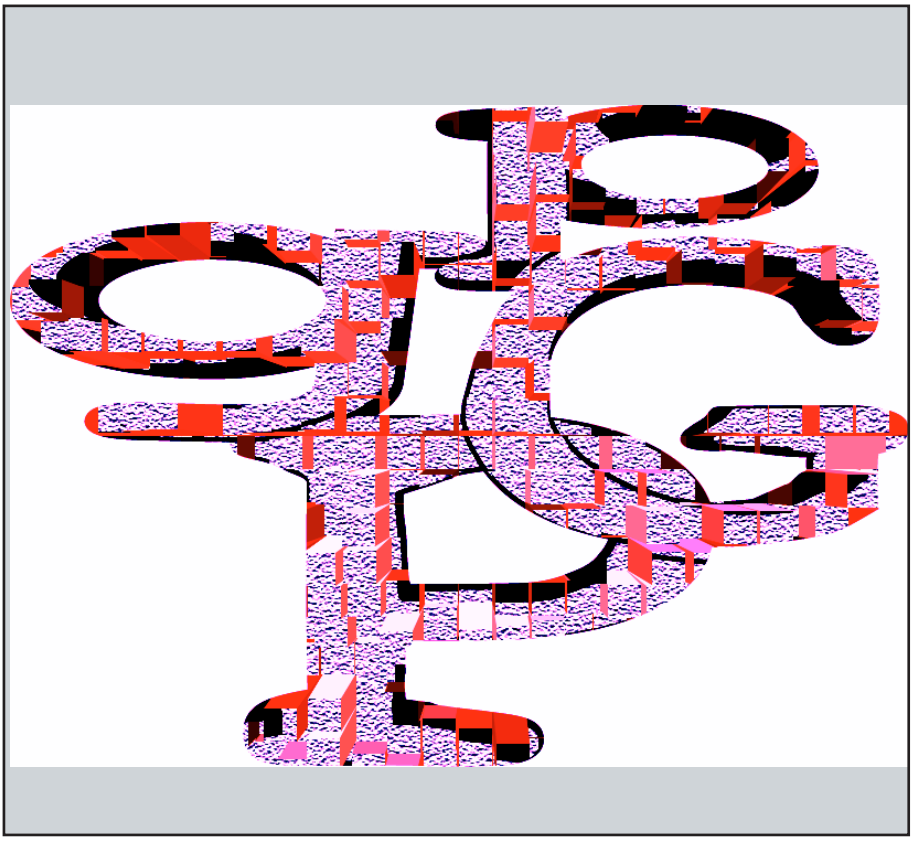
Drugs and addiction



Risk Reduction Linked to the Use of Substances other than by Injection

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RISK REDUCTION LINKED TO THE USE OF SUBSTANCES OTHER THAN BY INJECTION

p r o c e e d i n g s

Seminar organised by
the Co-operation Group to Combat Drug Abuse
and Illicit Trafficking in Drugs
(Pompidou Group)

Strasbourg (France), 21-22 February 2002

Drugs and addiction

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The Pompidou Group

The Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (Pompidou Group) is an inter-governmental body formed in 1971. Since 1980 it has carried out its activities within the framework of the Council of Europe. It provides a multidisciplinary forum at the wider European level where it is possible for policy-makers, professionals and experts to discuss the exchange information and ideas on the whole range of drug misuse and trafficking problems. Its current work programme includes the promotion of global drug strategies at national, regional and local level; the improvement of data collection systems in Europe; the stimulation of transfer of knowledge and experience between the relevant administrations and professional groups in Europe on issues, policies and programmes for drug demand reduction; the promotion of effective implementation at European level of international drug control treaties and the improvement of cross-border collaboration against trafficking.

Foreword

The seminar on “Risk reduction linked to substance use other than by injection”, organised by the Pompidou Group as part of its work programme for 2000-2003, was held in Strasbourg on 21 and 22 February 2002. It was attended by participants from twenty-one countries.

In order to attract participants from a variety of disciplines, the seminar was aimed not only at policy-makers or their representatives, but also at professionals working at grass roots level in the various fields of risk reduction and involved in specific risk-reduction programmes. Over the course of the two days, the seminar was chaired in turn by Mr Patrick Sansoy (France), Ms Mari Jarvelaid (Estonia), Ms Bernard Vandenbosch (Belgium) and Mr Milan Krek (Slovenia). Mr Krek was also the general rapporteur. The programme and list of participants are set out in the appendix.

