal norms make it difficult for women to present to services. Female drug users are difficult to reach as they maintain a low profile due to illegal activities, they lack stable housing and they feel stigmatised as a mother with a drug problem (Goode, 2000). These women are likely to conceal their drug use for fear of public disapproval (Barnard, 1993). Furthermore, drug-using mothers often avoid seeking help because of the risk of social service intervention (Goode, 2000). Some female drug users are also involved in sex work and fear attending social services because of stigmatisation (Starmans, 1998). Similarly, young male sex workers are a hard-to-reach group as they are often suspicious of authority and avoid services (Illing *et al,* 1993).

Drug users from minority ethnic groups in Ireland do not access services due to lack of knowledge, language barriers and lack of experience among drug service providers to deal with this group (Ana Liffey, 2001). Furthermore, few drugs agencies have employees from minority ethnic groups; this further alienates these groups (Perera *et al,* 1993).

Drug users are prone to more health problems than the general population and are at significant risk of HIV and Hepatitis due to risky injecting practices (EMCDDA, 2001b). It is estimated that between 12% and 15% of the injecting drug-using population in Ireland are HIV positive (Johnson *et al.* 1994; O'Gorman, 1998). It is also estimated that between 70% and 95% of injecting drug users in treatment have Hepatitis C anti-bodies (Smyth *et al.,* 1995). Unfortunately, many injecting drug users show little desire to access health services as they have more pressing demands such as housing, money and food (Rhodes *et al.,* 1991). Concerns relating to HIV, Hepatitis C and other health problems are usually of secondary importance.

2.4 Drug Use and the Wider Community

Hard-to-reach groups often use drugs in public places such as streets and parks. Drug use and related activities in local estates impact negatively on local residents (Mayock and Moran, 2001). Drug specific anti-social behaviour includes discarding used injecting equipment, open drug dealing, consumption of illicit drugs and any engagement in problem behaviour resulting from such consumption (Lawless and Cox, 2003). In a study on social problems in seven estates in Dublin, children reported encountering drug users and being exposed to drug paraphernalia in their local environment (O'Higgins, 1999). Furthermore, parents were also concerned about their children's high levels of exposure to drugs. But the drug problem is not just a concern for those living in estates where heroin use is most prevalent. A national survey on drug-related knowledge, attitudes and beliefs in Ireland by Bryan *et al.* (2000) found that there was a high level of concern among the general population. Overall, societal attitudes to those who use drugs was negative although respondents did believe that high priority should be given to providing help to drug users.

The relationship between drugs and crime remains elusive. People living in communities where there are many opiate users risk being victims of criminal acts or are at risk of acquisitive or property crime (Veale, 1994). In D'Arcy's (2000) study in Blanchardstown, 66% of the opiate users interviewed had committed property crime and 41% had committed a crime against a person. UK studies have found that gang violence related to suppliers of controlled drugs, property crime and mugging raises the cost of goods to the public and drives businesses away from housing estates. This increases unemployment and the cost of travel to work as well as reducing access to cheaper shopping (cited in O'Higgins, 1998).

The social costs of drug-related crime include fear of crime itself and negative influences on children who may see drug use as an attractive option for them. They also include high insurance costs to cover personal crime and unemployment arising from a shift of resources away from areas with high drug use. Cullen (1994) points out that drug use also has more debilitating effects relating to loss of community morale, the acceptance of the inevitability of young deaths, the internalisation and denial of grief and a sense, in many communities, that the public have little interest in their social predicament.

During the early 1980s, a number of local communities in inner-city Dublin came together to address the drug problem. In 1983, as a result of the absence of an adequate government response, residents from the inner-city, affected by the opiate epidemic, formed social movements such as the Concerned Parents Against Drugs (CPAD) and later Community Action against Drugs (CAD). These movements, however, declined in the mid-1980s because of antagonism with the police and media over their alleged use of vigilante tactics (O'Gorman, 1998).

During the early 1990s, communities were finally recognised by the government as having a key role to play in the provision of local services and also in the development of policies and anti-drug strategies (Loughran, 1999). The *Government Strategy for the Prevention of Drug Misuse* (1991) attempted to introduce community services, based on drug teams incorporating a major role for GPs. This, according to Loughran (1999), was the most innovative move at the time. But the community-based aspect of the *Strategy* was not totally welcomed by all local people. Residents of inner-city areas were concerned that their areas might become stigmatised and labelled as 'drug areas', while simultaneously attracting drug users into the community to use special services (Loughran, 1999). The *Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs,* (1996) created local Drug Task Forces to develop and co-ordinate strategies in locally deprived areas. These Task Forces advocated co-operation between voluntary agencies, community action groups and local partnerships with statutory interests (Loughran, 1999).

In the latter half of the 1990s Ireland experienced a moral panic in regard to drug use and related crimes (Lawless and Cox, 2003). O'Donnell (1999) attributed this to an increase in the number of murders between 1994 and 1995 and the media's portrayal of the lavish lifestyle of key figures of organised crime. There was a resurgence of anti-drug and vigilante groups who again began to march on the houses of known drug dealers with the intention of 'cleaning' their communities of drug pushers (Mayock and Moran, 2001). Public outrage and intolerance of drug-related activities came to a head in 1996 with the murder of journalist Veronica Guerin. This forced the drugs issue to the top of the political agenda (Memery and Kerrins, 2000). As a result, the Housing (Miscellaneous Provisions) Act was introduced in 1997 to demonstrate to concerned communities that the government was 'tough on drugs' (Memery and Kerrins, 2000). The Act addressed drug pushing and drug-related crime in local authority housing estates. It introduced exclusion orders for persons believed to be engaging in anti-social behaviour. It also provided for the speeding up of procedures to evict known drug dealers from local authority estates. According to Memery and Kerrins (2000) instead of emphasising the exclusion of those involved in drugs from local authority housing, the government should have worked to resolve the wider and complex drug issues for these communities and to address the needs of drug users directly. In a study on homelessness and drugs, respondents reported that they were discriminated against by the local authority and resident committees because of their drug use (Costello and Howley, 2000). Drug users are leaving local authority housing and finding themselves in a cycle of homelessness, where access to drug treatment is near impossible and where access to alternative accommodation is equally difficult (Memery and Kerrins, 2000).

2.5 Outreach Work in Ireland

The first outreach project in Ireland was established by the Eastern Health Board in 1988.[4] This outreach service reports to the HIV prevention unit in Baggot Street Hospital, Dublin (Sweeney, 1993). Outreach workers target IDUs, women in prostitution (especially drug users) and gay or bisexual men (Korf *et al,* 1999). Other outreach projects have been set up since 1988 focusing on specific target groups such as women at risk of sexual and drug-related HIV infection (Korf *et al.* 1999).

Overall, outreach work aims at moving clients through a 'hierarchy of harm reduction goals' (McDermott, 1993). Harm reduction is now central to Irish drug policy. Little emphasis has been placed however on the importance of outreach work in consecutive government strategies; it is therefore still at a developmental stage. Nevertheless, outreach services are being developed at a local level by NGOs and local health boards. Some of these outreach services offer needle exchanges, support for sex workers and referral to methadone maintenance programmes. The emphasis is on 'the importance of community presence, which enables them to intervene and 'fast-track' individuals to treatment while concentrating on making contacts and on increasing service accessibility' (Korf *et al,* 1999: 131).

In the *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* (1996) the government acknowledged outreach work as an important working method. It recommended that health boards should co-ordinate locally-based treatment and outreach services to encourage drug users to link in with services. The emphasis was on outreach workers improving access and service uptake rather than *in situ* service provision. This ignores the fact that some drug users do not perceive a need help or do not want to contact services (Rhodes *et al,* 1991).

The most recent drug strategy, *Building on Experience* (2001), focuses on the four pillars of supply reduction, prevention, treatment and research. One of the action plans of the *Strategy* is 'to continue to develop good practice outreach models, including mechanisms to reach drug misusers who are not in contact with mainstream treatment or support agencies'. However, to date there has been little movement on this action. The *Strategy* did not offer any concrete examples on how to link hard-to-reach drug users into services. Merchants Quay Ireland (2001) welcomed the new *Strategy* but it pointed out the need to introduce a wider

[4] However, anecdotal evidence suggests that during the 1960s and 1970s the Catholic Church and other voluntary organisations carried out outreach work with people 'misusing' alcohol and those leaving tenements in Dublin. Therefore they probably were in contact with drug users and individuals working in the sex industry.

range of harm reduction strategies in Ireland, including more outreach work 'to ensure that risks associated with needle sharing, accidental overdose and dangerous injecting techniques can be minimised. These measures should include greater access to clean injecting equipment, advice and training on how to avoid overdose and infection, and safe supervised facilities where professionals can assist in minimising harm associated with actual drug taking' (7).

2.6 Summary

Outreach work has been developing since the late 19th century. It has been influenced by developments in youth and community work, ethnography and public health. Outreach work is now carried out by people from a range of different disciplines (youth workers, social workers, drug workers and nurses). The most common model used today is the Public Health Model which advocates harm reduction through the promotion of safer sex and safer drug use and also through the distribution of syringes and condoms. Recent evaluations of outreach work have shown that peer-based approaches are more effective in reaching hard-to-reach populations and reducing risk behaviour compared to professional interventions. Hard-to-reach groups include young chaotic drug users, homeless drug users, female drug users and drug users from minority ethnic groups. These groups are marginalised, socially excluded and highly mobile and are often not in contact with any services. The first outreach project in Ireland was established by the Eastern Health Board in 1988. Since then a number of outreach services have been set up by NGOs and local health boards targeted at specific groups at risk of HIV and Hepatitis C infection. Merchants Quay Ireland (2001) has emphasised the need to introduce a wider range of harm reduction strategies in Ireland, including more outreach work, targeted at hard-to-reach groups.

3

Methodology

This chapter outlines the research methodology which was employed to achieve the objectives of the study. The aim of the evaluation was to work with outreach workers to self-evaluate their service and the benefits of this approach are outlined. Thereafter, the chapter explains the research instruments that were used and describes how the data were analysed.

3.1 Empowering Research

This evaluation was designed in such a way as to enable the outreach workers to self-evaluate their project. This demystifies the evaluation process for the outreach workers and encourages them to use it as a developmental tool (EMCDDA, 2001a). For this approach to be empowering, outreach workers were included in all stages of the research process. They were encouraged to reflect on their performance and analyse what they had learnt. This enabled them to make strategic, organisational and operational decisions about the delivery of their service. Empowering research should underpin all evaluations of service provision but it is particularly appropriate for outreach workers as they face several problems such as;

> structural isolation [...], difficult relations with host organisations, over-involvement with clients, disagreements over methodology and objectives, duplication and overlaps with other services, and the lack of 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 (Korf *et ah,* 1999: 159).

3.2 Process Evaluation

Process evaluation was used to evaluate the outreach programme. This is the most common and most feasible method used to evaluate outreach work in Europe (Korf *et ah,* 1999).

> 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 (Korf *et al,* 1999: 96).

Outcome evaluation is not suited to outreach work as the target group are usually highly mobile and difficult to track. Furthermore, outreach work is loosely structured by nature and it is difficult to isolate the specific effects of outreach interventions from those of other influential factors.

3.3 Data collection

A combination of qualitative and quantitative methodologies was used as evaluation benefits from the use of multiple methods (Robson, 1998).

3.3.1 Contact Sheets

The main method for monitoring the outreach work was the use of retrospective 'contact sheets' which were filled out daily by outreach workers based on answers to specific questions or on informed guesswork. The

'contact sheets' collected data on the characteristics of the client population and on the services provided by the outreach workers. The indicators used included:

- Extent, location and type of clients contacted
- Number of harm reduction interventions
- Number of referrals to treatment and support services
- Behaviour changes towards safer drug use or away from drug use

3.3.2 In-depth Interviews

In-depth interviews were carried out with two outreach workers to put the quantitative data into context. This was the most appropriate way of gaining an in-depth insight into the outreach workers' experience of, and perspectives on, issues relating to their work. The interviews enabled the outreach workers to offer a holistic view of the complexity of the interactions involved in outreach work.

