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**An  
Information  
and Resource  
Booklet for  
Agencies  
Engaged in  
Drug  
Education**

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# **HARM REDUCTION**

## **AN INFORMATION AND RESOURCE BOOKLET FOR AGENCIES ENGAGED IN DRUG EDUCATION**

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# Introduction

*Elizabeth Kiely & Elizabeth Egan*

This booklet is concerned with the concept and practice of harm reduction as a response to drugs issues in Irish society.

It is hoped that this booklet will fulfil three aims;

- Firstly, the authors wish to open up an understanding of the concept of harm reduction as applied to the area of drug policy and intervention;
- Secondly, it is designed so that individuals working with young people, who are currently using or intending to use a harm reduction strategy in their work will have a framework for such a strategy;
- Thirdly, it is intended that this booklet might break the silence surrounding harm reduction prompting discussion among all sections of society dealing with drug issues and not just among those who are working directly with young people.

The booklet is by no means a definitive statement on the application of the concept and practice of harm reduction. It is not a source book so it does not include a step by step guide to working with young people so as to minimise the harms associated with their drug use. Rather the booklet has arisen from the following concerns of the authors and the committee who worked on this project;

Currently, there is a silence around the concept and practice of harm reduction as applied to the area of drugs in Irish society; this tends to be exacerbated by a lack of real understanding as to what is actually meant by harm reduction and a reluctance to engage in discussion in relation to this issue.

Many adults working with young people who are actively seeking to enable young people to reduce the harmful consequences that can result from their drug use are currently in limbo, having few opportunities to share ideas about good practice.

The current climate of silence around this work is not favourable to the development of realistic and effective responses to drugs in Irish society, particularly if front line workers with young people do not feel comfortable to discuss their work, or to seek endorsement or support from flinders, management representatives or other bodies.

The authors of the booklet engaged in extensive research, reviewing the literature that existed on the subject of harm reduction in relation to drugs and analysing Irish policies and legal documents to examine the status of harm reduction in Irish society.

The authors hope that this is a starting point and that it may be the springboard for many other developments in this field.

The booklet is divided into the following four chapters;

The **first chapter** deals with a theoretical analysis of the concept and practice of harm reduction.

The **second chapter** reviews the policy documents which frame drug interventions in Irish society, in an attempt to analyse the current status of harm reduction.

The **third chapter** of the booklet documents three profiles of practice in the Irish and British context which are distinctive because of their strong harm reduction orientation. The projects / programmes are noteworthy not so much for their radicalism but for their willingness to respond to drug related issues among young people in a manner that is practical and which places the young person in the centre of the analysis.

The fourth **chapter** outlines some key issues that need to be considered before any agency embarks on a harm reduction initiative; while this is not a comprehensive list of issues, it should provide some framework for the kind of preparatory work that needs to occur before launching into a strategy.

## **Chapter 1**

# **Harm Reduction – The Concept and Practice**

*Elizabeth Kiely & Elizabeth Egan*

Key principles of good youth work practice have been specified in numerous national and organisational policy documents over the years. *'In Partnership With Youth'* (National Youth Policy, 1985) recognised that young persons have rights which must be identified and safeguarded. It also stressed the need for the development of educational policies to meet contemporary needs. Young people at risk through substance abuse were identified as a key target group to be involved in youth service provision. The Youth Work Support Pack for Dealing with the Drugs Issue (National Youth Health Programme, 1996 ; 9) states that;

*whatever societal responses prevail, youth work has a responsibility to provide a response to the drugs issue which is balanced, non-judgmental and addresses the double standards as they exist within Irish society.*

Inherent in this statement, is a recognition that there are difficulties involved in ensuring that key principles are prioritised in practice, when societal laws, policies, moral and cultural considerations impact on youth work practice. The challenge that confronts any youth organisation is to ensure that the principles guiding practice are not compromised while it operates within societal frameworks. This challenge is particularly evident when one focuses on the area of drugs and young people in Irish society and more particularly, when one considers the place of harm reduction in Irish youth work practice.



## What is Harm Reduction ?

Harm reduction possibly induces many fears when first mentioned. It is a term that has been used interchangeably with other terms like “*damage limitation*”, “*casualty reduction*” “*harm minimisation*” “*risk management*” or “*secondary intervention*”. Part of the reason for this interchange of terminology has been due to the controversy generated by the contrasting definitions of the concept of harm reduction. As a concept, harm reduction has been explained in ways that make explicit the basic thrust of its orientation, as indicated in the definitions offered.

According to Newcombe (1992 ; 1);

*harm reduction... is a social policy which priorities the aim of decreasing the negative effects of drug use.*

‘The Youth Work Support Pack for Dealing With The Drugs Issue (National Youth Health Programme, 1996; 70) describes harm reduction or harm minimisation as “*any activity which aims to reduce the harm caused by drug use.*”

However such broad definitions of harm reduction, allow drugs initiatives with many different aims and different methods to be included under the harm reduction umbrella. In an attempt to allay confusion and misunderstandings, commentators (Heather et.al., 1993; Single, 1995; Wodak & Saunders; 1995) identified the need to define the concept of harm reduction more clearly.

According to Heather et.al., (1993) harm reduction as a strategy includes;

*any activity which is directed at reducing the harm associated with drug use without necessarily reducing drug use itself.*

Similarly Duncan et.al., (1994; 281) state that the strategy of harm reduction;

*recognises that people always have and always “will use drugs and therefore, attempts to minimise the potential hazards associated with drug use rather than the use itself.*

Inherent in Heather’s and Duncan’s definitions is an acceptance that drug use can continue while a harm reduction strategy is being employed. In fact Single (1995; 288) considers that the key feature of harm reduction programmes distinguishing them from any other drug programmes is “*whether they attempt to reduce the harmful consequences of drug use while users continue to use.*” A harm reduction initiative has not failed on the basis that abstinence is not achieved, but it also does not exclude abstinence as a long-term goal. Achievement of goals like the alteration of dangerous drug taking practices and the adoption of safer patterns of use are successful outcomes of a harm reduction strategy.

Clements et. al. (1996 ;42) comprehensively define harm minimisation as;

*an approach to education which aims to reduce the harm from drug use to the lowest level possible..... by providing accurate information about drug use and it’s risks; developing the skills of less dangerous drug use; developing coping and helping skills; opposing discrimination against drug users. It encourages existing and would-be drug users to discover less dangerous ways of using and promotes helping and coping skills.*

Watson’s definition of harm reduction (1991; 14) states that harm reduction is;

*...the philosophical and practical development of strategies so that the outcomes of drug use are as safe as is situationally possible. It involves the provision of*

*factual information, resources, education, skills and the development of attitude change, in order, that the consequences of drug use for the users, the community and the culture have minimal negative impact.*

The above two definitions are significant for including within the parameters of the concept, the community and culture of the drug user, where harm reduction strategies can and have been applied. The applications of harm reduction will also be discussed in a subsequent section of this chapter.

### **Controversies Surrounding Harm Reduction**

After defining the concept it is important to note that some of the points made in the above definitions have given rise to controversies surrounding harm reduction strategies. For example, Duncan et al.'s definition which acknowledges that people have and always will take drugs, could be perceived as representing a loss of idealism inherent in the view that (illegal) drug free societies are no longer an attainable aspiration.

Clements et. al.'s definition which aims "*to reduce the harm from drug use to the lowest level possible by ... developing the skills of less dangerous drug use*" can be perceived as condoning rather than condemning outright drug use. Indeed, a person might argue that the end result of condoning drug use might be an increase in drug use and ultimately drug related problems.