This publication was produced at the seminar. It contains a preliminary report (a review of research articles on this topic), drafted by Mr Wouter de Jong (Netherlands), and the texts of the papers presented at the seminar.

Preliminary report

Introduction

On request of the Pompidou Group a literature search and review has been conducted on experiences and examples of risk reduction policies in Europe.

Data collection and review of the data took place between June and August 2001. The findings of the review are presented in this report.
The report is meant as a resource for further critical discussion about the relevance and impact of risk reduction interventions, which will take place at a meeting with members of the Pompidou Group later this year. As was agreed on beforehand the author has tried to withhold himself from drawing conclusions or making evaluative statements regarding risk reduction interventions.

Method

In order to identify and select literature and documentation for the review, a search strategy was agreed upon. It was decided that the search would have a broad scope: included are risk reduction interventions in all member states of the European Council regarding a variety of substances, including alcohol, tobacco, heroin, ecstasy, cocaine, marihuana and volatile substances. both licit (alcohol, tobacco) and illicit substances. In the light of the available resources and time for conducting the review, it was also agreed to limit the search to examples and research published in English since 1996, as well as to publications written in French but with an abstract written in English. Three different online databases would be used for conducting the search.

Sources

The online databases in which the search has been undertaken are MEDLINE, PsycINFO and EDDRA.

MEDLINE is a bibliographic database of the National Library on Medicine (NLM) in the USA, covering various fields including medicine, nursing, the health care system, and the preclinical sciences. MEDLINE contains bibliographic citations and author abstracts from more than 4,000 biomedical journals published in the United States and 70 other countries. The file contains over 11 million citations dating back to the mid sixties. Coverage is worldwide, but most records are from English-language sources or have English abstracts.

PsycINFO is a large database from the American Psychological Association, which contains abstracts and indexing for 1,500 journals.

EDDRA is the online database of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) on demand reduction interventions within the European Union. Inclusion of interventions in the database is managed by EDDRA national coordinators. Information on interventions, including, is collected and described in a standardised format. Though not exclusively, the primary focus of EDDRA is on illicit drugs. Included in EDDRA is information on evaluation outcomes, however, it appears that most interventions within EDDRA either are not evaluated or provide only limited information on evaluation outcomes.

Search strategy and terms

In PsycINFO en MEDLINE four sets of searches have been conducted (see box)

Box: search strategy PsycINFO and MEDLINE

Set 1. Authors address (i.e. 'Sweden' or 'Denmark' or 'Finland' or 'Poland' or …. (etc.)
Set 2. Free text on type of intervention: 'Harm Reduction' or 'Harm Minimization' or 'Risk Reduction' or 'Risk Minimization' or 'Demand Reduction' or 'Maintenance Therapy' or 'Methadone Maintenance' or 'Intervention*' or 'Policy' or 'Prevent*'.
Set 3.Free text on type of substance use: Alcohol use or Alcohol Abuse or Alcoholism or Alcohol Drinking Attitudes or Alcohol Intoxication or Tobacco Smoking or Smoking Cessation or Drug Use or Drug Abuse or Substance Abuse or Amphetamine or Methamphetamine or Cannabis or Marihuana or Hashish or Ecstasy or MDMA or Cocaïne or Crack or Heroin or Intravenous Drug Usage or Volatile Substance*
Set 4: Set 1 AND Set 2 AND Set 3

In EDDRA, which is a much smaller database, we used a wide variety of search terms, through which we must have scanned almost the complete database.

Selection of publications

Publications included in the review have been identified through a stepped selection process.

The first searches resulted in long lists of publication titles. Through title reading and deciding on relevance for the review most titles could be skipped, which left a list with 339 titles and abstracts with potential inclusion relevance. Through abstract reading a further selection of titles could be made. For example, effect evaluation studies are included when control groups or a longitudinal design was used in the study design. In general NOT selected for inclusion are: publications on cross sectional surveys without control groups; general prevalence and incidence studies which claim to indicate effect of generalised harm

reduction policies; studies on patient retention in certain programmes; studies on health effects among HIV infected drug users before introduction of multiple drug therapies; studies in which relations between reduced substance use and reduction of risks are measured without specifying the type of intervention(s) which is responsible for the effect.

A number of selected abstracts did not provide sufficient information on the contents; in most of the cases the full articles were requested and could be obtained.

The next step was to categorise all selected titles as research, intervention or review publications, code the publications and systematically summarise them within data grids.