3.4 Reliability of Data

Due to the nature of outreach work, systematic monitoring and evaluation are difficult (Rhodes *et al,* 1991). This is because the outreach workers' first priority is to engage with the target group; data gathering is of secondary importance. Client information was not 'actively' sought unless it was thought appropriate to the contact itself. Therefore the reliability of data collected is more restricted when applied to this type of work (Rhodes *et al.,* 1991). Nevertheless, the outreach team are confident that the majority of outreach contacts were recorded. There is also some uncertainty about client information as the target population is transient and less likely to engage in lengthy contact and re-contact.

3.5 Data analysis

Data collected on the 'contact' sheets were analysed using the statistical package *SPSS for Windows.* All percentages given in the report are based on valid responses adjusted for missing data. Categorical variables were analysed using chi-squares and 95% confidence interval (CI).

The outreach workers agreed to tape the in-depth interviews and these were transcribed verbatim. The qualitative data were coded into different themes and ideas and analysed accordingly.

4

Results of Evaluation

This chapter presents quantitative and qualitative evaluation findings covering 10 months of operation of the Outreach Service. The chapter summarises data collected on the 'contact' sheets as well as findings from in-depth interviews conducted with the outreach workers.

4.1 Overview of Outreach Work

The outreach team collected data during the period between 11th December, 2000 to 5th October, 2001. During this period 587 separate contacts were made by the outreach team with a mean of 5 contacts each day (median = 5; mode = 5; SD = 2.5). Over half of the contacts (n = 314, 54%) were with clients younger than 25 years.

During the first year of the project the outreach team collected or disposed of 2,741 needles with a mean of 22 each day (median =19; mode = 19; SD = 15.6). The outreach workers considered this as one of the main strengths of the Outreach Service:

> *A lot of the clients will say 'fair play to you 'for going round picking them up. It also breaks down a lot of barriers and clients will actually come up and say where people are using, so you can go and get the needles. This has a two-pronged effect because then you go into this new place that they 're telling you about. You can go in and take the needles but you can also see who's using there. [...] It is appreciated around here and I think it has taken a hell of a lot of pressure off Merchants Quay. Whatever amount of needles we have picked up in this area, you can imagine what it would have been like if we hadn 't picked them up. They 'd be everywhere now. They 'd be carpeted with them.*
>
> (Outreach Worker A)

Other work carried out by the outreach workers included providing information and advice on safer drug use to over a fifth of the contacts (n = 132, 22%). Eighty-nine times (15% of all contacts) the outreach workers provided information on health issues. During one-tenth of the contacts (n = 57, 10%) the outreach team made referrals to treatment services.

4.2 Demographics of Clients

Overall the Outreach Service met 262 individual clients. Figure 4.1 illustrates the gender breakdown of clients.

FIGURE 4.1 GENDER BREAKDOWN OF CLIENTS

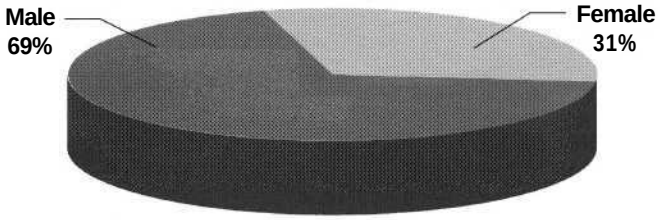


Figure 4.1 shows that almost one third of clients were female (n = 81, 31%) and over two-thirds were male (n = 181, 69%). The gender breakdown is the same as that found in low threshold services in Ireland (Cox and Lawless, 1999).

Practically all the clients were Irish (n = 254, 98%). However the outreach team also met 4 English people, 1 Scot and 1 non-EU national.

The following table shows the age groups of clients contacted.

TABLE 4.1 AGE OF CLIENTS

Age group	Number	Percentage	Cumulative Percentage
Under 18 years	26	10	10
18- 24 years	109	42	52
25 - 34 years	112	43	95
35 - 39 years	7	3	98
40 years +	6	2	100
Total	**260**	**100**	**100**

Missing Values: 2

The above table shows that over half those contacted were under 25 years (n = 135, 52%). Female clients were significantly younger than their male counterparts (df = 1; p = 0.01), which is consistent with research carried out in low threshold services (Cox and Lawless, 1999). The majority of female clients were younger than 25 years (68%) compared to 45% of male clients. The outreach workers felt that a peer-based approach would be the most effective way of engaging more young people:

> *Young people [...] are doing it at night. They're moving around. There was a squat [...] where a lot of them were hanging out. I'd go in there and talk to them but there's a suspicion around you because they've only started using and they're still enjoying it. What's the point in me sitting there telling them this is shite, because they 're actually enjoying the gear [heroin] at the moment. It's hard to get in with them and I think to get in with young people, you need people that they know [...] If you could get someone from the local community that everyone knew had used and got clean, you 'd get in there a hell of a lot faster than two strangers trying to get in there.*
>
> (Outreach Worker A)

4.3 New Clients

Outreach work has a preventive element as it makes contact with people who are new to the streets and links them into appropriate services quickly. Over a quarter of those contacted were new clients[5] (n = 71, 27%). So the Outreach Service was successful in contacting hidden populations of drug users.

[5] i.e. clients not met by the outreach team before

Less than a quarter of new contacts were female (n = 16, 23%), while over three-quarters were male (n = 55, 77%). This may indicate that female drug users are more difficult to reach. However, over half of new contacts were younger than 25 years (n = 40, 56%).

UA Current Accommodation

Three-quarters of the clients were homeless at some point during the year (n = 169, 75%)[6], while 25% (n = 70) were living in local authority housing, private rented accommodation or with their parents. Over one-third of the clients (n = 77, 34%) lived in more than one type of accommodation during the year. In fact, 2 clients lived in 5 different types of accommodation and one client stayed in 6 different types. The accommodation used by the clients is displayed in the following table.

TABLE 4.2 TYPES OF ACCOMMODATION

Accommodation Type	Number	Percentage
Sleeping Rough	98	44
Emergency Hostel	94	42
Parents' Home	45	20
B&B	23	10
Local Authority Housing	23	10
Long-Term Hostel	12	S
Friends	11	5
Prison	9	4
Squat	9	4
Relatives	9	4
Private Rented Accommodation	2	2

Percentages do not add up to 100 as multiple responses were possible

The above table shows that almost half the clients had either slept rough (n = 98, 44%) or stayed in an emergency hostel (n = 94, 42%) during the year. Overall, one fifth of the clients (n = 43, 19%) had slept rough and stayed in emergency accommodation. Age had an impact on where clients reported staying. Clients younger than 25 years were significantly more likely to have stayed in an emergency hostel ($df = 1$; $p = 0.01$). Although not significant, only younger clients had stayed in a squat and a larger number of younger clients had also been in prison.

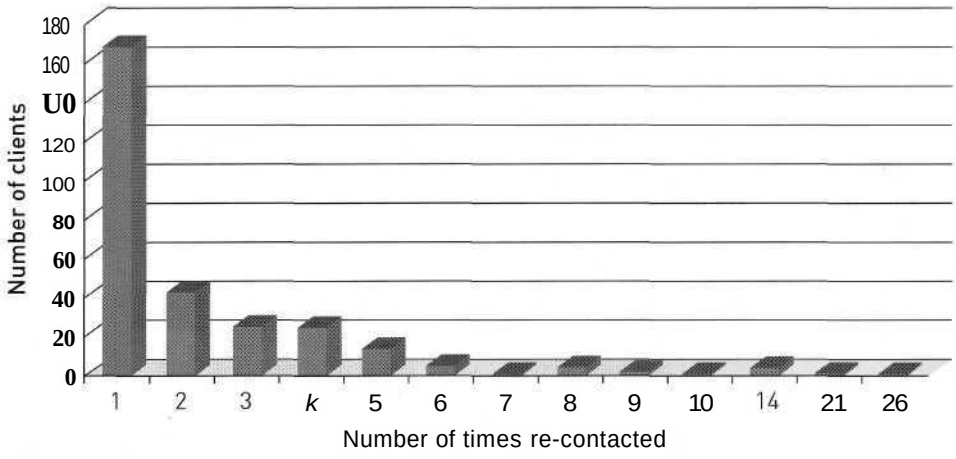
Accommodation was also highly influenced by gender. Female clients were significantly more likely to have stayed in a B&B ($df = 1$; $p < 0.05$), whereas male clients were significantly more likely to have slept rough ($df = 1$; $p < 0.05$). Furthermore, only male clients had been in prison. Finally, although not significant, new clients met by the Outreach Team were proportionately more likely to be sleeping rough compared to those who had been met before (55% vs. 42%).

45 Contact Work

An important aspect of outreach work is following up contacts on the streets. However, Figure 4.2 shows that the majority of clients were only met once by the outreach workers (n = 163, 62%). The outreach workers hoped to make more re-contacts as effective outreach depends on reliable, long-term street contacts (Korf *et al,* 1999). Nevertheless, this is a higher re-contact rate than in British studies (Rhodes *et al,* 1991). Further outreach re-contacts were made with 99 (38%) of these clients, with a mean of 4 contacts. It was not surprising to find that outreach workers were significantly less likely to re-contact new clients ($df = 1$; $p < 0.0005$). Only 17% (n = 12) of new clients were re-contacted, compared to 46% of regular clients.

[6] For the purpose of this report homeless clients are defined as those who reported living in a hostel, a B&B, a squat, staying with friends/relatives or sleeping rough.

FIGURE 4.2 DISTRIBUTION OF OUTREACH RE-CONTACTS



Thirty-seven clients (14%) were met twice while nineteen clients (7%) were met 3 or 4 times respectively. The most any client was contacted during the first year was 26 times. The outreach workers explained that it was difficult to re-contact chaotic drug users as they are highly mobile and do not frequent the same using sites in Dublin, in part as a result of police pressure. Similarly in London, clients become more mobile and less open to contact when areas are policed (Rhodes *et al,* 1991). However, the outreach team are liaising with police in Dublin in order to make them aware of the outreach workers' presence, their purpose and the nature of their work:

> *I've met a good few of the guards up there. Some of them would be fresh out of college, wouldn 't know anything about drugs and they 11 sit there and have a sneaky fag and I'll sit there talking to them. It seems to have broken down barriers with some of them [...] Some of them seem alright and they listen and there 's a certain amount of sympathy there. I noticed that they are a lot more tolerant and I think they have been told to be a lot more tolerant to the homeless and to the ones that live in the area.*
>
> (Outreach Worker A)

The outreach workers also listened to complaints and concerns of the local community and took appropriate actions:

> *If they [local businesses or community groups] have a concern about a particular client who might be turnin' on*[7] *in a certain spot, rather than them approachin' him and gettin' into a confrontation, they 're tellin' me about it and I go and talk to the person. That seems to ease it a lot better and it's taking a lot of the confrontation away.*
>
> (Outreach Worker A)

The outreach workers did receive positive feedback from local business people however they were finding it particularly difficult to appease concerns of the local residents. Obviously problematic drug use and the associated anti-social behaviour are more concerning for people if it is impacting on their home life.