If harm reduction is equated with decriminalisation or legalisation, then strategies appear to condone or accept an activity that may be illegal. There is also the suspicion that many of the fears associated with drug use are dispelled by harm reduction information strategies and these may have the unintended consequence of encouraging use among non-users.

It is important to examine some of the above controversies that have surrounded the concept of harm reduction. According to Inciardi and Harrison (2000) the lack of clear consensus as to what is meant by harm

reduction, has prevented it from gaining broad acceptance. Supporters of harm reduction are divided on the issue as to what is involved in making a commitment to harm reduction as a strategy. Some proponents of a harm reduction philosophy have argued for changes in drug policies toward the introduction of legalisation, decriminalisation and more treatment alternatives to incarceration (Inciardi & Harrison, 2000). Other proponents of harm reduction offer a different perspective, claiming instead that harm reduction seeks to preserve prohibition or to make prohibition work better, while softening some of the harsh consequences of drug use and prohibitionist policies (DuPont, 1996 ; Nadelmann, et. al.1997; 114). Although at times harm reduction is equated with legalisation, it is important to note Inciardi and Harrison's claim (2000) that most advocates of harm reduction do not support the idea of legalising drugs, yet they recognise that prohibition is not enough to stop drug use. Indeed some commentators have been very critical of policies of drug prohibition which they argue have only served to exacerbate drug related harm (Hawks, 1993 ; Riley & Oscapella, 1997). Harm reduction is indeed a practical endeavour, which does not have idealised goals. The philosophy underpinning harm reduction seeks to avoid moralistic stances in favour of adopting realistic or pragmatic responses to drug related situations. Single (1995; 290) succinctly summarises the pragmatic philosophy underpinning harm reduction ;

*harm reduction should be viewed as the middle ground where people with widely differing views on drug policy can agree with one another regarding practical immediate ways to reduce drug-related harm among users.*

Single argues that harm reduction strategies do not threaten different moral positions and approaches on drugs, rather the pragmatism that underpins harm reduction strategies can be the unifying force for people who are positioned on different sides of the drug policy spectrum. This means that a person who believes that a drug free society is attainable and that law enforcement is a necessary element of any societal response to drugs; or a person who claims that a society free of drugs is an unrealistic ideal and that policy responses should move in the direction of decriminalising drug use, can both support a harm reduction strategy. It does not necessarily conflict with the ideals that inform any of the above two positions. Evidence to support Single's argument can be

found in countries where there exists diverse policy perspectives on the decriminalisation of drugs and yet where harm reduction strategies are being applied. Even in the United States where drug policy is very much underpinned by prohibition, elements of harm reduction are evident. Inciardi and Harrison (2000) state that methadone maintenance has been in place in the United States since the 1960s. Therefore, the argument that harm reduction creates a practical option for action even where polarised opinion exists, is quite a convincing one.

Harm reduction proponents also argue on pragmatic grounds that drug free societies are indeed aspirational, particularly in present day society where the evidence from local, national and international surveys (ESPAD 1996, Jackson, 1998) show extensive and increasing experimentation and recreational use among young people. On humanitarian grounds, harm reduction proponents argue that withholding information necessary for people to make safer use decisions, only contributes to the risk of young people experiencing avoidable drug related harms. They also claim that services can no longer only afford to work with those who seek to stop using drugs and have to maximise contact with drug users generally.

Proponents of harm reduction also acknowledge that it is only one response to drug problems and argue that any harm reduction strategy has to be effectively targeted. Non-users of drugs are not a usual target group for a harm reduction strategy aimed at bringing about safer patterns of drug use. Effective targeting of harm reduction strategies limits the possibility of prompting use among non-users.

### **The History of Harm Reduction**

Harm reduction has gained prominence in recent years, mainly due to the connections between illicit drug use and AIDS, however it has a long history. In relation to alcohol, the promotion of responsible drinking and the avoidance of drinking and driving are obvious and acceptable harm reduction strategies. Nicotine patches, gum and inhalers have become popular means of reducing the harms of tobacco incurred by smoking, while avoiding some of the negative symptoms associated with stopping smoking.

An early example of a harm reduction approach used in the US in relation to illegal drugs has been documented by Duncan et. al. (1994). Following an epidemic of paint and solvent huffing (inhaling spray paint out of plastic bags to achieve a high) which resulted in two deaths, a local drug treatment centre decided to prioritise the prevention of deaths resulting from these incidents. Thus, in making educational presentations to youth groups, the focus was extended to describe ways of reducing the risks associated with huffing (e.g. using paper bags instead of plastic bags) in addition to spelling out the hazards that were involved in this activity.

In Britain, the problem of HIV infection among injecting drug users was the major stimulus behind harm reduction strategies. An early example of a model of drug service provision based on the philosophy of harm reduction was in Merseyside, which had witnessed the growth of opiate use in the early 1980s. The prescription of injectable opiates and the introduction of syringe exchange schemes as well as a harm reduction policing policy, all formed part of a comprehensive service to drug users in this area and Liverpool gained a reputation as a centre for harm reduction (Riely & O'Hare, 2000).

In Ireland, it was not until the early 1990s, that the AIDS crisis forced the Government to acknowledge a role for harm reduction in the area of treatment and rehabilitation. Intravenous drug users were identified as a “high risk category” in the transmission of the AIDS virus and so there was the discrete introduction of methadone maintenance, outreach programmes and needle exchange schemes, all harm reduction measures designed to curb the transmission of the virus. In Irish national drug policy, the first acceptance of the need for a harm reduction strategy in relation to illicit drugs appeared in *The Second Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1997)* (See chapter 2).

The application of harm reduction as a response to illicit drug use marked a new departure, as national policies in relation to alcohol consumption have always promoted moderation for those who wish to drink and have focused on reducing the prevalence of alcohol-related problems. The 1998 Alcohol Awareness Campaign was designed to promote responsible drinking among young people and it included posters with the following harm reduction messages;

*“Excessive drinking affects your performance...at everything” and “Too many shots.... and you could get fired.”*

### **Applications of Harm Reduction**

Harm reduction strategies can have very wide and extensive application. Harm reduction approaches have for very understandable reasons, focused on the most serious drug related behaviours, like for example the risks involved in injecting drugs and needle sharing. Therefore harm reduction has been perceived as being confined to the area of health and treatment, thus having quite limited application. However proponents of harm reduction have shown how it is a strategy, that can be used in different ways and in many different spheres. In fact the harm reduction philosophy has extended beyond health to include legal and educational fields. Stockwell (1999 ; 206) emphasises the benefits to be gained by being clearer about;

*the full range of potential harms associated with different levels and patterns of drug use for people operating in different social and developmental contexts. Once we understand the range of ways in which drug use can be either functional or dysfunctional for young people in these ‘high risk’<sup>1</sup> groups, then there may be a chance, to define the many ways in which the different agencies may best respond and what policies are most likely to succeed.*

O’ Hare et.al., (1992) have documented many applications of harm reduction models in different societies, targeting many different groups. Harm reduction measures do not always target drug user groups, but instead other groups may be targeted like parents, school personnel, families and communities. These harm reduction measures may be designed to increase understanding and reduce the stigmatisation or prejudice experienced by users resulting in their social exclusion, which can arguably be a greater source of harm to them, than the actual drug use itself. Dance club owners and staff, publicans and police have all been targeted by harm reduction measures aimed at promoting safer dancing or introducing different policing practices.

