EMCDDA FINAL REPORT

Outreach work among drug users in Europe: Concepts, practice and terminology

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Executive summary

Outreach work has gone through substantial changes over the past few decades. Both in the history and in the current practice of outreach work, we can observe similarities and differences between the countries of the European Union. Broadly speaking, there has been a gradual shift in focus from the poor in general, to the youthful poor, to flower-power youth, and then to drug users. Subsequently, in the wake of the HIV epidemic, emphasis has shifted further to ‘hidden drug users’. The most recent developments lie in the targeting of users of the so-called ‘new’ or synthetic drugs, such as ecstasy. The latter such efforts are still in their infancy, however, and the predominant focus of outreaching activities remains on the users of ‘old’ drugs, chiefly heroin and cocaine.

Throughout the EU, four general aims of drugs outreach work have been defined at national policy levels: (i) to identify and contact hidden populations; (ii) to refer members of these populations to existing care services; (iii) to initiate activities aimed at prevention and at demand reduction; and (iv) to promote safer sex and safer drug use. A further aim, defined in national policy in only a few countries, is to identify the needs and perceptions that drug users have with respect to existing drug care services, and to relay this information to those services as feedback. This emerging task of outreach provides food for further thought, because such information could greatly enhance the effectiveness and co-ordination of drug care services. Of the three working methods we distinguish in this report – detached, domiciliary and peripatetic – detached outreach work is by far the most common.

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

Three types of workers are active in the field of outreach work: professionals, peers and volunteers. In the light of the ongoing process of professionalisation in outreach work, the involvement of peers and volunteers is of crucial value for keeping in touch with the target groups. However, the inclusion of peers (who are current or former drug users) often gives rise to controversy, not so much in theory but in operational practice. Such conflicts are more likely to arise in relation to ‘old’ drugs than ‘new’ drugs.

Four models of outreach work can be distinguished. The Youth Work Model is the oldest in Europe. Since the 1960s, youth workers have been emerging from their offices and actively seeking contact with ‘problem youth’. Characteristically, their aim is to stand beside the young people to seek solutions to their problems, rather than deciding behind their desks what they feel is best for the youth. The goal here is to prevent any further marginalisation and to encourage social integration. The Catching Clients Model has its roots in the early to mid-1970s, and it originated in the therapeutic communities. The primary aim is to draw drug users into care programmes, and in particular into drug-free, inpatient treatment. Abstinence, followed by social reintegration, is the ultimate goal.

The Self-help Model, like the original youth work model, responds to the wishes and possibilities of the drug users themselves. It focuses more explicitly on drugs than the youth work model, and its actions are based more on the perceived interests of the group than on those of the individual.
Originating in the late 1970s, it has clear links to the drug users’ self-organisations, as well as to the idea of acceptance of drug-taking as a social reality. The Public Health Model is built on the self-help model, the main difference being that it assigns a more important role to professionals. This model came into its own in the mid- to late 1980s, notably under the influence of HIV and Aids. The primary aim here is harm reduction through safer drug use and safer sex. More recently, outreach work along the lines of the public health model is also being practised among users of ‘new’ drugs. More than in the case of ‘old’ drugs, peers are recruited for such initiatives.

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

National overviews reveal many similarities and differences in national policies and practices. Also with regard to terminology there are both differences and similarities. One crucial difficulty at present is that the term ‘outreach’ itself is scarcely known, much less used, in most countries among the people who do the work. People outside the UK normally use terms such as ‘street work’.

Outreach projects report on their aims and their work activities in different formats depending on the audiences they are addressing. Reports are usually designed for funding agencies, policymakers or the larger organisation of which the outreach is a part. It is common practice in most outreach projects to collect at least some basic data about their activities and the target groups. However, few standardised guidelines exist, even at local or regional levels, let alone at national or European levels. Meanwhile, such quantitative types of data collection are perceived by many workers as far from ideal.

The need for evaluation is widely recognised, both within individual outreach projects and at regional, national or European levels. Three types of evaluation methods are discussed in this report: structural, process and outcome evaluations. Process evaluation appears to be the most frequently applied. Yet the evaluation of outreach projects is still in its infancy in many countries. Data collection and evaluation instruments are often invented ad hoc and are specifically geared to certain projects, making comparison of different projects on a nation-wide or European basis a very difficult task. The current EDDRA questionnaire could serve as a prototype, although it should preferably be revised in a number of ways to make it more suitable for evaluating outreach practice.

In the final analysis, however, given the unique nature of outreach work and the widely divergent state of the art, the most urgent needs of the outreach projects themselves at the present juncture seem to lie in improvements to the actual practice of outreach work.

Some ways to achieve this would be to formulate working standards and methods, to create training facilities, to strengthen inter-organisational working relations, and to develop methods for the recruitment of peers and volunteers.