The outreach workers recommended strategies to increase the number of re-contacts. They felt that the use of peer education, involving influential drug users distributing information in their social networks, would increase the number of drug users reached and would help change drug-using behaviour among groups. It is likely that a peer-based approach would work well in the Irish context as many drug users are in contact with each other:

> *If you educate peers on safe injecting they will naturally pass the word around, just by talking about things and being in the company of people that are using [...] We 've got a*

[7] Taking drugs, referring to injecting.

good network of drug users coming in here [MQI]. It's a waste of relationships that have been formed downstairs if we don't look into a peer approach.

(Outreach Worker B)

Ireland is smaller and less populated and all the drug-using population know each other. London was so big and there were so many different areas that you might be known in your area but if you step over into another area you mightn 't know anybody. Through communication, the word goes out in a day whereas in London you can put a word out about something and it might not be heard for months.

(Outreach Worker A)

The outreach workers would also like to operate beyond the designated boundaries to target more of the Dublin 8 area. They felt that this would enable them to maintain contact with the target group, who are highly mobile.

Both outreach workers also wished to expand their team. British research has shown that the greater the resources in time and staffing, the greater the corresponding number of outreach contacts (Rhodes *et al,* 1991).

Table 4.3 shows that most of the contacts were made either in the morning or afternoon. The outreach team offers its service from 0900 to 1800, Monday to Friday, which means that clients can be contacted when other services are closed.

TABLE 4.3 TIME OF CONTACTS

	Percentage
Morning (0900 - 1200)	46
Lunchtime (1200 - U00)	15
Afternoon (U00 - 1800)	39
Total	**100**

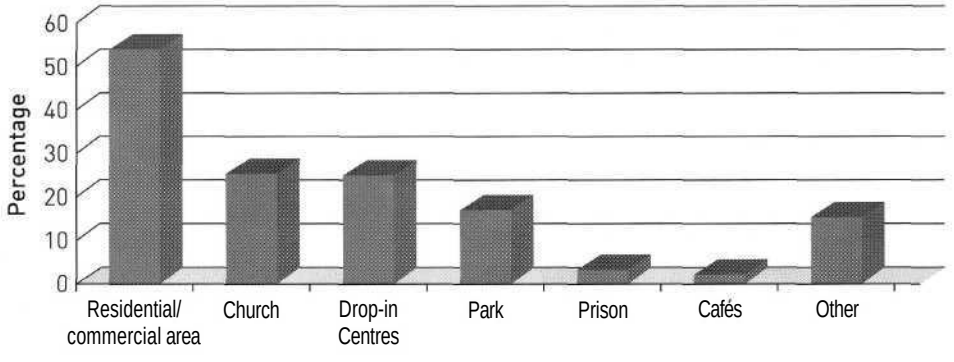
The outreach workers felt they could contact more chaotic users if the service was available later in the evenings and at the weekend:

/ think we would see a hell of a lot more clients if we were out there in the evenings and at the weekends because that's when it's needed [...] We should be out there at weekends when everywhere else is shut and night time when people are settling down.

(Outreach Worker A)

Figure 4.3 reveals that the Outreach Team spent proportionately more time doing detached outreach work than peripatetic outreach work. This is similar to British outreach projects (Rhodes *et al.* 1991).

FIGURE 4.3 PLACE OF CONTACT



* Percentages do not add up to 100 as multiple responses were possible

Over half of the clients (n = 139, 53%) were met in residential or commercial areas. Many of these areas are notorious for drug dealing. The outreach workers felt this was a good contact point with clients although there is high police presence in the area. A quarter of the clients were contacted at a local church (n = 65, 25%) which is particularly popular during the winter months as it is sheltered and quiet. Almost a quarter (n = 63, 24%) were met in local drop-in centres while 17% (n = 45) were met in a park. Other areas included prison (n = 9, 3%) and cafes (n = 6, 2%).

The outreach workers felt they spent too much time in low threshold services engaging in meetings, supervision or helping out when short-staffed. Outreach Services elsewhere have faced similar difficulties (see Rhodes *et a/.,* 1991; pages 94 - 96). The outreach workers were keen to point out that the balance between client-based work and other activities had direct implications for their outreach work. They also felt that this had the potential to lead to role confusion and risked undermining their street-based work:

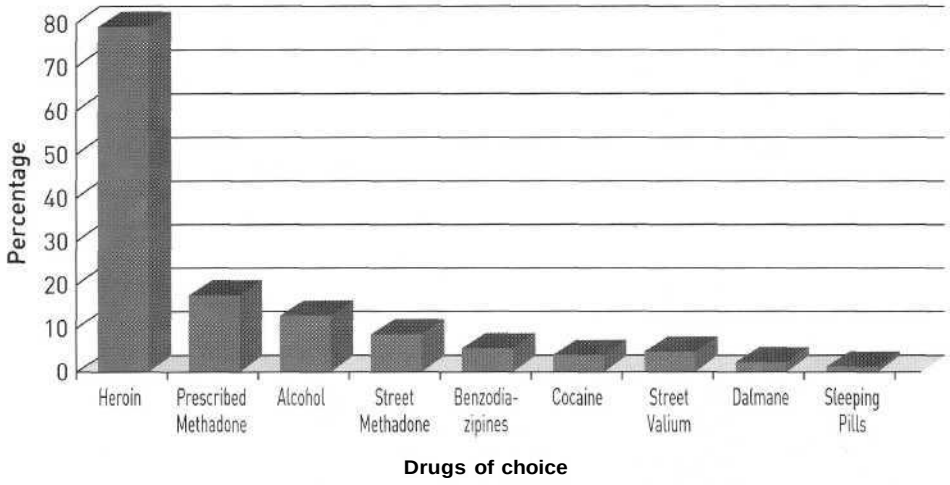
> *We were helping out in the Contact Centre[8] and then we thought how can we justify our jobs if we're sitting in the Contact Centre [,..] There's nothing better for the clients than regularity and normality. If we say we 're going to be in a certain spot everyday well it's good to be there and if we pull back to work in the Contact Centre it's an entirely different ballgame. Clients will talk to you on the street and they 'II say things to you that they 'II never say in a service.*
>
> (Outreach Worker A)

The outreach workers would prefer to work independently of the low threshold service at Merchants Quay in order to maximise the amount of street-based work carried out.

4.6 Drug Use

The Outreach Team noted that 88% (n = 189) of clients were using drugs, other than alcohol. The following figure illustrates the drugs used by clients.

FIGURE *UM* CLIENTS' DRUGS OF CHOICE



* Percentages do not add up to 100 as multiple responses were possible

The above figure shows that heroin was used by more than three-quarters (n = 168, 79%) of the clients. Other drugs most commonly used were prescribed methadone (n = 36, 17%) followed by alcohol (n = 25, 12%). In

[8] Merchants Quay Ireland's low threshold service.

relation to gender differences, there were significantly more female clients using benzodiazepines than male clients (df = 1; p = 0.05). Although not significant, there were proportionately more female clients (24%) than male clients (16%) on prescribed methadone. Conversely, there were more than twice as many male clients (15%) than female clients (7%) who were using alcohol.

There were also significant differences in relation to age. Those younger than 25 years were significantly more likely to be on prescribed methadone (df = 1; p < 0.05). There were twice as many clients younger than 25 years (n = 24, 24%) on prescribed methadone than those over 25 years (n = 12, 12%). However, there were significantly more older clients than younger clients using alcohol (df = 1; p = 0.01). There were four times as many clients over 25 years of age (n = 20, 20%) using alcohol than those younger than 25 years (n = 5, 5%).

A surprising result was that over one fifth of the clients were not using heroin (n = 46, 21%). One outreach worker explained that heroin use depended on its quality and/or availability:

> *There was a phase when the heroin was of such poor quality that they all switched to tablets. But a lot of the people we talked to who weren 't using heroin, either had done or would use again. There was that time with the dodgy gear [heroin] where a lot of people switched and turned to tablets. Now I notice that there is a hell of a lot more coke use because Dublin was flooded out with a lot of good coke at Christmas. Everyone was using coke and gear [heroin].*
>
> (Outreach Worker A)

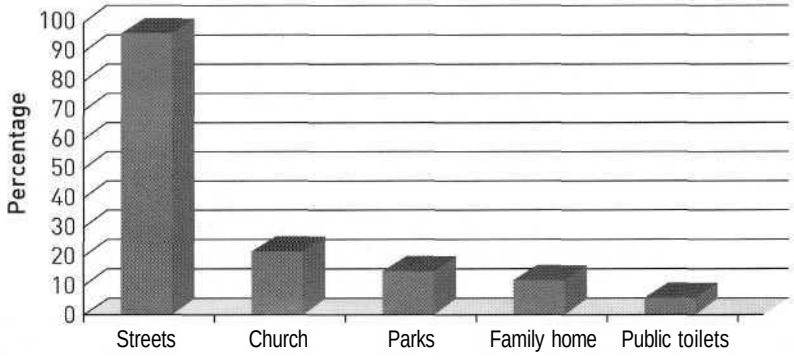
The outreach worker also explained that many of the clients attended different treatment and detoxification programmes but because of lack of aftercare many started using heroin again.

Almost one in three of the clients were polydrug users (29%, n = 62)[9]. This is not surprising as other research carried out in Dublin has found that there is a growing problem of polydrug use (Farrell *et al,* 2000). New contacts made by the Outreach Team were significantly more likely to be polydrug users (df = 1; p = 0.001). Almost one-fifth of the clients were taking 2 different drugs (n = 39, 18%) while 15 (7%) were taking 3 different types of drugs. Two clients were known to be using 6 different drugs. One of them was using prescribed methadone, Valium, benzodiazepines, Dalmane, sleeping pills and heroin. The other client was using heroin, prescribed methadone, benzodiazepines, cannabis, ecstasy and alcohol.

A third of those using heroin (n = 57, 34%) were also using other drugs. Twenty-three (14%) were using prescribed methadone, fifteen (9%) were using street methadone, while eleven (7%) were using alcohol or benzodiazepines.

The most popular places used for drug-taking or street drinking are shown in the following graph.

FIGURE 4.5 USING SITES



[9] This could be an underestimate as the outreach workers may not have been aware of clients' secondary drug.

The range of locations demonstrates how the outreach workers were successful in meeting clients in their 'natural' setting. Figure 4.5 shows that streets were the most popular location for drug taking (n = 186, 96%) followed by a local church (n= 41, 21%). The third most popular location for drug taking was parks (n =29, 15%) while 11% (n = 21) used at home. Less than 5% of the clients used in public toilets, cars, hostels, prison, flats or school playgrounds. The outreach workers were concerned about the high levels of drug taking in public places:

> *You 're a danger to yourself as you are rushing and using bad practices because of the environment and lack of proper facilities. Like they 'd be injecting behind a wall or something. That's dangerous for the individual and there's the risk of the police coming in and nabbing you.*
>
> (Outreach Worker B)

One of the outreach workers recommended a safe injecting room as one way of reducing levels of public drug use:

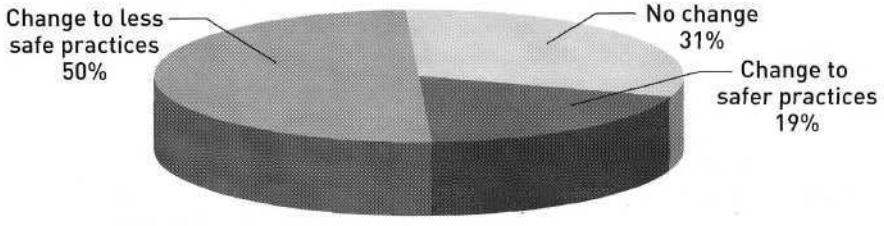
> *The majority of our clients would either be homeless or living in communities where they can't be seen to be using. If they're seen to be using they would be put back onto the streets. The streets are where they would be using. So I think if we had consumption rooms, it would stop a lot of the street use.*
>
> (Outreach Worker A)

Over a third of the clients used drugs in more than one location (n = 70, 34%). The mean number of using sites was 2. According to one outreach worker, this was because of changing drug markets and police surveillance.