The E.M.C.D.D.A. annual report (1999; 32) stated;

*Aside from 'rave' parties, wider community approaches in specific neighbourhoods and youth centres aim to involve 'techno' clubs in preventive efforts. Guidelines for safe dancing developed by local authorities and NGOs have a tradition in the UK and are also being adopted in Denmark and Germany.*

Pearson (1991) has argued for a focus on how drug prohibition could be best policed, to minimise harm. Maher and Dixon (1999; 506) acknowledged that official policy commitments to harm minimisation in Australia were not matched by street-level police enforcement practices, but they also claimed that;

*Australia has a considerable reputation for its commitment to harm minimisation as the foundation of its national drug strategy.*

Riley and O' Hare (2000) have documented the role of Merseyside police in co-operating with the local health authority in a harm reduction approach. The police have agreed not to conduct surveillance on the health authority, to refer arrested drug offenders to services, not to prosecute for possession of syringes that are to be exchanged and to publicly support syringe exchange. The emphasis is on using policing resources mainly to deal with drug traffickers, while operating a cautioning policy toward users.

### **Harm Reduction and Youth Work Practice**

It has been established that youth work has a responsibility to young people at risk of drug use. National reports and organisational policies have strongly validated the role of youth agencies in responding to drugs issues with young people. Some of these documents strongly recommend that a harm reduction approach be included in any comprehensive strategy employed. Such a recommendation indicates the



following; firstly, a willingness to recognise what is occurring at the coal face of youth work and secondly, a call for the acknowledgement of strategies being employed which are broadly representative of a harm reduction approach.

In this chapter, the concept and practice of harm reduction have been explored. In the next chapter, harm reduction will be examined in the context of drug policy.

## **Chapter 2**

# **The Status of Harm Reduction in Drug Policy**

*Elizabeth Kiely*

To a greater or lesser extent, harm reduction strategies co-exist with repressive and preventive responses to drugs in most European countries. The E.M.C.D.D.A. annual report (1999; 12) stated that;

*After years of semi-marginal status in many countries, harm reduction is increasingly recognised as an important tool in national and local drugs policies.*

In the Netherlands, official policy is very much rooted in a harm reduction philosophy. Indeed, the Dutch instituted the first needle exchange programme in 1984 in an effort to curb the growing number of hepatitis cases related to injecting drugs (van Haastrecht, 1997). In Britain, there is some debate about what should be the defining thrust of official policy, but harm reduction is a key element of many strategies. According to Pearson (1991) the British system of drug control policy, has its inadequacies, but it has also been a highly flexible instrument, which has traditionally combined enforcement efforts with systems of education and health care provision. Other countries have not really been so involved in debate about harm reduction and in some of the Scandinavian countries, abstinence is the central plank of official policy (Calafat, undated). In European Union publications (E.M.C.D.D.A., 1997), harm reduction strategies are included under the umbrella of demand reduction, making different responses hinged on abstinence or on safer use less mutually exclusive. However, as shown when discussing the concept and practice of harm reduction, stopping drug use is not the overriding objective. Including harm reduction under the umbrella of demand reduction, involves viewing drug prevention as a broad strategy, with different objectives when responding to different situations. This allows harm reduction to be positioned more appropriately in the “*middle ground*” with a strong association to preventive strategies based on abstinence.

In Ireland, it is in the context of health care where the concept and practice of harm reduction is most readily associated. AIDS and HIV surveillance identified intravenous drug users as a “high risk” category in transmitting the AIDS virus and this prompted the introduction of methadone maintenance, outreach programmes and needle exchange schemes, all harm reduction initiatives. This harm reduction strategy was motivated by the need to respond to the threat posed by HIV in Irish society. The Government Strategy to Prevent Drug Misuse produced in 1991 first acknowledged the limited role to be played by harm reduction in the area of treatment and rehabilitation of heroin misusers (National Co-ordinating Committee on Drug Abuse, 1991). It was the threat posed by AIDS that became the catalyst for the adoption of harm reduction strategies in many countries; including Ireland, Britain, Switzerland and Australia (Inciardi & Harrison, 2000).

Following the Government strategy (1991), in the Government Health policy document “*Shaping A Healthier Future*” (Department of Health, 1994; 61) the Department of Health expressed its commitment to;

*The provision of at least four additional primary care clinics to service catchment areas in the Dublin area where harm reduction and assessment services will be provided to drug misusers [as well as] the involvement of general practitioners in the implementation of the methadone protocol.*

Thus it is clear that a harm reduction approach was introduced in interventions developed to curb the spread of the AIDS virus. For example, in the report of the National AIDS Strategy Sub-Committee on Education and Prevention, it was stated that

*..... everyone involved in the implementation of preventive policies must recognise that large numbers of people will continue to behave in a way that exposes them to infection. It is therefore essential that much of the preventive effort is concentrated on making risk practices as safe as possible, as well as trying to change long-standing behaviour.*

(Department of Health, 1992; 68)

A harm reduction approach has been a central strand of Irish policies in relation to the legal drug, alcohol. The National Health Strategy “*Shaping A Healthier Future*” (Department of Health, 1994) and the Health Promotion Strategy (Department of Health, 1995) both advocated a national policy to promote moderation in alcohol consumption and to reduce risks to physical, mental and family health associated with alcohol misuse. The National Alcohol Policy (Department of Health, 1996; 7) aimed;

*to promote moderation in alcohol consumption, for those who “wish to drink, and reduce the prevalence of alcohol-related problems in Ireland, thereby promoting the health of the community.*

Harm reduction has not secured the same status in policy documents on illegal drug issues. The role of harm reduction as an educational approach in relation to illegal drugs was not discussed in the *First Report of the Ministerial Task Force on Measures To Reduce The Demand for Drugs 1996*. The report focused mainly on heroin abuse as the most pressing aspect of the drug problem in Irish society and it emerged in a political and social climate characterised by a period of moral panic. The most important policy document to date which provides a limited framework for the development of a broader harm reduction strategy is *The Second Report of the Ministerial Task Force On Measures To Reduce The Demand For Drugs (1997)*.

In this report, a discussion did ensue around the issues of decriminalisation and harm reduction. Some public submissions received by the Task Force criticised media campaigns delivering a “No” message as ineffectual and argued for a greater emphasis to be placed on harm reduction. The Task Force claimed that available evidence did suggest that some young people do not believe that all drugs are dangerous and may due to peer pressure or other factors start using “soft” drugs such as cannabis or ecstasy. The Task Force concluded that to assist young people who become involved in using drugs;

*..consideration should be given to developing information/media campaigns here in Ireland which replicate the “harm reduction” approach being adopted in countries like Britain (1997;46).*

The Task Force (1997; 45) also reiterated an earlier Government decision taken in February 1996, that;

*there should be no move to decriminalise so-called “soft drugs” and that hand in hand with this approach, the main focus of education and prevention campaigns should be to discourage young people from becoming involved with drugs in the first instance.*

In the 1997 Task Force report stated that a simple “No” message was deemed unsuitable for “a highly educated and sophisticated younger population” (1997; 45). Similarly it was claimed “that many young people, through peer pressure or otherwise, may be tempted to ignore advice not to take drugs and start using so called ‘soft drugs’” (1997, p.45).

It is important to point out that in the second report of the Ministerial Task Force (1997) there is no firm commitment to anything more than “consideration” to be given to replicating the harm reduction approach adopted in countries like Britain. Thus there is no strong policy ‘ framework underpinning harm reduction in relation to illicit drug use in Irish society and this has meant that there is no legal framework built around the strategy of harm reduction.