In addition to the search within the online databases, a brief search was conducted to identify and collect possible relevant reports from international organisations, such as WHO Europe, the European Union and EMCDDA, which resulted in 5 additional reports and publications to be included in the review (REV 09-13).

The search and selection procedure has finally resulted in a selection of 77 relevant publications (abstracts, full text articles and reports), including 30 intervention oriented publications (coded INT**), 33 research publications (RES**) and 14 reviews (REV**). The data grid with the coded and summarised publications, which forms the basis of the review, is enclosed as ANNEX to this report

Limitations of the method

This review should not and cannot be considered as a full assessment of all risk reduction interventions which take place in the member states of the Council of Europe. First of all, a lot of possible relevant interventions are probably not published.

For example, in the city of Rotterdam in the Netherlands there are currently about 80 distinct interventions targeted on illicit drugs, which are being implemented by health and addiction care organisations. More than half of these interventions can be defined as risk reduction interventions. Except for one intervention (heroin substitution treatment) none of the other interventions could be traced back as publications within the databases we used for the literature search.

A second reason for not considering this review as a representative overview of risk reduction activities is the decision to select only publications in English (or French provided that the abstract is in English). It is obvious that interventions in some countries are over

represented while others are underrepresented. For example, during the search we came across a number of titles and abstracts from Italian and Spanish authors. However, some of the abstracts could not be included in the review because on the one hand the provided information was to limited while on the other hand the full text of the abstracts could not be read because it was written in the mother tongues of the authors.

Before going into the findings of the review we first reflect on the conceptualisation of risk reduction.

Risk reduction defined

A characteristic of the international discourse on alcohol, tobacco and other psycho-active substances is that there is no uniform use of terminology. For example, one can find in English publications a variety of terms for people who consume a certain substance and who are the subject of the publication, such as: drug abuser, drug misusers, drug user, substance user, user of psychoactive substances or drug addict.

Quite often one is not very specific about who is meant. Different terms may be used for the same population or sometimes the same terms are used when different populations are meant. Not seldom it is up to the reader to make a guess to what or whom the author is pointing at.

Also risk reduction is not a term which is used in a uniform way. Different people may understand different things under risk reduction. Having a fully drug-free society will certainly reduce (or even eliminate) risks from drug consumption, the question than is what makes risk reduction different from supply reduction, demand reduction or harm reduction approaches. In order to define the scope of the review more precisely, the first exercise is than to define the concept risk reduction.

According to the United Nations Drug Control Programme risk reduction is related to the concept of harm reduction. Risk reduction is described as “policies or programmes that focus on reducing the risk of harm from alcohol or other drugs” (UNDCP Demand Reduction Glossary). In this definition risk reduction is a means to realise reduction of harm. Harm reduction or harm minimization is described as “policies or programmes that focus directly on reducing the harm resulting from the use of alcohol or other drugs, …. without necessarily requiring abstinence”. In EDDRA, the online database from EMCDDA, harm reduction is defined as : “Any activity aimed at stopping harmful consumption practices or decreasing drug-related social and health problems or death. It does not envisage a drug-free status or reintegration of the users.”

For researchers the concept risk reduction may have a practical advantage over harm reduction, for example when risk reduction outcomes (such as reduced needle sharing) are easier to measure than harm reduction outcomes (in this case reduction of HIV incidence). In the field of policy and implementation, it is our impression that the use of the terms risk or harm reduction is not based on a precise understanding of definitions, so for the purpose of this literature search it is not considered to be useful to differentiate between risk and harm reduction programmes.

In a broad definition of risk or harm reduction, abstinence-oriented programmes can be considered as harm reducing if they can be shown to reduce drug related harm. The more commonly used narrow definition refers to interventions which are aimed to influence the use of drugs among current users, with a focus of reducing risk behaviours and harmful effects from drug use, without requiring abstinence from drugs. Within the framework of this review the latter (narrow) definition of risk reduction is used, which means that not requiring abstinence has been the major criterion for including published interventions within the review. This also includes interventions which are defined as harm reduction, harm minimization and risk minimization.

RESULTS

General Results

As we can see in the table below, the interventions covered in the selected intervention and research publications are not equally distributed over the European region. More than half of the 63 research and intervention publications refer to interventions in 5 countries: the Netherlands (13), the United Kingdom (6), France (6), Germany (5) and Switzerland (5).