> *They'll follow the gear [heroin] and also if the guards come round they'll shift from there to another spot. It's wherever the gear [heroin] is at the moment and they'll move from there to somewhere else. What happens is that, someone will find a spot, start using and then they 'II tell their mates and they 'II start using and then the word of mouth will go round that this is a good spot, then everyone starts hitting it. Then the guards and the community start noticing it. So they start hanging around there to stop people and then they 'II move to another spot and then the whole cycle will go on again. Then the guards will concentrate on that one and then they'll start on another one and they just keep moving.*
>
> (Outreach Worker A)

During the first year of the Outreach Service, the workers noted that among the 99 clients (38%) who were met more than once, almost one-fifth (n = 19, 19%) changed to safer drug using practices.[10] Any small change towards safer/healthier activities was viewed as a success. However, half the clients who were met more than once (n = 49, 50%) started using more or injecting more. Changes in drug-using behaviour are displayed in the following figure.

FIGURE 4.6 CHANGES IN DRUG USE



[10] Changes to safer using practices refer to cleaning used injecting equipment, not sharing equipment, less frequent injecting or stopping injecting. It also refers to clients who started methadone maintenance or detoxification programmes.

It is not feasible to attribute these changes, positive or negative, to the outreach intervention as there are a host of factors which can influence a person's behavioural change. Among those who had changed to more unsafe practices, 20 clients had stopped using and started again while 17 were using more. A further 12 clients had started injecting more. Others had started using cocaine or heroin or started injecting. The outreach workers explained that this was the nature of problematic drug use and that the main obstacles to sustaining positive behavioural changes were lack of treatment options and respite care in Dublin.

> *They're going to use more and more and more and more to stop the sickness coming on.*[11] *There's nothing more you can do about it. You can't recommend anything else. It's hard enough to get methadone in this country as it is. Without methadone there is nothing else they can do. I can recommend that they only use when they 're dying sick but the reality is that they 're only going to stick to that for a couple of days and then go back to the way they were before. There's nothing you can do about that. If you had a respite house where you could take people, or it was easy to get someone onto a clinic that would change.*
>
> (Outreach Worker A)

Although many clients showed a desire for referral to a drug treatment programme the long waiting lists restricted the outreach workers' ability to make effective referrals.

> *The reality is that someone will come to you and they 'II say I want to get off this shit, I want to get on phy [methadone], I want to sort my life out. You ring around a few clinics, you find that the nearest waiting list is 6 or 7 months. So you tell the client, well if you can just keep your drug use under control for 7 months, we might be able to get you on a phy [methadone] course. You 're telling them to their back as they 're walking away from you. It s pointless.*
>
> (Outreach worker A)

Among the nineteen clients who had changed to safer practices, 9 were using less, 5 were looking for a detox and six had successfully detoxed. Others were injecting less or were on a methadone maintenance programme. One client started using less when he gained employment.

As well as employment, time spent in prison or pregnancy also seemed to act as a catalyst for clients attempting to modify or abstain from drug use. However, this was usually not sustained because of lack of aftercare. As one outreach worker explained:

> */ think the majority of women are human, they have feelings and they don't want their babies to go through that. Once the baby's out of them they'll start again because there is a lack of support. There's a real lack of support for women with young babies. They come out, they have great ideas. It's the same as any other women with a baby. It's just they have no support networks and everything starts crumbling around them. The only thing that makes that bearable is to go back to using drugs again. It's just a big vicious circle. I think if there was more aftercare, it would make a difference.*
>
> (Outreach Worker A)

Eight clients were released from prison during the first year of the Outreach Service. Six of them were on a methadone maintenance course in prison and started using again on release. The other two clients used less in prison but started using more once they were released.

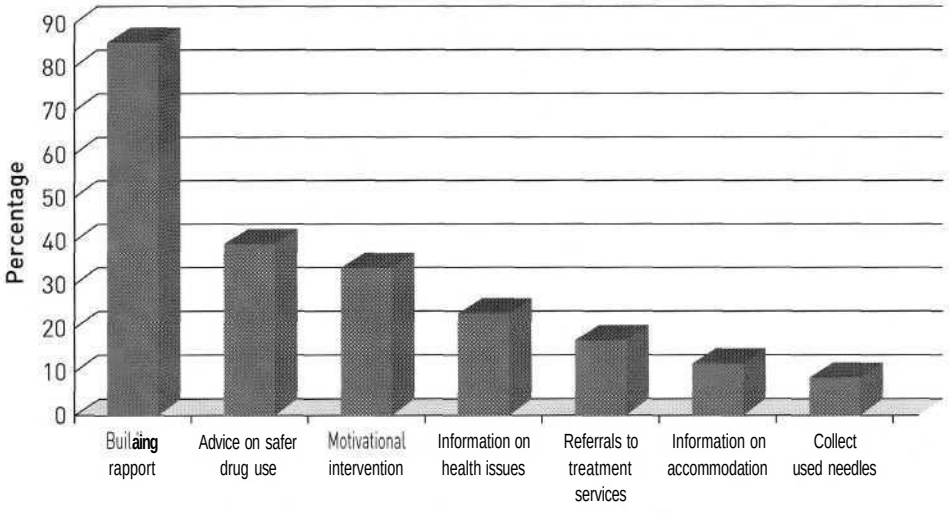
> *In prison it is the routine as well [...] The key things are a routine, a roof over their head and food, a regular timetable. That regularity seems to work. The problem with many is that when they come out they don't have anywhere to go, especially the homeless, and the old routine is just waiting there. That's why it is so difficult to stay clean.*
>
> (Outreach Worker B)

[11] The 'sickness' refers to symptoms experienced in initial stages of withdrawal.

4.7 Services Accessed by Clients

The services provided by the outreach workers are displayed in the following graph.

FIGURE 4.7 BREAKDOWN OF OUTREACH SERVICES



The above graph highlights that building rapport was carried out with more than four-fifths of the clients (n = 221, 84%).[12] This is an integral part of outreach work. The Homeless Initiative (1998) stated:

> a continuing confidential one-to-one relationship between the outreach worker and the user is vital if a trusting relationship is to be established. This is itself essential if people are going to be helped to make positive choices about their lives (4).

This is one of the most difficult aspects of outreach work as the engagement period can be lengthy and the time from initial contact to engagement can range from a few hours to two years (Erickson and Page, 1998). One outreach worker felt that carrying out street-based work helps build relationships with clients:

> *When you see someone out on the street it is a very good way of building rapport and you see a different perspective on things which is always interesting. Not that people gossip or anything but you see a different side to things and you see the dynamics of what goes on in groups and maybe how an individual reacts in a group. Plus they see you. I think the main key to outreach is relationship building. Although people do link in here they may not necessarily have the relationship with the staff in here but they see you in a different role outside. So it's just another way of working with people.*
>
> (Outreach Worker B)

Harm reduction strategies used by the outreach workers included advice on safer drug use (n = 102, 39%),[13] motivational intervention (n = 88, 34%),[14] referral to treatment services (n = 45, 17%)[15] and the collection of

[12] Obviously if the outreach workers knew a client they would not need to build rapport and time would be spent giving advice or motivational interventions.

[13] This includes advice on better injecting techniques, better preparation procedures and on the importance of utilising multiple injecting sites.

[14] Motivational intervention is an effective therapeutic tool often used with problematic drug users. It is particularly effective as part of a low threshold approach (Whitehead, 1997).

[15] Positive referral outcomes are unknown.

used needles (n = 22, 8%). Other services offered by the workers, which are important aspects of outreach work, were giving out information on health issues (n = 60, 23%) and accommodation (n = 30, 12%).

Safe injecting advice includes advice on better injecting techniques, better preparation procedures and on the importance of utilising multiple injecting sites. Although the outreach workers gave advice on safer drug use to over a third of the clients (n = 108, 41%) this may still not deter people from sharing injecting equipment. Choices about the sharing of injecting equipment are made within the socio-environmental context in which it occurs. According to the outreach workers, one of the most pressing needs of street injectors is access to clean injecting equipment and they would prefer to carry out needle exchanges on the street:

> *I'm watching people having turn ons,[16] they've got 2 needles, they're trying to get veins, those needles go blunt very quickly, so if you 've got someone who 'sjabbin' away at themselves, trying to get a vein, that needle goes blunt so they'll flip it away and they'll put another one in. That needle will go blunt as well. It would be nice to have a couple of spare ones there, just to give them [...] There have been times where I have seen needles swapping around and I'd love to have a pack so I can say, you don't need that, use this.*
>
> (Outreach Worker A)

In London, outreach workers have successfully carried out needle exchanges with 75% of drug injectors met (Rhodes *et al,* 1991). The two outreach workers were concerned that if they carried out needle exchanges during the day it might jeopardise the work carried out by Merchants Quay's needle exchange. However, they felt that a street-based needle exchange was essential during the evenings and at weekends.

> *There is a role for it [needle exchanges] on the streets but it shouldn 't take away from the work in Merchants Quay. If you carried out needle exchanges on the streets they wouldn 't come into the needle exchange and the whole idea of outreach is to get people in. But there is a need for an out-of-hours service.*
>
> (Outreach Worker B)

> *During the day, it would be nice to have a couple of packs there but if it got round that we were giving out needles there would be a lot less people coming into Merchants Quay. They 'd be waiting for us to get needles [...] They can't get works at the weekend so they are more likely to either share or borrow off someone else or sometimes you see them picking them up off the streets.*
>
> (Outreach Worker A)

The following quote indicates how desperate some IDUs are for clean injecting equipment when services are closed:

> */ know at night time needles and syringes are getting sold around here. At Christmas time they were being sold for 15 quid [19 euro], just for a barrel and a spike.*
>
> (Outreach Worker A)

As already mentioned, while the outreach workers referred almost a fifth of the clients onto treatment programmes they found this problematic due to lack of places and long waiting lists. Another issue was the lack of treatment options available in Ireland:

> *It's frustrating for the people themselves because there aren 't enough services and there aren 't enough options of services for people who want to get a bit of respite. There aren't enough places for clients to do a detox or simply go cold turkey [...] So we need more places but more variety and more choices, more types [...] There's too much dependency and too much emphasis thrown onto methadone by the State and by clients and people think that that's the only way.*
>
> (Outreach Worker B)

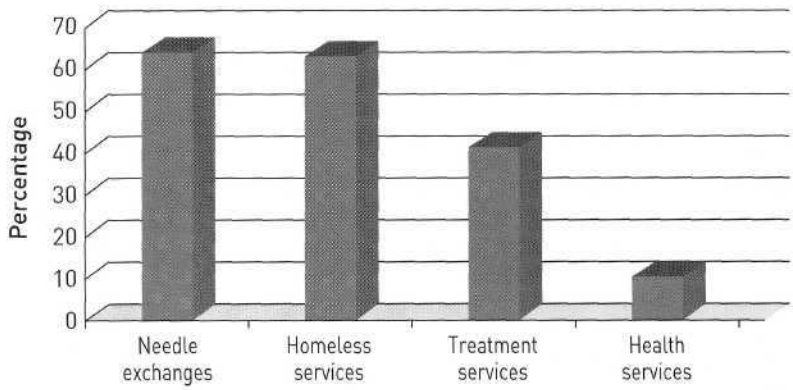
[16] Taking drugs, referring to injecting.

Given the vast amount of issues the outreach workers had to address, (drag use, housing, health issues, legal issues etc.), one of the outreach workers suggested co-operating with other outreach services in order to pool knowledge and resources:

> *That way you 're spreading the knowledge. They would have the knowledge about housing we'd have the knowledge about drugs. So then you 're informing them, they're informing you and you 're building up links between services.*
>
> (Outreach Worker B)[s]

The vast majority of clients (n = 206, 87%) were in contact with at least one service, other than the outreach service. These services are displayed in the following graph.