When they entered Government, the Fianna Fail / Progressive Democrat coalition endorsed the two Task Force Reports. The Minister of State, Chris Flood (Flood, 1997) at the launch of the Union of Students in Ireland Drug Awareness Campaign which had a distinct harm reduction orientation, stated that;

*The Taoiseach has already indicated that the present Government supports the broad thrust of the policies outlined in the two reports of the Ministerial Task Force.*

The Expert Group on the Probation and Welfare Service in their report (Government of Ireland, 1999) acknowledged that however desirable total abstinence is as a treatment goal, it is not easily or quickly achieved and thus agencies set intermediate goals for themselves and their clients

under the label of harm reduction. The dilemmas raised by harm reduction for those who work within the criminal justice system as acknowledged by Maher and Dixon (1999; 506) (see page 15 in this booklet) were also mentioned in the report of the Expert Group, although no solutions were offered to tackle this issue;

*By its nature, criminal law is infused with concepts of right and wrong, and this reduces its flexibility for dealing pragmatically with residual illegalities committed by people on the road to recovery. From a health-care perspective, persuading a dependent heroin user to stop needle-sharing, or to stop injecting, or to reduce levels of use, may properly be regarded as an achievement, in both social and moral terms; from a criminal justice point of view, on the other hand, it could be regarded as continued law-breaking.*

*(Government of Ireland, 1999; 75)*

Many national youth agencies and local agencies have developed their own drug policies to guide their practice. Some of these policies have also endorsed the use of a harm reduction strategy as one strand of a holistic response to young people's drug use.

It is important for youth workers or other workers engaging in harm reduction practices to know that these practices when associated with illicit drug use, receive very limited validation in Irish laws and policies generally. Due to this limited validation, engaging in some harm reduction strategies will bring legal considerations for many youth workers to the fore.

- **To guide good practice and to adequately protect workers engaging in harm reduction, it is essential that agencies receive legal advice when devising drug policies, confidentiality policies and working methods in their organisations.**
- **Agencies need to formulate clear policy statements on confidentiality. This policy should be communicated to each relevant individual in the agency. It should include a statement to the effect that confidentiality resides in the agency rather**

**that in the individual worker. Criteria and structures for breaching confidentiality and sanctions for unauthorised breaches of confidentiality, should be clearly stated in the policy. The confidentiality policy should be communicated appropriately to the target group and it should be reviewed on a regular basis. (For further discussion on the issue of confidentiality as it relates to young people, consult Gallagher, 1996 or Dalrymple, 1999)**

- **Identifying and working co-operatively with a local Garda/Community Garda/Juvenile Liaison Officer, who is aware and supportive of organisational policies and working methods, can have benefits. It may mean, that if and when drug related incidents arise in the youth agency or in other local settings which receive Garda attention, they are handled in a sensible and sensitive manner.**

## **Chapter 3**

# **Profiles of Harm Reduction Strategies**

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## **Dublin Safer Dance Initiative:**

### **The Staying Alive Campaign**

*Steven Hording*

**Key Agency Involved :** Eastern Health Board

**Timescale:** The campaign was initiated in 1997 and is ongoing.

**Funding:** Funded (£5000) by Dun Laoghaire Rathdown Local Drugs Task Force

**This case study outlines the development of The Dublin Safer Dancing Initiative (The Staying Alive Campaign). It was initiated in 1997 in the Eastern Health Board Area and is designed to provide training and support to night-club staff to respond *more* effectively to drug related situation in night clubs.**

## **INTRODUCTION TO THE INITIATIVE**

For some time, concern has been expressed in various quarters over the use of drugs such as Ecstasy, Amphetamines and, more recently, Cocaine and the close association between this drug use and dance music. There have been a small number (under 20) of recorded deaths attributed to Ecstasy use since it became a popular recreational drug in the early 1990's. Of equal significance has been the number of health related incidents which have been reported such as dehydration, heat stroke, organ failure and depression experienced by Ecstasy users.

No figures are readily available on the extent of these health issues and highly detailed Research through Accident and Emergency Department records and other sources would be needed to give any kind of accurate figure. Anecdotal evidence from various drug workers, youth service workers, drug users, medical personnel and media reports would suggest, however, that it is a cause for some concern. Certainly, if one considers the quantity of Ecstasy tablets seized in 1998, which was 692, 000 (as at 10/12/98) and reflects on the number that was not detected, it points to quite a sizeable use of

**Sizeable use of ecstasy in Ireland**

the drug. Some surveys would seem to confirm this. Three surveys carried out with third level students showed estimated usage levels of 21% (U.C.D. Survey 1996), 18% (T.C.D. 1997) and 19% (D.I.T. 1997).

**Train staff in night clubs to deal more effectively with drug related situations**

As a result of all the information being circulated, but particularly reports of young people suffering heat stroke and dehydration and being ejected from clubs the Education Officer for the South-east Sector (E.H.B.) had a preliminary meeting with Dr. Des Corrigan, Director of the School of Pharmacy, Trinity College and Chairperson of the Dun Laoghaire-Rathdown Local Drug Task Force about funding for training of Night-club staff. It was based on the premise that, if drug workers or healthcare staff cannot be readily available in clubs, the next best thing is to train up staff who work in Night-clubs to help them respond more effectively to drug related situations.

## **BACKGROUND**

- In 1997, a proposal for funding was submitted by the Education Officer, Eastern Health Board (Southeast Sector) to the Dun Laoghaire Rathdown Local Drugs Task Force (L.D.T.F.) to carry out training on drug related issues for Night-club Door Staff in the Southeast Dublin area. This proposal was accepted and £5, 000 was allocated to carry out the training.
- In November 1997, the Eastern Health Board hosted a one-day conference on Ecstasy at which there was a speaker representing the London Drug Policy Forum, which in December 1996, had produced a report entitled "*Dance 'till Dawn Safely*". The speaker detailed how, initially, they too had targeted door staff but, good practice instead indicated the need to

**Good practice indicates the need to concentrate in the first instance on owners and managers of night clubs.**

concentrate in the first instance on owners and managers of night clubs.

- A small working group set up to monitor the project decided re-evaluation was necessary to decide how to proceed with the Safer Dancing initiative.

- A three phase plan evolved which targeted:-

Owners and Managers

Door Supervisors

Club Goers

- In May 1998, the Release Drugs Agency in London was contacted to give advice on the project. This is a long established agency that has built up considerable expertise in training night club staff and designing prevention / education initiatives targeted at club goers. A member of staff from the Release agency visited Dublin in May and carried out some research to acquaint himself with the club and music scene. A report concentrating on his findings and recommendations was commissioned. This report was completed in October 1998.

**“Release” Report**

- Two planning meetings were held in early June with Owners/Managers of clubs in the Southeast Sector. The first meeting was poorly attended as in the Dun Laoghaire/Rathdown area, there were only 14 clubs which had been identified and invited - less than half of them turned up. For the second meeting, the E.H.B. Education Officer, whose own area of responsibility was much wider and stretched from the City Centre to South Wicklow, decided to invite other well-known clubs in his area to send representatives.

- Considering that there are well over 50 clubs in the South Dublin area, the response was very encouraging and in all, 12 clubs were represented.
- The purpose of the meeting was to have an open and frank discussion about clubs and drug use and consider the training needs of Owners/Managers and Door Supervisors to help them to respond more effectively to the issues.
- Arising from the planning meetings, two half-day training sessions were subsequently organised for July and invitations sent to almost fifty clubs including a number of late night bars and leisure venues. With days to go, the response was disappointing and, following consultation with the Director of Communications, Eastern Health Board, it was agreed to give the project media coverage. The response was very positive and, instead of our contacting clubs to see if they would send a representative, we began to receive calls from clubs asking could they attend.