Most of the interventions within the selected publications are targeted on risks from use of single substances: tobacco, alcohol and illicit drugs. In only one publication the described intervention is explicitly targeted at a mixed population of licit and illicit substance users. The large majority of the research and intervention publications (52 out of 63) is dealing with interventions targeted at users of illicit drugs.

Table : Intervention and research publications coverage by country and by substance

COUNTRY	*TOBACCO*	*ALCOHOL*	*ILLICIT DRUGS*		*TOTAL*
			Heroin	*X, others*	
Austria	*1*		*3*		*4*
Belgium			*3*		*3*
Denmark		*1*			*1*
Finland		*1*			*1*
France			*6*		*6*
Germany		*1*	*3*	*1*	*5*
Greece			*1*		*1*
Ireland			*3*		*3*
Italy		*1*	*3*	*1*	*5*
Luxembourg			*1*		*1*
Netherlands		*1*	*8*	*4*	*13*
Norway	*2*				*2*
Spain	*1*		*2*		*4*
Sweden		*1*	*2*		*3*
Switzerland			*5*		*5*
U.K.			*3*	*3*	*6*
Total	*4*	*7*	*43*	*9*	*63*

A number of member states of the European Council are not represented in the intervention and research publications. No publications were identified from Bulgaria, Croatia, Cyprus, Czech Republic, Estonia, Hungary, Liechtenstein, Malta, Poland, Russian Federation, San Marino, Slovak Republic, Slovenia and Turkey.

The under representation of interventions in these countries is partly corrected by making use of documentation (reviews, state of the art reports, action programmes from international organisations), which provides additional information on risk reduction programmes in the European region; especially reports from WHO Europe and the annual report on the state of the drug problem in the European Union from EMCDDA proved to be valuable in this respect.

Besides, as can be seen in the table below, the review publications also provide more balanced information regarding the different substances.

Table: review publications (14) coverage per substance

	Tobacco	*Alcohol*	*Illicit drugs*	
			Heroin	*Xtc,other*
Review publications	7	4	6	2

Tobacco

Smoking is bad for your health, which hardly will need further argumentation. Smoking-related harm include mortality due to cardiovascular disease and lung cancer, which are highly prevalent diseases in Europe. Especially tar and carbon monoxide and toxic combustion products in tobacco smoke can cause tobacco-related disease. There is some evidence that nicotine, besides its potential for physical dependency, is in itself is non-toxic.

As the level of smoking related mortality is to a large extend mirrored by the level of smoking among the population, not surprisingly many countries in Europe have developed tobacco control policies with the aim to reduce the demand for tobacco.

Risk reduction is not a commonly used approach in the field of tobacco control policy. The major approach of national and international policy bodies is oriented at cessation of smoking. The ultimate aim is a smoke-free society. However, looking into the generally applied policy instruments of tobacco control policies, specific measures and programmes can be considered as basically risk reductionism, aimed to regulate smoking behaviours without pressing for abstinence. Risk reduction measures include the control of harmful substances in tobacco (tar and nicotine levels), regulations on smoke-free environments and the provision of Nicotine Replacement Therapy (NRT).

WHO is a leading international organization in developing tobacco control strategies and promoting interventions (i.e. The health for all policy framework for the WHO European region and WHO (WHO 1998) and the Third Action plan for a Tobacco-free Europe (1997 – 2001), in which 5 key strategies are laid out: regulation of the market, litigation and product liability, smoke free environments, support for smoking cessation and education, public information and mobilising public opinion. the focus is on reducing the harm done by tobacco. In order to

promote implementation of the Action plan within Europe WHO has initiated the WHO European Partnership Project on Tobacco Dependence, with the objective of reducing tobacco related death and disease among tobacco dependent smokers. Initial target countries for the programme are the U.K., France, Poland and Germany. Though most efforts are aimed at cessation of smoking WHO is also supportive for efforts which are aimed at reduction of cigarette smoking among dependent smokers, i.e. through use of nicotine replacement products.

Most membership countries of the Council of Europe have regulations regarding tar/nicotine levels and smoke-free environments, which are aimed at protecting non-smokers. In western European countries there are generally more regulations than countries in central and eastern Europe.

In most European countries nicotine replacement products or therapy (NRT) can be provided (such as patches, chewing gum, inhaler), often under strict regulations. In some countries you need prescription for NRT, in others over the counter sale is permitted but restricted to pharmacies. According to one author, risk reduction through NRT would benefit from a wider access to NRT. Denmark is the first country where the regulatory authorities have granted approval for smokers to use nicotine replacements products concomitantly while continuing to smoke fewer cigarettes (REV04).