FIGURE 4.8 OTHER SERVICES USED BY CLIENTS



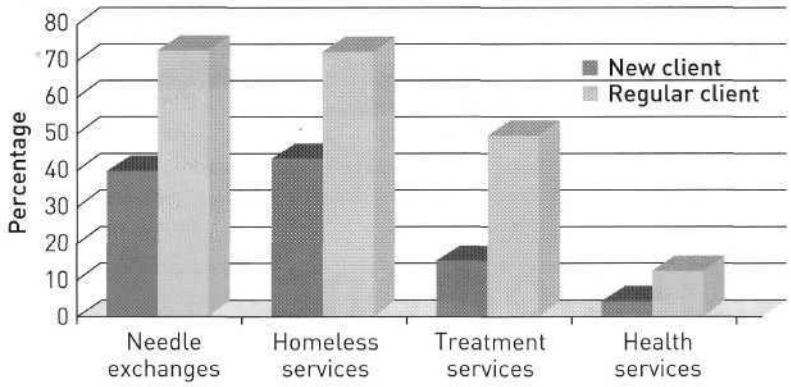
The above graph shows that almost two-thirds of the clients were in contact with needle exchanges (n = 149, 64%). A similar number were in contact with homeless services (n = 137, 63%) while almost half were in contact with drag treatment services (n = 95, 41%). Female clients were significantly more likely to be in contact with drag treatment services than male clients ($df = 1$; $p < 0.05$). Over half of female clients (53%) were in contact with drag treatment services compared to 37% of male clients. A much smaller proportion of clients (n = 23, 10%) were in contact with health services. Female clients were significantly more likely to be in contact with health services than male clients ($df = 1$; $p < 0.005$). There were three times as many female clients (21%) than male clients (7%) in contact with health services. Few clients were in contact with health services. The outreach workers explained that many of them did not have medical cards and also many did not wish to visit doctors or Accident and Emergency Departments because of long waiting lists and the negative attitude of staff towards drug users.

> *If they have bad wounds or anything you tell them to go to the hospital. They come back with horrendous stories of waiting therefor 12 hours and then get treated like shite because they are drug users. So they won't go, they just won't go anywhere near the health service.*
>
> (Outreach Worker A)

New contacts were significantly less likely to be in contact with any other service ($df = 1$; $p < 0.0005$). This difference in contact with services is illustrated in Figure 4.9.

The graph shows that new clients contacted by the Outreach Service are less likely to be in contact with any service. This emphasises the need for outreach workers to reach out to new clients to try and link them in with services.

FIGURE 4.9 DIFFERENCES IN CONTACT WITH SERVICES BETWEEN CLIENTS



4.8 Summary

During the first year of the Outreach Service the workers met 262 clients and collected 2,741 needles. The majority of the clients encountered were male, Irish and homeless. The outreach team were successful in contacting hard-to-reach populations including young chaotic drug users, homeless drug users and those not in contact with any services. Most of the work was detached outreach work carried out during the day in local residential or commercial areas, at a local church or in low threshold services. The outreach workers felt, however, that working in Merchants Quay's low threshold service was jeopardising their street-based work. More than three-quarters of the clients were heroin users and almost a third were polydrug users. The most popular places for drug taking were local streets, a local church and parks. Harm reduction strategies used by the outreach workers included advice on safer drug use, motivational interviewing, referral to treatment services and the collection of used needles. The workers were also engaged in building rapport and giving out information on health issues and accommodation. During the first year of the Outreach Service, the workers noted that among the clients who were met more than once, almost one-fifth changed to safer drug using practices, while half of them started using more or injecting more. The main barriers to sustaining positive behavioural change were a shortage of treatment places, long waiting lists, lack of treatment options and an absence of effective aftercare services. Almost two-thirds of the clients were in contact with needle exchanges and homeless services while almost a half were in contact with drug treatment services. A small number were in contact with health services. Outreach workers felt that the situation could be improved by introducing a peer-based approach to outreach and using influential drug users to distribute harm reduction information in their social networks. The outreach workers would also like to operate beyond designated boundaries, expand their team and offer their service later in the evenings and at weekends. They also expressed a need to carry out street-based needle exchanges when other services are closed. Furthermore they would like to co-ordinate with other outreach teams as well as linking in with, but working independently of, the low threshold service at Merchants Quay. The outreach workers also felt that policy makers should consider offering treatment options other than methadone, opening a respite house for chaotic drug users and approving the establishment of a safe injecting room.

5

Discussion and Conclusions

This chapter will discuss the results of the evaluation in relation to the development of Merchants Quay Ireland's Outreach Service and to their general implications for drug service development and drug policy.

Overview of Outreach Service: The outreach workers considered the collection of used needles as one of the main strengths of the Outreach Service. This service is particularly important for the local community. American research has found that, although IDUs try and dispose of used needles safely, they usually leave them on streets because of fear of arrest for possession of used needles and fear that possession of used needles will identify them as IDUs (Macalino *et al,* 1998). Syringe disposal measures recommended by Macalino *et al.* (1998) include converted letterboxes where needles can be disposed of and pocket-sized personal sharp bins distributed by outreach workers.

Demographics: Over half (52%) of clients contacted were under 25 years old. The Outreach Service hoped to contact a larger proportion of young drug users as they are more likely to be engaging in higher levels of HIV risk behaviour and less likely to be receiving harm reduction information (Cassin *et al,* 1998; Cox and Lawless, 2000). This group is particularly hard-to-reach and many of them view drugs outreach workers with suspicion. Moreover, young drug users are highly mobile and many do not realise the potential harm associated with their drug use and do not see the need to engage with drugs outreach workers. The outreach workers felt that a peer-led approach would be the most effective way of targeting young drug users. A study carried out among young people in Dublin by Mayock (2000), concluded that a peer-led approach to outreach would be an effective means of passing on information to vulnerable young people.

The Outreach Team met mostly Irish drug users and came across only 1 non-EU national. This is not surprising; American studies have found that minority ethnic groups are unlikely to be contacted by outreach projects and that special interactions, such as culturally-relevant drug services, are needed to reach these groups (Lundgren *et al,* 1999).[17]

New Clients: Just over a quarter of those contacted were new clients although the outreach workers hoped to contact a larger number of 'hidden' drug users. British research has consistently found that the more 'direct' and 'aggressive' the outreach worker's approach, the more clients are contacted and the more new clients are recruited (Yates and Gilman, 1990; Rhodes *et al,* 1991). This means giving priority to 'cold' contacts as long as the necessary resources are in place to deal with the increased workload. However Korf *et al* (1999) question this approach as they feel it 'reflects a research agenda that may underestimate the complexities of a detached worker's position' (48). New female clients were more difficult to contact than their male counterparts. Gilman (1992) stated that outreach workers find it difficult to reach out to women who, in many cases, lead lives which revolve around settings dominated by a male partner who may not welcome the intrusion of an outreach worker.

[17] Merchants Quay Ireland is currently carrying out research to explore how services can become more accessible to those from different communities.

Accommodation: Overall three-quarters of those contacted were homeless at some point during the year. The relationship between substance use and homelessness is complex. Those who support the social selection theory argue that problematic drug users are at high risk of homelessness (Spinner and Leaf, 1992). They often see homelessness as the end result of substance abuse because an individual's resources gradually become depleted (Baum and Burnes, 1993). Conversely, advocates of the social adaptation theory argue that substance abuse is often a consequence of homelessness as it is often a means of adapting to life on the streets and coping with the stress of homelessness (Johnson *et al,* 1997). Johnson *et al.* (1997) claim that neither of these models is mutually exclusive and they propose a third multi-directional model. This model recognises that homelessness and problematic drug use are risk factors for one another.

The fact that the majority of drug users are homeless is a cause for concern given that research studies have found that drug use increases when people are homeless (Cox and Lawless, 1999; Fountain and Howes, 2001). Furthermore, homeless clients are more likely to share injecting equipment and paraphernalia (Cox and Lawless, 2000).

Almost half those met were sleeping rough, perhaps because many direct homeless hostels in Dublin operate a 'no drugs' policy. This is concerning as homeless people sleeping rough are significantly more likely to be practising risky injecting practices than those living in other types of homeless accommodation (Cox and Lawless, 1999). Drug use on the streets can lead to an increased likelihood of sharing injecting equipment and increased vulnerability to attacks and muggings, as well as the risk of an overdose going undetected (Costello and Howley, 2000). Therefore, street injectors are more likely than other drug users to be at a high risk of acquiring and transmitting diseases such as HIV infection (Klee and Morris, 1995). Street injectors are also at risk of developing physical and mental health problems. Homeless drug users have complained of chest problems and arthritis, loss of weight, loss of appetite, general weakness, tiredness, tooth decay, abscesses, Hepatitis C and HIV infection (Costello and Howley, 2000). Street injectors have a number of mental health problems they attribute to their drug use and/or their state of homelessness including depression, mood swings, personality changes and suicidal feelings (Costello and Howley, 2000). The high number of homeless drug users re-enforces the need for specialist services to address their needs.

Contact Work: The majority of clients contacted by the outreach team were only met once. During in-depth interviews the outreach workers offered a number of recommendations on how to increase the number of re-contacts, especially with new clients. The geographical area for the Outreach Service is Dublin's south-inner city, an area identified by the National Drugs Strategy as having a serious opiate problem. If the Outreach Service operated beyond the designated boundaries the workers feel they could re-contact a larger proportion of the target group.

The majority of outreach work takes place in the morning or afternoon. The outreach workers felt that more chaotic users could be contacted if the service was available later in the evenings and at weekends. Late evening work is generally considered an integral part of outreach work (Warnes and Crane, 2000).

The Outreach Service would also like to consider using drug users as 'agents of education and change within their peer groups and social networks' (Rhodes, 1997a: 2). Current drug users who have local knowledge and acceptability would provide harm reduction messages to their peers. A successful example of this is the *Boule de Neige* project in Belgium. Evaluations of it have found that peers establish relations more easily with target groups, they increase the project's legitimacy in the eyes of the users, they access difficult to reach populations and provide an opportunity for professionals and former drug users to exchange knowledge and experiences (Korf *et al,* 1999). Similarly, an evaluation of an outreach service in Dublin targeted at women in prostitution found that outreach work was more effective when it was carried out by women who were engaged in prostitution as they could access women working in its more hidden forms (O'Connor, 1996). This approach would probably work effectively in Dublin as the influence of peer groups is much larger in relatively closed subcultural groups (Heckmann *et al,* 1991), which is the case in Dublin.

The outreach workers felt they spent too much time in low threshold services engaging in meetings, supervision or helping out when short-staffed. They felt that this arrangement had the potential to lead to role confusion and risked undermining their street-based work. Gilman (1992) commented that this is difficult for outreach workers as it leads to lack of structure and outreach workers feeling uncertain about their role. An

essential part of outreach work is establishing a 'presence' in a particular area and being predictable (i.e. being in the same places at the same time) (Tommasello *et al,* 1999). The outreach workers felt that as long as they were connected to the low threshold service their street-based work would be jeopardised. Therefore they suggested when the team expanded they should work towards managerial independence.

***Drugs** Use:* The vast majority of clients were using heroin. It was surprising that more than one fifth of the clients were not using heroin but the outreach workers explained that this depended on availability and/or quality. Moreover many clients attended different treatment and detoxification programmes but, because of lack of aftercare, started using heroin again. Almost one in three of the clients was a polydrug user. This makes outreach work particularly demanding as polydrug users are more difficult to engage with than heroin users. They are often rambling, incoherent and menacing (Gilman, 1992). Furthermore, polydrug users are more likely to engage in injecting risk behaviour (Klee *et al,* 1991). Outreach work may become more demanding in the future; new clients were significantly more likely to be polydrug users and this trend may continue.