**Meetings organised with club representatives**

**Training sessions organised and media coverage of die project**

## **MANAGERS / OWNERS TRAINING PROGRAMME**

- Both sessions were very well attended by Owners/Managers, Garda representatives and E.H.B. staff with approximately 40 people present for each session. The sessions were very informative and offered an opportunity for different perspectives to be aired (some of the issues are outlined later in the case study). The content of the training included:-

- ⇒ Extending drugs knowledge
- ⇒ Exploring attitudes (including Club goers perspective)

**Content of Training Sessions**

⇒ Legal issues

**Positive evaluations of Training received**

⇒ Health and Safety considerations

⇒ First Aid overview

⇒ Identifying staff training needs

**Training for Door supervisors**

- Participants were asked to fill out evaluation forms at the end of the course. In all, fifteen forms (representing 11 venues) were completed. All were extremely positive.

### **DOOR SUPERVISORS TRAINING PROGRAMME**

**Content of Training For Door Supervisors**

- Based on information supplied by the Owners and verbal advice from the Release agency, a training programme for Door Supervisors (more commonly referred to as Bouncers) was designed to be run over ten Monday evenings from early September 1998.

- All the clubs promised that they would send door staff to the training and the 20 places on offer were eventually filled.

- Unfortunately, some door staff were not advised of the training until after it had commenced and only 14 of the expected 22 participants attended on the first night.

- The 10 week programme ran for 2 hours each session and consisted of:-

⇒ Exploration of attitudes (1 session)

⇒ Drug Facts, Legal Aspects and Discussion (2 sessions)

⇒ Basic First Aid (4 sessions)

- Health and Safety Issues (1 session)
  - Fire safety - discussion and practical demonstration (1 session)
  - Evaluation - identifying future training (1 session)
- Of the 14 who commenced the course, eight ‘participants were awarded certificates on the 16<sup>th</sup> November 1998.

## **EVALUATION OF TRAINING**

- Instead of using evaluation forms, the course used open discussion concerning the content, duration, tutors and benefit to the participants to help evaluate its effectiveness. In addition, a freelance journalist, (Cormac O’Keeffe) who has written a number of articles for various publications on drugs and dance culture, (see for example “Uproar Magazine”, November 1998) was given permission to sit in as an observer during the final session on first aid. He conducted interviews (anonymously) with all the participants and his feedback to the project co-ordinator was extremely positive. This concurred with the views expressed directly by the participants on the last evening of the course in which the general viewpoint was how informative, interactive, helpful and practical all the sessions had been. Some negative feedback particularly relating to the time and the day of the sessions was recorded and is considered in more detail in the next section of the case study.

<b>The evaluation process</b>
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## **REVIEW - DISCUSSION - PHASE I**

- The original aims and objectives of this project were revised before and during the training in line with new information or perspectives, which came to light. Initially, it was seen as a

straightforward training programme for ‘Bouncers’. It soon encompassed Owners / Managers and then Door Supervisors. In between, other issues emerged which needed to be acknowledged and they were placed on the agenda for further deliberation (such as giving accurate information to club goers).

**Issues which were of concern for owners/managers and staff of night clubs**

- Some of the issues which arose in the Owners/Managers group centred on the following;

⇒ If clubs provide “chill out” areas, they can be accused of condoning drug use.

⇒ If they do not provide “chill out” areas and a club goer suffers heat stroke or dehydration, they are leaving themselves open to litigation.

⇒ If club owners go to the local Gardai and ask for support to eliminate drug use in their clubs, there may be cases of too much help in the form of raids or “word” in the community that such a club is rife with drugs. Consequently, most clubs have tried to deal with the situation themselves, whereas co-operative action might prove more effective, provided it is not seen as too intrusive.

**The decision not to operate a “sin bin”**

- Information from Release indicates that many clubs in the U.K. operate a “*sin bin*” at their entrances, if a club goer is found with a personal supply of drugs, it is confiscated, no questions asked and placed in the sin bin. This eliminates the need for Police to call to the club, each time someone is discovered with an Ecstasy tablet, which could be many times a night. The positive and negative aspects of this

approach were given some consideration but overall, until such time as legislative policy supported the idea, clubs were advised that to adopt similar measures could leave them open to accusations of “*possession of illegal substances*”.

- An overall feeling from the Managers/Owners group, however, is that they will continue to do their utmost to stem drug use in the clubs by an active policy of door supervision but they cannot regulate for club goers who ingest their drugs 20-30 minutes before entering clubs and suffer adverse reactions later. When there are such occurrences that receive media attention, the club owners feel that the subsequent blame they receive is therefore not always justified.
- The club representatives were reluctant to accept that they may be contributing to drug use by playing certain music that attracted a drug using clientele. There was some agreement, however, that clubs playing rave (very fast beat) music did, but those clubs were not represented at the training programme.
- The Trainers, on the other hand, highlighted the information they had from a number of sources (Media, Club Goers, Release agency) that with the closure of specific rave venues, some of the music such as House, Drum and Bass and Triphop had dispersed across the entire dance scene and has become subsumed into main dance culture. With this phenomenon has come anecdotal evidence that drug use may be becoming the norm in many clubs even if only by a small number of club goers.
- Following discussion on some of these points and the accepted need for everyone to work closer together, a small working group

**Issues prompted the development of working group to produce a document on good practice in clubs.**



comprising of Owners, Managers, Gardai, Health and Safety Officer and E.H.B. personnel emerged. The purpose of this group is to look at producing a discussion policy document on good practice, which can be adopted by every club.

## **REVIEW - DISCUSSION - PHASE II**

- Most of the clubs are open at a minimum from Thursday to Sunday nights and the participants at the Door Supervisors Course were aggrieved that the training should be scheduled on what for many of them was their night off and also the time of commencement - 5.30 p.m. did not take into account those who worked full time during the day.
- The Owners/Managers group was the group who selected the best night and time for their staff's training. The training time from 5.30 p.m. to 8 p.m. was purposely chosen so that door supervisors who were rostered to work in a club that night could still get to work on time.
- While the training time arrangements suited the interests of the clubs, the Door Supervisors were of the opinion that the training times did not suit their needs.
- In the informal evaluation, the trainers were asked to consider breaking up the course into different elements so that participants could choose which elements they needed, rather than have to attend the whole course in one 10-week period.

**Dissatisfaction with training times**

**What the review of the training provided revealed**

- One of the fourteen participants was paid by his club to attend the course while another club (that also operates as a bar) attempted to send three staff members rostered on duty but their attendance was late and sporadic and eventually all three failed to complete the course.
- The overall lack of training previously provided for this group was very noticeable, with 3 or 4 exceptions.
- Staff, particularly those with less experience, reported differences in the way they managed situations - including conflict, assault, aggression injury, crowd control and decisions on search and detainment. Some staff also reported they were unsure of the legal situation pertaining to their jobs, including rights to search, the level of force permissible when dealing with patrons of clubs (if required), the duty of care the club has to patrons being evicted and who were intoxicated and/or incapable. The staff also lacked information regarding basic first aid and other health, safety and fire safety issues.
- While some staff reported that they had undertaken a small amount of training, they did not specify the type, level and scale of training, which they had undertaken. There was a general understanding that training consisted of working alongside more experienced staff and learning from them while working.
- The overall level of knowledge on various drugs was good, but the attitudes of some of the door supervisors to club goers who used drugs were negative. To generalise on this point, door staff consistently believed that alcohol and people

who drink too much were okay unless they were causing a disturbance but drug using club goers or even those perceived to be on drugs were not acceptable. This group of dance clientele, although not causing any disturbance could often be identified by showing signs of being warm (taking their shirts off while dancing) or by chomping (chewing vigorously on gum or lollipops).