Using Sites: Most of the clients used public places for drug taking. Reasons often given include no alternative options, a need to conceal drug use from relatives or friends, or desperation for a quick fix (Klee and Morris, 1995). Injecting in public places contributes to high levels of sharing and lending of injecting equipment and paraphernalia (Cox and Lawless, 1999). Furthermore, it impacts negatively on local residents (Mayock and Moran, 2001).

Because the majority of clients injected in open public places, consideration should be given to the provision of a supervised environment, such as a safe injecting room, which would allow safer injecting practices to occur. Although Ireland does not have a safe injecting room, a study carried out with homeless drug users in Dublin found that they favoured the introduction of such a facility. They felt it would enable them to use clean needles, to be safe from the risk of overdose, they would not inject in cold weather and they would have access to medical advice at all times (Costello and Howley, 2000). Injecting drug users in Australia felt that the introduction of safe injecting rooms had the potential to address both personal and wider community harms associated with public injecting (Fry *et al,* 1999). Furthermore, safe injecting rooms have the potential to help reduce some of the harm associated with injecting drug use, such as the incidence of fatal and non-fatal heroin overdose, blood-borne virus transmission (Hepatitis C and B and HIV) and the prevalence and impact of street-based injecting (Ruanes *et al,* 1997).

Changes in drug-related behaviour: One fifth of the clients met by the outreach workers changed to safer injecting practices whereas half changed to less safe practices. Any change in drug use can be a result of one, or a combination of, four factors; the individual; the interpersonal (i.e. other individuals), the community (e.g. peer opinions) and the wider socio-political environment (e.g. law enforcement policy) (Rhodes, 1996). Research has found that outreach projects that target groups of drug users as opposed to individuals are more effective in sustaining positive behavioural change (Friedman, 1992). This is because drug users' risk behaviour 'depends on the types of social relationships and situations in which such behaviour occur, and the social norms and values of particular peer groups, social networks and subcultures' (Rhodes, 1997b: 10). Irish outreach services should therefore place greater emphasis on targeting networks of drug users. Rhodes (1996) proposed that outreach workers should encourage change at four levels.

Individual Change	Changes are required in individuals' awareness, beliefs, intentions and motivation
Interpersonal Change	Changes are required in individuals' self-efficacy and interpersonal negotiation skills
Community Change	Changes are required in peer group and social 'norms' which influence individual behaviour
Socio-political Change	Changes are required in legal and drug policy and in health service organisation

Source: Rhodes, 1996

The main obstacles the outreach workers reported were lack of treatment places and options for drug users in Ireland. Currently, there are at least an estimated 7,000 drug users not in treatment in Dublin (Comiskey, 1998). Furthermore, methadone maintenance, methadone detox and total abstinence are still the only treatment options for chaotic drug users in Ireland. In a recent review of the potential usefulness of buprenorphine as an intervention in the treatment of opiate dependency the NACD (2002) concluded that 'buprenorphine may be viewed as an effective treatment option in the management of opiate dependence syndrome, with an acceptable safety profile' (64). The Irish government however has not yet piloted any buprenorphine programmes.

Employment, pregnancy and time spent in prison seemed to act as a catalyst for clients in attempting to modify or abstain from drug use. But because of lack of aftercare services, relapse seemed inevitable. This is a cause for concern as this puts drug users at risk of overdose as their physical tolerance to heroin is lost by enforced abstinence or reduced intake (EMCDDA, 2002). For instance, a study carried out among a cohort of male injecting drug users, infected with HIV, at Edinburgh's City Hospital, found that risk of death from overdose was 8 times higher within 2 weeks after release from prison than it was during the next 10 weeks after release (Seaman ef *al.*, 1998).

Outreach Services: Building rapport was carried out with the majority of clients. This is the most important part of outreach work as workers need to develop trusting relationships in order to motivate drug users to modify their behaviour (Sterk-Elifson, 1993).

The outreach workers gave out advice on safer drug use to over a third of the clients. Advice on safer injecting techniques is important as poor injecting methods often lead to health problems such as bruising, abscesses and thrombosis. However, this may not deter people from situational sharing. Ross *et al.* (1994) found that the primary reason for borrowing injecting equipment was difficulty in obtaining new equipment. Similarly, Grand *et al.* (1992) found that hard-to-reach drug users in Holland were more likely to share syringes and needles if new, clean equipment was not available. This highlights the paradoxical role of Merchants Quay Ireland's Outreach Service. While they are giving the clients the *knowledge* (i.e. the reasons why these changes are necessary) they are not giving the clients the *means* (i.e. clean injecting equipment), other than through referral. It is unlikely that the outreach workers will be successful in changing clients' risk behaviour unless they provide them with clean injecting equipment. For example, in America, outreach workers who encouraged bleach use, but did not distribute it, were not effective in changing risk behaviour. Conversely, those who distributed bleach in small bottles increased its use from 3% to 67% among the target population (Neaigus *et al,* 1990).[18] Therefore, the provision of emergency injecting packs by outreach workers to clients has the potential to reduce levels of situational sharing and unsafe use. This strategy would especially target the 'out of home' drug users who often experience difficulties in accessing sterile injecting equipment. There ire a number of reasons for operating an outreach needle exchange. These include:

- Providing clean needles sends a message to injecting drugs users that drugs workers consider clean equipment to be essential to their well-being
- Drug users might use the outreach exchange because of a genuine fear of infectious diseases (especially, HIV and hepatitis)
- New needles are easier to use than older needles
- Users may be concerned about personal hygiene

f) Users may derive a sense of ownership from having their own works

- IDUs might enjoy a sense of authority when exchanging needles for others
- A dislike of needle exchange venues may encourage use of the outreach facility

(Korfefa/., 1999).

[3] Bleach, which is often distributed in cities without adequate syringe exchanges, provide a method for IDUs to disinfect used needles and syringes (Rhodes and Stirason, 1998).

Another option for distributing clean injecting equipment are automated syringe exchange machines which are used in other European and Australian cities. These are fairly inexpensive and accessible on a 24 hour basis (CCSA, 1996). One disadvantage however is that they decrease the contact between drug users and drugs workers (CCSA, 1996).

The outreach workers addressed injecting risk behaviour but not sexual risk behaviour because of the unwillingness among the client group to address this issue. However drug injectors are increasingly more likely to transmit HIV through 'unsafe' or unprotected sex than through risky injecting practices (McKeganey and Barnard, 1991). International literature has consistently shown that changing sexual risk behaviour among injecting drug users is more difficult than changing injecting risk behaviour (Donoghoe, 1992) as 'the currency of drug injecting social networks are largely based on shared knowledge and practices of injecting drug use rather than those of sex and sexuality' (Rhodes, 1994: 56). Furthermore, outreach workers in New York have found that it is not only difficult to initiate sexual risk reduction but also to maintain it (Neaigus *et al,* 1990). Research has found that a peer-based approach to reducing sexual risk behaviour has the potential to influence safe sex through social relationships (Neaigus *et al,* 1990).

The number of referrals made to treatment programmes shows how outreach work complements existing treatment and drug services and acts as a potential gateway into drug treatment. However, the outreach workers reported that this was one of their most difficult tasks. This problem is not unique to Merchants Quay Ireland's Outreach Service. Since the late 1980s, experiences have shown that outreach workers,

> 'have (albeit unwittingly) been 'set up to fail'. If the local drug specialist agencies do not provide a wide range of services into which the outreach worker can 'plug' new clients, the outreach work will suffer'(Gilman, 1992:7).

This emphasises the need for an immediate increase in drug treatment places in Dublin.

Given the wide range of issues the outreach workers had to address, one worker suggested co-operating with other outreach services in order to pool knowledge and resources. According to Korf *et al.* (1999), networking and co-ordinating with other agencies should be an integral part of outreach work. Unfortunately, like other workers in the drugs field, they are hindered by 'scarce resources, different or opposing aims, and divergent professional backgrounds' (Korf *et al,* 1999: 158).

Other Services Accessed by Clients: The core of outreach work involves contact with people who are not linked into services. Rhodes (1996) claims that the least effective outreach is that which engages with people who already have service contact. The most surprising result obtained in this study was the fact that the majority of users were in contact with different services. This shows that there is substantial overlap between outreach work and other services. This may partly be explained by the relatively high number of homeless and drugs services in the area. Therefore, outreach services are even more important in areas where few services are located and access is difficult.

The level of contact with needle exchanges and homeless services was quite high. Other Irish studies also found relatively high levels of contact with homeless services among drug users. For instance, Cox and Lawless (1999) found that 86% of homeless drug users attending Merchants Quay's low threshold service also attended at least one centre that explicitly provided services for the homeless. Similarly, a study carried out among rough sleepers using drugs in London showed that the respondents were very knowledgeable about services for homeless people and how to access them (Fountain and Howes, 2001).

Over half the clients were not in contact with drug treatment services, other than needle exchanges. British studies found that apart from needle exchanges, contact with drug services is usually quite low, especially with residential detoxification units, self-help groups and day programmes (Fountain and Howes, 2001). As already mentioned, clients in this study were unlikely to be in contact with treatment programmes because of long waiting lists and lack of places.

The difficulties the outreach workers reported in encouraging clients to access health services (clients' perception that health care staff were unhelpful and insensitive, the financial difficulties and also problems applying for a medical card) are consistent with findings from other studies (Holohan, 1998; Feeney *et al,* 2000). Therefore, the development of outreach services that could provide some basic primary health care and

st Aid would be valuable. Furthermore, alternatives to mainstream health care also need to be considered, mplementary therapy has been shown to benefit drug users by its relaxing effects on the mind and body, ieving sleeplessness, anxiety and stress (Whittaker and MacLead, 1998).

nsistent with findings from- other research (Cox and Lawless, 2000) female drug users were more likely to in contact with drug treatment and medical services. This is also true of the general population where imen make more health care visits than men (Kandrack *et ah,* 1991).

6

Recommendations

Despite constraints placed on the outreach workers by time and resources, they succeeded in reducing levels of public nuisance as well as reaching out to many chaotic drug users. Usually outreach projects use one model, yet Merchants Quay Ireland's outreach service has shown that outreach services can effectively use a number of different strategies. According to Rhodes (1997b) a multi-strategic approach to outreach is most effective as it encourages individual, collective and community-wide changes. Although the outreach service is still in a developmental stage, it has the potential to develop into an innovative and proactive response to problematic drug use in local communities in Dublin. To this end, the following recommendations aim at ensuring that outreach work in Ireland does not fall into the same trap as programmes in the UK where their full potential was not realised due to 'theoretical orientation and inbuilt structural limitation' (Stimson *et al,* 1994: 1601).