**Phase III Getting accurate information to club goers and young people of club going age**

### **INFORMATION FOR CLUB GOERS - PHASE III**

Samples of posters designed by Release (London) on five different drugs (Ecstasy, Cannabis, Amphetamines, LSD and Cocaine) were shown to the Managers/Owners group for comment. Generally, it was felt that, while they were very attractive and informative, because of their size they were too “intrusive” for a Night-club.

**Distribution of the Vital Information Pack (V.I.P.)**

Another concern was that the language used in the posters, which was intended to be very straightforward, but could be construed by licensing authorities as condoning drug use which obviously reflected on the club.

Samples of a small information booklet for club goers were also circulated. This is a credit card size booklet produced by the Release drugs agency and referred to as a V.I.P. (Vital Information Pack). The response to this being distributed to club goers was far more positive and, while the majority of club representatives said they would not distribute the booklets, they had no objections to an approved healthcare (e.g. outreach worker) worker coming in periodically to distribute them.

The idea of convenience advertising in club toilets, similar to HIV messages was discussed and, while there was no sample to distribute, the concept was

acceptable provided it was again not seen as encouraging drug use.

A consignment of 5000 V.I.P. leaflets will be piloted in a number of venues such as clubs and third level colleges. It is intended to evaluate their impact before ordering larger quantities. An unexpected problem has also arisen over the cost. The cost was originally quoted as between 8 and 10 pence each, but this has since risen to 35 pence each. This seriously affects the number of booklets that can be ordered. An Irish source is being considered.

**V.I.P. leaflets**

**One day conference to garner support from the music/ dance industry to develop policy in dance venues and to disseminate the findings of the working group.**

#### **PHASE IV**

This phase will target all Night-club Owners and Managers in the Eastern Health Board region (i.e. Dublin, Kildare and Wicklow). It is hoped to attract a sponsor in the music/dance industry and host a one-day conference targeted at senior staff. The purpose of Phase IV is to garner support from the entire music/dance industry for developing acceptable policies in dance venues across the region.

The working group report referred to earlier should have a report ready for circulation and discussion at the conference.

**The introduction of Training Modules for Door Supervisors**

#### **PHASE V**

Phase V is concerned with standardising training for door supervisors. It is not intended to offer 10 session blocks like in Phase II. Instead, different elements of training will be provided in modular form such as

⇒ Drugs/Facts/Legal issues (4 sessions),

⇒ First Aid (4 sessions)

⇒ Crowd control, Health and Safety and conflict resolution  
(4 sessions)

In the provision of training modules, it is hoped that more participants will undertake training because they will be afforded an opportunity to undertake all elements of the course at different times rather than consecutively.

**Dublin Safer Dance  
Initiative c/o Steven  
Harding, Education  
Officer, Eastern Health  
Board, Centenary  
House, 3 5 York Road,  
Dun Laoighre, Co.  
Dublin.**

## **Cascade Youth Led Drug Awareness Programme**

*Len Mackin*

**Key Agency Involved : CASCADE**

**Funding:** £162,000 for three years, provided by the Home Office Central Drugs Prevention Initiative & Crime Concern.

**Timescale:** 1992 - 1995 Three Year peer education programme

**This case study outlines the work of CASCADE, which is based in Solihull West Midlands, bordering the city of Birmingham.**

### **INTRODUCTION TO THE PROGRAMME**

A pilot programme was set up to test the efficacy of using people as peer educators delivering drugs awareness information. The project was to work in schools, clubs and colleges. CASCADE would remain independent of other agencies but was expected to form partnerships for joint working with relevant local agencies such as Health Promotion, Probation and Health services.

**Pilot peer education programme**

### **AIMS & OBJECTIVES**

The project has the following objectives:

- To provide accurate information on drugs and substances
- To provide harm reduction information
- To provide information on the law relating to drug use
- To provide access to support including treatment agencies and to the confidential counselling programme provided by the agency.

## TARGET GROUP

The target group is 13- 25 (inclusive). The CASCADE programme attempts to reach any young person, including users and non-users and to address their particular needs as appropriate.

**The need for clear and accurate information**

## NEEDS OF TARGET GROUPS

Original independent research carried out in 1991 found that many young people had concerns about drug use and dealing with friends who use. At that time cannabis was the most common illegal substance used in the area. Since then, many young people are involved with Heroin as well as a range of other drugs. Continued research carried out by CASCADE identified the need for clear and accurate information to be the main priority for most young people, including users. Users also identified the importance of information about drug and particularly “keeping safe” as being of major importance to them. Many young people were and still are confused about the consequences and risks of drug use, particularly with regard to legal status. The debate on cannabis legislation was also leaving young people with the wrong information. In a survey carried out by CASCADE with 1300 young people aged 14 - 16, 50% responded that cannabis was now a legal drug. Since 1996, CASCADE has employed a counsellor to provide confidential support to young people who feel that they have a problem with their drug use. This has also resulted from the needs of young people in the area who had no access to this kind of specialist support.

**Keeping Safe**

**Counselling service for specialist support**

## IMPLEMENTATION OF THE STRATEGY

The initial strategy was to work in all schools, youth clubs and colleges by the end of year 1. This proved too demanding and unworkable and was

Subsequently revised.

This initial development of the project was completed in **three** phases:

### **Phase 1**

- ⇒ The appointment of a project co-ordinator.
  
- ⇒ The co-ordinator came into the post in September 1992 and drafted an operation plan together with job descriptions for a part-time Administrator and Project Development Officer.

### **Phase 2**

- ⇒ Began work and recruited young people as peer educators.
  
- ⇒ One particular secondary school and one youth club were identified as good places to meet with young people and to try out some drug awareness activities.

### **Phase 3**

- ⇒ Five of six youth club volunteers remained with the programme and throughout 1993, they were instrumental in developing a programme of activities within the area.
  
- ⇒ The programme was launched in March 1993.
  
- ⇒ Emphasis was placed on training and support for the small group of peer-educators.
  
- ⇒ By the end of 1993, CASCADE had a small group of about 20 committed volunteers.
  
- ⇒ First residential for volunteer educators to develop teamwork and plan an activity programme.

<b>Training &amp; Support</b>
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⇒ During 1994, produced leaflets encouraging young people to develop images and text that reflected local need and would be cheap to produce.

**Produced Leaflets**

## **LESSONS LEARNED**

⇒ This programme and other similar programmes need six months lead in time.

⇒ It is unrealistic to expect immediate outcomes.

⇒ The establishment of a steering group and support from key agencies can reduce the lead in time considerably. They can also give the group credibility.

⇒ Clear messages must be relayed to main audiences on the programme's aims, approaches and anticipated outcomes.

⇒ It is important not to raise unrealistic expectations.

**Numbers Reached**

**Design of Materials**

## **RECENT WORK AND REVIEW OF CASCADE**

The CASCADE programme has trained over 300 volunteers and they have worked with over 18,000 young people.

Volunteers (aged between 14 and 26) have designed leaflets and posters, produced videos, designed and made their own materials for education in schools including schools for young people with special needs.

**Media**

They have taken part in radio and TV programmes

and have built a website that includes a facility to submit problems to CASCADE for advice.

**Helpline**

Working in partnership with the police, CASCADE provides a free and confidential support telephone line. Parents of heroin users in need of support and information mainly use this service.

**Support for Parents**

Furthermore in 1995, the lack of information and support for parents of drug users led CASCADE to work with the police and Health Promotion to devise a workshop for parents. This workshop was focused on “Drugs Information, legal information and What Can Parents Do?” Three interactive workshops were hosted and organised by local schools (primary and secondary) and were attended by 1500 parents.