Development of Outreach Service

- The Outreach Service should extend its hours to the evenings and weekends in order to contact more chaotic drug users when other services are closed.
- Easy access to sterile injecting equipment is essential for IV drug users. An Outreach Service operating at the evenings and weekends should carry out needle exchanges on the streets. This is when IV drug users find accessing clean injecting equipment most difficult. This type of service could decrease risk behaviour.
- It is imperative that drug users who are not in contact with outreach workers are contacted by outreacl teams. Therefore MQI's outreach service should co-ordinate with other outreach services to ensure thai drug users in Dublin's inner-city and Dublin 8 are reached.
- The outreach workers should target peer networks rather than individual drug users. Individua behaviour change is greatly influenced by peer groups and social networks (Korf *et al,* 1999; Rhodes 1997a). In this way the Outreach Service will become not only community-based, but also community-oriented (Rhodes and Stimson, 1998).
- Ex-users and users (i.e. indigenous outreach workers) are more likely to contact hard-to-reach group; of drug users, especially young people. Moreover, peers have at their disposal social and intellectua capital which they can use to mediate between drug workers and drug using networks (Korf *et al.* 1999). Therefore a peer-based approach to outreach should be implemented.
- Outreach workers should recruit 'opinion leaders' or 'key informants' (i.e. peer educators who exer influence over others) to distribute information in their social networks on harm reduction strategies such as safe drug use and safe sex. The idea is that these peer educators will encourage their peers t< subsequently educate others and so on.
- i# When the outreach team work in Merchants Quay's low threshold service this leads to role confusion They should work towards expanding their team and aiming for managerial independence. In this waj the outreach workers will have more time for street-based work and spend less time in centre-basei services. Rhodes (1996) advised that outreach teams are most cost effective when full-time staff co ordinate and supervise small teams of part-time workers or volunteers consisting of indigenous and non

indigenous workers. Furthermore, Rhodes *et al.* (1991) recommended that outreach teams should invest at least 65% of their time on detached outreach work.

- As the vast majority of clients are not in contact with health services, the Outreach Service should provide basic primary health care, such as First Aid and complementary medicine, either themselves or by referring clients to Merchants Quay Ireland's primary health care service, which will be operating in 2003.
- It is essential to keep in contact with the local community to meet their needs. This could be achieved by playing a more significant role in resident committee meetings and community development.
- Moreover, the outreach workers should co-operate with the police to avoid misunderstanding and to prevent unnecessary police interference. Rhodes (1996) recommended that outreach workers should emphasise the public health importance of their work, assure the police that they will not interfere with police work and ensure that the police are aware of the outreach workers' activities.
- Hard-to-reach drug users have a range of needs and it is unrealistic to expect one outreach service to cater for all their needs. The outreach workers should liaise with other outreach projects working with homeless people and ex-prisoners.
- While all these recommendations should be acted on, the outreach workers need to remain flexible and responsive to clients' needs.

Drug Services

This report has shown that outreach work is important and valuable but it is equally important that centre-based services are designed to accommodate hard-to-reach groups. Drug service providers and policy makers should make use of innovative responses such as the following:

- Specific training programmes should be designed to target outreach workers (professionals, volunteers and peers). These programmes should include items such as safety issues, communication skills, information and advice giving, counselling, relapse prevention, polydrug use, health issues, accessing accommodation and treatment, legal issues, welfare problems and making referrals. Korf *et al.* (1999) recommended that training should include professional accreditation and coherent job profiles in order to improve the terms of employment and career opportunities of outreach workers.
- Given the difficulty hard-to-reach drug users have accessing clean injecting equipment, injecting equipment should be more readily available. This could be done by having needle exchanges during the evening and at weekends; 24-hour machines providing an assortment of needles and syringes in areas where problematic drug use is most prevalent; and sharp bins in public places to ensure the safe disposal of injecting equipment.
- Given the high levels of public drug taking reported in this study, consideration should be given to the establishment of a safe injecting room in Dublin.
- The lack of treatment places is one of the greatest obstacles to problematic drug users changing to safer drug use or abstaining altogether. There is an urgent need to expand the number of places on methadone maintenance programmes and to eliminate waiting lists.
- The outreach workers experienced great difficulty in referring clients onto drug treatment programmes. Referral protocols need to be developed and implemented to ensure drug users a continuum of care. One strategy recommended by Rhodes (1996) is a coupon system which guarantees help as soon as possible after referrals are made.
- Given the lack of treatment places and treatment options in Dublin, there is an urgent need for a respite house in the city - a place where homeless drug users can go for a break from life on the streets.
- Methadone maintenance is not the most suitable treatment option for some drug users. Consideration should be given to piloting other treatment options. For instance the government should implement the recommendation of the NACD (2002) report of piloting buprenorphine as an effective treatment option.
- There should be more co-ordinated aftercare programmes for drug users in Dublin in order to prevent relapse. This is particularly necessary for those leaving treatment programmes, prisons, and maternity wards.

Homeless Services

There are high levels of homelessness among problematic drug users. This has implications for the development of homeless services.

- Staff in these services need to be trained to deal with this client group. Homeless hostels which refuse accommodation to homeless drug users should review their policies and provide adequate emergency accommodation to meet the needs of IDUs.
- In addition to emergency accommodation, there is a need for long-term stable housing for homeless drug users. Only when stable accommodation is secured can a drug problem be addressed. Lack of secure housing arrangements can adversely affect an individual's drug use in terms of risk behaviour, access to treatment, relapse prevention and success of recovery.

Implications for Policy

- Outreach work is an important component of a continuum of care for drug users. This work should receive appropriate support and funding from relevant government bodies to ensure that the necessary financial, legal and human resources are available to enable it to function effectively.
- The government should introduce a wider range of harm reduction strategies in Ireland, targeted at hard-to-reach populations. Those already mentioned include greater access to clean injecting equipment, a safe injecting room, improved access to treatment and a wider range of treatment options.

Further Research

- Qualitative research should be conducted to gain insights into the views and opinions of clients using Outreach Services so that these services remain responsive to their needs.
- Research should also examine the impact of Outreach Services on local communities.
- The needs and perceptions of drug users regarding existing drug treatment services should be examined.
- Feasibility studies and evaluations should be carried out on peer-based approaches to outreach work, the establishment of a safe injecting room and alternative treatment options.

The above recommendations have been divided into different categories but the problems and needs of 'hard-to-reach' groups are interrelated and cumulative. Drug service providers, homeless service providers, health board officials and policy makers need to work together to support outreach workers and offer a comprehensive service to 'hard-to-reach' groups.

Bibliography

\na Liffey Project. 2001. *Drug Services and Non-European Nationals: A Brief Survey.* Unpublished.

3arnard, M. 1993. 'Needle Sharing in Context: Patterns of Sharing among Men and Women Injectors and HIV lisks'. *Addiction:* 88: 805 - 812.

3aum, A.S. and Bumes, D.W. 1993. *A Nation in Denial: The Truth about Homelessness.* Boulder: Westview Press.

Bryan, A., Moran, R., Farrell, E. and O'Brien, M. 2000. *Drug-Related Knowledge, Attitudes and Beliefs in Ireland: Report of a Nation-Wide Survey.* Dublin: The Health Research Board.

Canadian Centre on Substance Abuse (CCSA). 1996. *Harm Reduction: Concepts and Practice.* Ottawa: CCSA.

Cassin, S., Geoghegan, T. and Cox, G. 1998. 'Young Injectors: A Comparative Analysis of Risk Behaviour'. *Irish Journal of Medical Science:* 167: 4: 234 - 237.

Comiskey, CM. 1998. *Estimating the Prevalence of Opiate Drug Use in Dublin, Ireland during 1996.*

Costello, L. and Howley, D. 2000. *Working towards inclusion: A feasibility study on the provision of accommodation for people sleeping rough and using drugs in Dublin city.* Dublin: Simon Community and Merchants Quay Project.

Cox, G. and Lawless, M. 1999. *Wherever I lay my hat... A Study of Out-of-home Drug Users.* Dublin: Merchants Quay Project.

Cox, G. and Lawless, M. 2000. *Making Contact: Evaluation of a Syringe Exchange Programme.* Dublin: Merchants Quay Project.

Cullen, B. 1990. 'Community action in the eighties - A case study' in Combat Poverty Agency (ed.) 1990. *Community Work in Ireland: Trends in the 80s, options for the 90s.* Dublin: Combat Poverty Agency.

Donoghoe, M. 1992. 'Sex, HIV and Injecting Drug Users'. *British Journal of Addiction:* 87: 405 - 416.

Erickson, S. and Page, J. 1999. 'To Dance with Grace: Outreach & Engagement to Persons on the Street' in Fosburg, L. and Dennis, D. 1999. *Practical Lessons: The 1998 National Symposium on Homelessness Research.* USA: Department of Housing and Development and the Department of Health and Human Services.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). 2001a. *Guidelines for the Evaluation of Outreach Work.* Belgium: EMCDDA.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). 2001b. *2001: Annual Report on the State of the Drug Problem in the European Union.* Luxembourg: EMCDDA.

European Monitoring Centre for Drugs and Drug Addiction. EMCDDA, 2002. *Drugs in Focus: Drug Injecting Challenges Public Health Policy.* Drugs in Focus, Briefing 4.

Fahey, T. (ed.) 1999. *Social Housing in Ireland: A Study of Success, Failure and Lessons Learnt.* Dublin: The Kathleen Howard Foundation and Combat Poverty Agency.

Farrell, M., Gerada, C. and Marsden, J. 2000. *External Review of Drug Services for the Eastern Health Board* London: Institute of Psychiatry, National Addiction Centre.

Feeney, A., Hannah, H. M., Holohan, T. and Shannon, W. 2000. *Health of Hostel-Dwelling Men in Dublin Perceived health status, lifestyle and health care utilisation of homeless men in south inner city Dublin hostels* Dublin: Department of General Practice and Health Services Research Centre, Department of Psychology Royal College of Surgeons in Ireland and Department of Public Health

Frey, C, Foe, S. and Rumbold, G. 'Establishing safe injecting rooms in Australia: Attitudes of injecting druj users'. *Australian and New Zealand Journal of Public Health, 1999: 23: 5: 501 - 504.*

Friedman, S.R., Neaigus, A. and DesJarlais, D.C. 1992. 'Social Intervention against AIDS among injecting drug users'. *British Journal of Addiction:* 87: 393 - 205.

Fountain, J. and Howes, S. 2001. *Rough Sleeping, Substance Use and Service Provision in London.* London National Addiction Centre.

Frischer, M. 1993. 'Drug Injectors in Glasgow: a Community at Risk? A report from a Multidisciplinar Group'. *Health Bulletin:* 5:16: November, 1993.

Gilman, M. 1992 *Outreach.* London: ISDD.

Goode, S. 2000. 'Researching a Hard-to-Access and Vulnerable Population: Some Considerations oi Researching Drug and Alcohol-Using Mothers'. *Sociological Research Online,* vol.5, no.l www.socresonline.org.uk

Grand, J.P.C., Blanken, P., Adriaans, N.F.P., Kaplan, CD., Barendregt, C. and Meeuwsen, M. 1992. 'Reachinj the Unreached: Targeting Hidden IDU Populations with Clean Needles via Known User Groups'. *Journal q Psychoactive Drugs,* 24: 1: 41 — 47.

Hartnoll, R. 2002. 'Current trends in drag use and challenges for public-health policy' in *Drugnet Europe* May - June, 2002.

Heckmann, W., Krauss G., Gusy B., Redjeb G.S. and Seyrer Y. 1991. 'Outreach Work as a Strategy for Risl Reduction in Hard-to-Reach Populations. For Example: Injecting Drag Users' in Loimer, N., Schmid R. an< Springer, A. 1991 *Drug Addiction and AIDS.* Vienna: Springer-Verlag,

Holohan, T. 1998. *Health Status, Health Service Utilisation and Barriers to Health Service Utilisation amon\ the Adult Homeless Population of Dublin.* Dublin: Royal College of Physicians of Ireland.

Homeless Initiative. 1998. *Homing in on Outreach.* Dublin: Homeless Imitative.

Ming, J., Hulme, N., Gibson, B., Minchom, D., Aroney, R. and Barton, S. 1993. 'Outreach Work Targetini Young Men who Sell Sex: Accessing a "Difficult to Reach Group" into Sexual Health Care'. *Internationa Conference on AIDS,* 9:701 (abstract no. PO-C14-2906), June 6 - 11, 1993).