**Recruiting and training  
volunteers**

#### **APPROACHES USED**

The primary goal of CASCADE is to train and support local young people so that they have the knowledge and skills. The training programme delivered is comprehensive and certificates are awarded on completion. Volunteers are paid expenses and those who work in the office are given lunch. Volunteers can be non-users, users and ex-users. For those volunteers aged 16 and over, a police check is carried out so that the agency is aware if there is previous behaviour that might prove detrimental to the success of the programme. To date, no volunteer has been refused on any grounds, including the results of a police check. Volunteers work together in teams to ensure there are enough checks and balances so that they are not providing incorrect information.

Trained peer educators work in small groups led by a peer educator who has considerable experience.

The workshop programme developed is active and interactive, ensuring that individuals participate and learn, but at the same time enjoy the activity. They work in schools and colleges. The workshops take place without a teacher present, however the programme is cleared with a link teacher who is aware of the activity, content, aims and objectives.

**Peer education in schools**

**Resources**

Peer educators also develop leaflets, dramas, videos and resources for young people with special needs. The website launched in 1996, is 80% volunteer written. Two peer educators participating on the Government's New Deal scheme for the unemployed work on the "Mandy and Clare" problem page. The page deals with real problems for young people and is a method of providing confidential support and sharing knowledge with others in relation to drugs.

**Outreach Work**

CASCADE aims to deal with constraints posed by the little time devoted to drugs education in school based settings (usually 40 mins in Personal Social Education PSE classes) by working in hostels and with young people in care. The agency has encouraged schools to have "health days" to allow for a more comprehensive drug awareness input. Ice rinks have also been targeted in an effort to reach out of school populations.

**Work with other agencies**

## **WORK WITH OUTSIDE AGENCIES**

CASCADE is committed to working in partnership with other agencies but independence is also valued. CASCADE is committed to working with agencies needing support to develop appropriate strategies to deal with drugs and drug issues. Schools are encouraged to rethink their policy on drug related exclusions, so that more acceptable and socially responsible alternatives are put in

place. Youth justice agencies are also important partners and it is intended that in future CASCADE will actively involved young offenders in the programme delivery and provide them with appropriate supervision and support.

## EVALUATION

When the programme was originally established on a pilot basis, monitoring and evaluation were seen as key components due to one objective of the programme which was to replicate the success of the programme elsewhere in the UK. CASCADE has also been independently evaluated by the Home Office Central Drugs Co-ordination Unit (1994), the Department of Employment and Education (1995) and in 1996 as part of the British Government's "*Tackling Drugs Together*" strategy.

All evaluations, together with regular internal monitoring and evaluation procedures have found CASCADE to be a valuable programme of drugs education for young people. Whether the programme reduces or stops drug use is not the criterion governing a successful evaluation. Providing accurate information to help young people stay safe is the stated goal and if as a consequence, drug use is reduced, this is considered an added benefit.

**What evaluations reveal**

**The goal:  
Helping young people stay safe**

**Len Mackin  
(Programme Director)  
Nicki Gilbert (Training &  
Youth Development Co-  
ordinator) Website :  
[www.cascade.u-net.com](http://www.cascade.u-net.com)**

**Student Assistant Programmes (SAPs) :**

**An Innovative Approach To Drugs in Bury High Schools**

*Ian Clements and Barbara Jack*

**Agencies involved:** The Programme has been a partnership between all (bar one) Bury High Schools, Bury Local Education Authority (LEA) and The Early Break Drugs Project.

**Timescale:** The SAPs were initiated in 1996-7 and the programmes are ongoing.

**Funding:** The development and implementation of the SAPs were funded through the GEST (now Standards Fund) money made available to LEAs by the Government, for which the LEA had to bid.

**This case study outlines the development of a Student Assistant Programme which has been in operation in Bury since 1996. Bury is part of the greater Manchester region, lying to the north of the city.**

“A Student Assistance Programme is a system involving all the things we need to know, think, feel and do in order to help students deal with all the ways in which they’re affected by their own alcohol/drug use or that of someone else”

Gary L. Anderson, 1988.

**What is an SAP?**

Constant reminders in the press and media tell us that drug use is a growing and complex challenge for society. Ignoring this challenge doesn’t mean that it will simply go away. The DFEE guidance to schools has stimulated considerable positive action in schools, but simple drug policies and “Dealing with Drugs” checklists do not effectively recognise the complexity of drug use by young people. Student Assistance Programmes attempt to open up the issue for debate and ensure that good

practice in pastoral care, employed in all schools, works equally well with drug situations.

”  
**Underlying Principle:  
“Minimising Problems.**

The Students Assistance Programme (SAP) Model for dealing with incidents of drug and alcohol use by school students, was developed in the USA in the 1980s. The idea was adapted from workplace responses to drugs and alcohol that many companies now employ. In Bury, each school interprets the model to fit their own pastoral care system. However, all the programmes work on the underlying principle that early detection of, and intervention with, drug use can help to minimise the many problems that can occur for individual students, their families, friends and, of course, the school.

**How schools can be  
equally tough and  
supportive...**

The SAP has received support from many agencies and has enjoyed a positive response in the local press.

The co-operative nature of the scheme has taken away the element of competition that some schools may fear in feeling that they have to be tougher on drugs than a neighbourhood school. Whilst retaining their autonomy, all schools are equally tough and supportive when responding to drug and alcohol situations.

All schools wish to react strongly to incidents of possession, use or supply of drugs by students at school. Indeed, any breaking of school rules will result in some form of sanction. SAPs do not necessarily alter this in situations where drugs or alcohol may be involved. However, what can be offered, in addition, is support for young people and their parents/carers. Some schools have decided that they will insist that a student receives help and support as a condition of the discipline process, or as a second chance alternative. This may be offered alongside a temporary exclusion, for example.

Drug incidents in Bury schools are still relatively infrequent. Discovery at school, though, is a poor method of finding out whether a student is experiencing drug problems. Many young people will suffer in silence, often unsure of the response if they do pluck up enough courage to seek help in school and share their problem. Equally, some parents and teachers may suspect that behaviour or academic performance are being affected by drug use and may not feel confident in broaching the subject with the individual student. The SAPs support school discipline policies concerning drugs as well as giving a message that although drug use will not be tolerated in school, the school can and will support those who are experiencing problems or who have concerns about drugs.

**Central Principle of SAPs**

### **THE STUDENT ASSISTANCE PROGRAMME MODEL FOR BURY**

**Who is involved in the Student Assistance Team?**

The following model was developed from studying a range of SAPs in the USA, all of which subscribe to a central principle that young people who are using, or who are considering using, both legal and illegal substances, may require information, support and possibly counselling or treatment. Some students will also be affected by the drug and alcohol use of others, including parents. These young people may also require the support provided by a SAP.

Each school will adapt and shape a model of working to suit their own particular circumstances.

### **STUDENT ASSISTANCE TEAM**

This team will usually include several members of the teaching/pastoral staff, school nurse, youth worker, a drug service worker (in this case from the Early Break Drugs Project) and maybe others from the community, which may include parents. Further back-up may be available from the Police,

Educational Welfare Worker, School Nurse, for example.

The team will offer the initial contact with a young person, assess the scale and type of the problem and devise the support and help to be offered.

### **REFERRAL TO THE SAP**

Referral is open to anyone in the school community. A student may wish to refer him/herself, or a student may wish to talk about a friend's use of drugs. As long as there has been no contravention of school rules, as laid out in the school drug policy, there should be no discipline issue here. A teacher may be concerned about a student's behaviour or performance and may wish to refer the student to the SAP. Equally, a parent may suspect or be concerned about their child's involvement with drugs and they could use the resource of the SAP.