Johnson, T., Freels, S. A., Parsons, J.A. and Vangeest, J.B. 1997. 'Substance Abuse and Homelessness: Socia Selection of Social Adaptation?' *Addiction:* 1997: 92: 4: 437 - 445.

Johnson, Z., O'Connor, M., Pomeroy, L., Johnson, H., Barry, J., Scully, M., and Fitzpatrick, E. 1994 'Prevalence of HIV and associated risk behaviour in attendees at a Dublin needle exchange'. *Addiction,* 89: f 063 - 607.

Kandrack, M., Grant, K. and Segall, A. 1991. 'Gender differences in health related behaviour: Som unanswered questions'. *Social Science and Medicine:* 32: 579-590.

Killas, M. and Rabasa, J. 1997. 'Less Crime in the Cities through Heroin Prescription? Preliminary Resuli from the Evaluation of the Swiss Heroin Prescription Projects'. *The Howard Journal:* 36:4: 424 - 429.

Klee, H., Faugier, J., Hayes, C. and Morris, J. 1991. 'Risk Reduction among Injecting Drug Users: Change in the Sharing of Injecting Equipment and in Condom Use'. *AIDS Care:* 1991: 3 :1: 63-73.

Klee, H. and Morris, J. 1995. 'Factors that characterize street injectors'. *Addiction:* 90: 837 - 841.

Korf, D.J., Riper, H., Freeman, M., Lewis, R., Grant, I., Jacob, E., Mougin, C. andNilson, M. 1999. *Outreac Work among Drug Users in Europe: Concepts, Practice and Terminology.* Lisbon: European Monitorin Centre for Drug and Drag Addiction.

Lawless, M. and Cox, G. 2003. *Managing Urban Tensions: An Integrated Approach to Drug-Related Anti-Social Behaviour in Dublin.* Dublin: Merchants Quay Ireland.

Lennon, L. 1998. *Under One Roof? A Report on the Future Options for the Organisation of Homeless Services in Dublin.* Dublin: Homeless Initiative.

Loughran, H. 1999. 'Drugs Policy in the 1990s' in Quin, S., Kennedy, P., O'Donnell, A. and Kiely, G. 1999. *Contemporary Irish Social Policy.* Dublin: University College Dublin Press.

Lundgren, L., Amodeo, M., Thompson, D. and Collins, C. 1999. 'HIV/AIDS outreach and substance abuse treatment for hard-to-reach populations: results from a multi-site demonstration project'. *Evaluation and Program Planning:* 22: 245 - 250.

McCarthy and McCarthy. 1997. *Dealing with the Nightmare: Heroin Addiction in the South Inner City.* Dublin.

McDermott, P. 1993. 'The Personal Touch'. *Druglink,* July/August, 1993.

McElrath, K. 2001. *Heroin Use in Northern Ireland: A Qualitative Study into Heroin Users' Lifestyles, Experiences and Risk Behaviours.* 1997 - 1999. Belfast, School of Sociology and Social Policy, Queen's University.

McKegnaney, N. and Barnanrd, M. 1991. 'Drug Injectors' Risks for HIV .in Aggleton, P. Hart, G. and Davies, P. 1991. *AIDS: Individual, Cultural and Policy Dimensions.* London: The Palmer Press.

Macalino, G., Springer, K., Rahman, Z., Vlahov, D. and Stephen Jones, T. 1998. 'Community-Based Programs for Safe Disposal of Used Needles and Syringes'. *Journal of Acquired Immune Deficiency Syndrome and Human Retrovirology:* 18:1: July, 1998:111 - 119.

Mayock, P. 2000. *Choosers or Losers? Influences on Young People's Choices about Drugs in Inner-City Dublin.* Dublin: The Children's Research Centre, TCD.

Mayock, P. and Moran, R. 2001. 'Social Issues and Public Attitudes Associated with Drug Misuse' in Moran, R., O'Brien, M., Dillon, L. and Farrell, E. with Mayock, P. 2001. *Overview of Drug Issues in Ireland 2000: A Research Document.* Dublin: Health Research Board.

Memery, C. and Kerrins, L. 2000. *Estate Management and Anti-Social Behaviour in Dublin: A Study of the Impact of the Housing (Miscellaneous Provisions) Act, 1997.* Dublin: Threshold.

Merchants Quay Ireland. 2001. *Annual Report, 2000.* Dublin: Merchants Quay Ireland.

Ministerial Task Force on Measures to Reduce the Demand for Drugs. 1996. *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Ministerial Task Force.

Montello, F., DiSora, F. and Recchia, O. 1992. 'Can HIV-1 infection be transmitted by a discarded syringe?' *Journal of Acquired Immune Deficiency Syndrome and Human Retrovirology:* 5: 1274 - 1275.

National Advisory Committee on Drugs (NACD). 2002. *Use of Buprenorphine as An Intervention in the Treatment of Opiate Dependence Syndrome.* Dublin: NACD.

Neaigusm A., Sufian, M., Friedman, S., Goldsmith, D.S., Stepherson, B., Mota, P., Pascal, J. and Des Jarlais, D.C. 1990. 'Effects of Outreach Intervention on Risk Reduction among Intravenous Drug Users. *AIDS: Education and Prevention:* 2: 4: 253 - 271.

O'Brien, M., Moran, R., Kelleher. T. and Cahill, P. 2000. *National Drug Treatment Reporting System.* Dublin: Health Research Board.

O'Connor, A. 1996. *Women Working in Prostitution .-Towards a Healthier Future : Second Report Prepared for EUROPAP and the Eastern Health Board (Women's Health Project).* Dublin: Women's Education Research and Resource Centre, University College Dublin.

O'Gorman, A. 1998. 'Illicit drug use in Ireland: an overview of the problem and policy responses'. *Journal of Drug Issues:* 155 - 165.

O'Higgins, K. 1998. *Review of Literature and Policy on the Links between Poverty and Drug Use.* Dublin: The Economic and Social Research Institute.

O'Higgins, K. 1999. 'Social Order Problems' in Fahey, T. (ed.) (1999). *Social Housing in Ireland: A Study of Success, Failure and Lessons Learnt.* Dublin: The Kathleen Howard Foundation and Combat Poverty Agency.

Pain, R., Francis, P., Fuller, I., O'Brien, K. and Williams. S. 2002. *Hard-To-Reach Young People and Community Safety: A Model for Participatory Research and Consultation.* Police Research Series Paper 152.

Paone, D., Des Jarlais D.C, Gangloff R., Milliken J., Friedman S.R. 1995. 'Syringe-Exchanges: HIV Prevention, Key Findings and Future Directions. *International Journal of Addiction:* 30: 12: 1647 = 1683.

Perera, J., Power, R. and Gibson, N. 1993. *Assessing the Needs of Black Drug Users in North Westminster.* Hungerford Drug Project/The Centre for Research and Planning Unit Paper No. 89, Home Office, London.

Power, R., Hartnoll, R., and Chalmers, C. 1993. 'Help-seeking among illicit drug users: some differences between a treatment and non-treatment sample'. *Inter nationalJour nal of the Addictions:* 127: 887 - 904.

Rehm, J., Gschwend, P., Steffen, T., Gutzwiller, F., Dobler-Mikola, A. and Uchtenhagen, A. 2001. 'Feasibility, Safety and Efficacy of Injectable Heroin Prescription for Refractory Opiate Addicts: A Follow-up Study'. *The Lancet* 358: 9261.

Rhodes, T., Holland, J., Hartnoll, R. Johnson, A. and Jones, S. 1990. 'Reaching the Hard to Reach'. *Druglink,* November, December 1990.

Rhodes, T., Holland, J. and Hartnoll, R. 1991. *Hard to Reach or Out of Reach? An evaluation of an innovative model of HIV outreach health education.* London: Tufnell.

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

Rhodes, T. 1996. *Outreach Work with Drug Users: Principles and Practices.* Strasbourg: Council of Europe.

Rhodes, T. 1997a. 'Models of Outreach among Injecting Drug Users'. *Executive Summary, No. 56.* The Centre for Research on Drugs and Health Behaviour.

Rhodes, T. 1997b. 'How to reach injecting drug users: What models of outreach work are being used? And which are the most effective? *Addiction Counselling World: 9:* 49: 10 - 12.

Rhodes, T. and Stimson, G. 1998. 'Community Intervention among Hidden Populations of Injecting Drug Users in the Time of AIDS' in Bloor, M. and Wood, F. 1998. *Addictions and Problem Drug Use: Issues in Behaviour, Policy and Practice.* London: Jessica Kingsley.

Robson, C. 1998. *Real World Research: A Resource for Social Scientists and Practitioner-Researcher.* Oxford: Blackwell Publishers Limited.

Rosenbaum, M. and Murphy, S. 1987. 'Not the Picture of Health: Women on Methadone'. *Journal of Psychoactive Drugs:* 19: 2: 217 - 226.

Ross, M.W., Wodak, A., Stowe, A., and Gold, J. 1994. 'Explanations for Sharing Injection Equipment in Injecting Drug Users and Barriers to Safer Drug Use'. *Addiction:* 1994, 89: 4: 473-479

Ruanes, S., Dolan, K. and Woadak, A. 'Rooms for rent: Injecting and harm reduction in Sydney'. *Australian and New Zealand Journal of Public Health,* 1997: 21: 1: 105.

Seaman, S., Brettle, R., and Gore, S. 1998. 'Mortality from overdose among injecting drug users recently released from prison: database linkage study'. *British Medical Journal.* 1998: 316: 426 - 428.

Single, E. 1995. 'Defining Harm Reduction'. *Drug and Alcohol Review.* 1995:14: 287 - 290.

Spinner, G.F. and Leaf, P.J. 1992. 'Homelessness and Drug Abuse in New Haven'. *Hospital and Community Psychiatry:* 43: 166-168.

Starmans, R. 1998. 'Marginalised Groups' in Robertson, R. (ed.) *Management of Drug Users in the Community: A Practical Handbook.* London: Arnold.

Sterk-Elifson, C. 1993. 'Outreach among Drug Users: Combining the Role of Ethnographic Field Assistant and Health Educator'. *Human Organization:* 52:2:162 - 168.

Stimson, G.V., Eaton, G., Rhodes, T. and Power, R. 1994. 'Potential development of community oriented HIV outreach among drug injectors in the UK'. *Addiction:* 1994: 89: 1601 - 1611.

Sweeney, B. 1993. 'Outreach Work and Methadone Treatment in Dublin' in EMCDDA. 1993. *AIDS and Drug Addiction in the European Community: Treatment and Mistreatment.* EMCDDA: Brussels.

Tommasello, A., Myers, P., Gillis, L., Treherne, L. and Plumhoff. M. 1999. 'Effectiveness of outreach to homeless substance abusers'. *Evaluation and Program Planning:* 1999: 295 - 303.

Van den Brink, W., Hendriks, V.M., Blanken,.P., Huijsman, I. and van Ree, J. 2002. *Medically Co-Prescription of Heroin: Two Randomized Controlled Trials.* The Netherlands: Central Committee on the Treatment of Heroin Addicts.

Veale, J. 1994. 'Harm Reduction and the Community'. *The InternationalJournal of Drug Policy:* 5: 2: **115** — **119.**

Warnes, A and Crane, M. 2000. *Meeting Homeless People's Needs: Service development and practice for the older excluded.* London: King's Fund Publishing.

Whitehead, B. 1997. 'Motivational Interviewing'. *Executive Summary, No. 55.* London: The Centre for research on Drugs and Health Behaviour.

Whittaker, A. and MacLead, J. 1998. 'Care in the Community' in Robertson, R. (ed.) 1998. *Management of Drug Users in the Community: A Practical Handbook.* London: Arnold.

Yates, R. and Gilman, N. 1990. *Seeing More Drug Users: Outreach Work and Beyond.* Manchester: Lifeline Project.