<b>Factors considered in assessment.</b>
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### **ASSESSMENT**

When a young person is referred to the SAP, the team will assess the situation and offer an education / support / counselling / information / treatment intervention option to the student. Assessment of drug problems can be a difficult area, especially with young people whose drug use can vary greatly. The assessment scales used nationally and internationally to ascertain levels of addiction do not help with experimental and recreational use. Assessment of drug problems in young people goes far beyond whether they are "addicted" or not. Areas of concern may include drugs used; drug situations; need for drugs; cost; achievement and performance; relationships and any other factors which may be pertinent to that individual in his/her context.



## **SUPPORT, COUNSELLING AND TREATMENT**

After a student has been assessed and agrees with assessment, a programme will be offered to them. The support work could be undertaken by any member of the SAP team, according to their expertise. This can be either in school, at Early Break or maybe at home. In some cases a student may require a medical intervention. In such cases, support will still be forthcoming from the SAP team.

Most situations do not require long term action but some may need more in-depth support. The SAP team will review work regularly and provide information for the Head teacher, the form of which will differ from school to school according to requirements. Issues surrounding confidentiality and recording are obviously considered.

## **TRAINING**

Members of the SAP teams receive specialist training and supervision. Other members of the teaching staff in school require information about the SAP scheme and its aims, as well as how to use it. Students are also informed about the SAP and are given the opportunity to discuss any fears or concerns. This tends to be covered in PSHE/tutorial sessions.

Young people are hardest to convince that the SAP is designed to help them. They may be suspicious about motives and how any disclosure may be used in the future.

Parents and Governors are informed and Parents' Evenings, letters home and mentioning the SAP in school drug policies, all help this. Many parents do see this as a positive approach by schools as more parents are becoming concerned that their child could become involved with drug use. Just because

**Convincing young people that SAP is designed to help them.**

**How parents view this approach.**

the school has a drug policy and a SAP does not mean that the school has a “drugs problem”. Positive approaches to discipline and bullying, for example, show that the school is caring and proactive, and this can be used as positive marketing, rather than suggesting that the school has “problems.”

**A school drug policy does not mean a school has a “drugs problem.”**

**For further details, please contact:**

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## **Chapter 4**

# **Preparing to Adopt A Harm Reduction Strategy**

*Elizabeth Kiely*

A good starting point for any organisation engaged in drugs work with young people is to carry out a curriculum audit, documenting the entire range of provision of drug education to young people in the organisation. Organisations are now very strongly advised to evaluate different aspects of their work and if this is not happening, some of the following questions could be asked, to critically review the current strategies as employed by the organisation.

### **Curriculum Audit**

What are the different elements of the existing range of drug education provision?

What is included in the programme content?

What approaches are being used?

How are these approaches effective / How are they ineffective?

What resources are being used ?

Who are the target groups?

How are the different approaches meeting the needs of the different target groups?

What is the place of drugs education within the overall health education programme of the organisation?

Who is involved in the delivery of the provision and what training have they received?

Identify strengths and weaknesses of the current provision?

Source : National Youth Health Programme (1996) Youth Work Support Pack for Dealing With The Drugs Issue.

At this stage, the critical review might mean that the organisational staff are satisfied that they are using resources effectively and that the current provisions are meeting the needs of their target groups. Some organisations may feel that there are gaps in provision, that the strategies being used are not realistic, that they are unsuccessful or that they need to focus their energies at another target group. If organisations come to the conclusion after the curriculum audit that a harm reduction approach might be necessary, then the following characteristics of harm reduction adapted from a list outlined by Riley and O' Hare (2000) and the checklist adapted from the Youth Work Support Pack (National Youth Health Programme, 1996) may be of some value.

**Characteristics of Harm Reduction** (Riley & O' Hare, 2000)

**Pragmatism** : The containment and amelioration of drug related harms are considered be more pragmatic or feasible options than efforts to eliminate drug use entirely.

**Humanistic Values:** Avoid making moralistic judgements either condemning or supporting an individual's use of drugs or mode of intake. The dignity and rights of the drug user should be respected in the harm reduction strategy adopted.

**Focus on Harms:** Of primary importance is the risk of harms consequent to a person's drug use, of secondary importance is the fact or extent of the person's drug use. The harms to be addressed could be individual, community based or societal. In prioritising harms to be addressed, scientific, political, moral, cultural and other factors are brought to bear and this makes agreement difficult. The inherent danger is that societal harms are sidelined in favour of a focus confined to the individual or to the local community.

**Balancing Costs/Benefits** : Identify, measure and assess the relative importance of drug -related problems, their associate harms and the costs/benefits of intervention. This information is important for focusing on resource issues and for evaluating the impact of the intervention on the reduction of harms, in both the short term and in the long term.

**Hierarchy of Goals :** Establish a hierarchy of goals so that the most immediate and realistic goals can be identified and addressed. This is the first step toward achieving risk free use.

### Checklist



- Define and name the harm reduction strategy being used.
- Define and identify the target group or groups for which the harm reduction strategy is being planned;

*The target group may be one of the following; drug users, non-drug users, inexperienced drug misusers, experienced drug misusers. The target group may also be club owners/managers, local Gardai, other agencies, school personnel.....*

- Assess the needs of the target group;

*Information and awareness of the ways of reducing the risks and harms associated with drugs and their use; What to do in the event of a drug related incident at school so as not to aggravate problems associated with drug use/misuse; Individuals affected by other people's use or misuse of substances may need information and support.*

- Develop clear aims and objectives for the approach - these should relate to the goal

*The goal in this instance is to reduce harm.*

*Is the aim to increase knowledge in relation to the risks and harms associated with using drugs as a whole?*

*Is the aim to increase knowledge in relation to the risks and harms associated with using specific drugs?*

*Is the aim to change drug users behaviours, to reduce harms associated with their use of substances?*

*Is the aim to change organisational practices or to influence other organisations, to change their practices because they are serving to compound the problems associated with drug use or drug related incidents?*

- Agree on the stages needed for the strategy

*Example*

<i>Stage 1</i>	<i>Meetings and Discussion among those involved in relation to proposed strategy</i>
<i>Stage 2</i>	<i>Planning of Training Needed</i>
<i>Stage 3</i>	<i>Training Programme Implementation</i>
<i>Stage 4</i>	<i>Strategy Design and Pilot</i>
<i>Stage 5</i>	<i>Strategy Implementation</i>
<i>Stage 6</i>	<i>Review and Evaluation</i>

- Evaluate the resources available to implement the strategy  
*What human resources are available?*  
*What financial resources are available?*  
*What time frame is needed to implement the strategy?*  
*How will all the resources be used?*
- Plan, develop and implement an appropriate training and support system for those involved in the implementation of the strategy.

*This will necessitate discussion with people involved in implementing the strategy to allow them to identify their training needs and to become more acquainted with the values underpinning the strategy.*

- Establish an evaluation design.

*A small pilot study will be required before general implementation to ensure the strategy is appropriate for the target group. An evaluative framework should be built into the strategy, when it is being designed. This method might have two components; a process evaluation documenting how the strategy was implemented and experiences of the process involved; a summative evaluation examining outcomes of the strategy in the context of the objectives outlined. For the process component of the evaluation, an ongoing monitoring and recording system at the different stages of the implementation of the intervention, should be put in place. Clear objectives and a set of performance indicators should be put in place at the design stage to carry out both the process and summative components of the evaluation. Performance indicators are measures used to investigate how much progress has been made toward meeting the defined aims and objectives. For further*

*guidelines on the practicalities of evaluating drug prevention initiatives, consult the manual 'Guidelines for the evaluation of drug prevention' by the E.M.C.D.D.A. 1998.*

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