In the literature search 11 relevant papers were identified, which refer to tobacco risk reduction programmes; 3 research articles (including two international literature reviews), 1 descriptive intervention article and 7 review articles.

The most significant effect on reduction of daily cigarette smoking is found in a well designed study (double-blind, placebo-controlled, randomised) on the effect of Nicotine Replacement Therapy (REV07). In the trials at Basel University significant reduction levels were found in experimental NRT groups, compared to control groups. Bolliger c.s. conclude that smoking reduction is a legitimate goal when cessation is not feasible (REV07). Also effect was found from a smoking prevention programme among students of a secondary school (RES17). Less effective appeared to be a self-help intervention (RES15) and an hypnosis therapy which was tested on pregnant women who smoke cigarettes (RES20).

In one of the review articles it is concluded that behaviour therapy and nicotine replacement therapy have the highest chances for success in smoking reduction (REV01). One other conclusion is that there is no indication that smoking reduction programmes undermine programmes which are aimed at cessation of smoking. In the other review article an

assessment was made of the effect of programmes which are aimed to prevent exposure to tobacco smoke among small children. The review shows, according to the author, that a decisive factor for success of these programmes is the focus on and succeeding in strengthening the parents faith in their ability to create a smoke-free environment (REV05).

Most authors in this section point out that there is a case for smoking reduction programmes, complementary to abstinence oriented measures and programmes.

In one article (REV04) the arguments for smoking reduction programmes are summarised as follows:

- smoking cessation programmes have only moderate success
- smoking cessation tends to aid low-dependent smokers who can quit easily, thereby increasing the relative proportion of high dependent smokers who are unable to quit abruptly in the smoking population.
- Based on a dose-response relationship for many tobacco-related diseases it is assumed that reduction of smoking reduces risks

Also Hughes claims that smoking reduction programmes work, though the assumption that smoking reduction is also beneficial for ones health still has to be proven. According to the author behaviour therapy and nicotine replacement therapy are the most promising risk reduction methods. (REV01)

There are number of behavioural changes among smokers that can lead to effective smoking reduction, including through short term periods of abstinence (voluntary or enforced), reductions in cigarette consumption and reductions in smoke intake from cigarettes through less intensive smoking of singular cigarettes.

Use of NRT can support smokers to change their smoking patterns.

The full range of possible uses of NRT is (REV04):

- control of withdrawal during cessation (symptom relief)
- aiding smoking cessation (primary and secondary prevention)
- aiding smoking reduction (primary or secondary prevention)

Alcohol

In the European region alcohol is the most popular psychoactive substance. The vast majority of the people enjoy alcohol; for its effect, for its taste or for the ritual in celebrations and festivities. In the same time alcohol causes serious harm for large numbers of people, including early death. Alcohol related harm includes (fatal) diseases such as chronic liver disease, cirrhosis and alcohol psychosis, and is also related to injury and poisoning, road accidents, violence, child abuse and neglect and family crisis.

The incidence of some forms of alcohol related harm within societies, such as cirrhosis, appears to be closely related to the average level of alcohol consumption per capita. The highest levels of chronic liver disease and cirrhoses as well as alcohol consumption are found in central and eastern Europe. Other forms of alcohol related harm are less obviously related to consumption levels. For example, in 1992 was the death rate caused by road accidents in which alcohol was involved higher in Sweden than in Spain (12,0 versus 10,6 deaths per 100.000 population), while per capita alcohol consumption in Sweden in this period was half of the amount which one would drink in Spain (5,5 litre versus 11,0 litre per capita in 1991). It is obvious that other factors, such as drinking patterns, traffic situation and general driving behaviour also influence the level of alcohol related harm.

Alcohol control policies in the European region form a mix of supply, demand and harm or risk reduction interventions. More than any other policy regarding substances the approach is most countries is focused on reducing the harm of drinking. While drug and tobacco free societies are often mentioned as an ultimate aim, this is seldom the aim of alcohol policies. Also the from WHO explicitly aims to reduce the harm caused by alcohol (REV12). Nevertheless, primary prevention and demand reduction interventions (such as mass media campaigns, school based prevention, taxation and bans on advertisement) do form a substantial part of the implemented policies, based on the assumption that reduction of demand will generally lead to reduction of alcohol related harm. Generally applied interventions in the European region, which can be considered more or less as harm or risk reduction oriented are drinking and driving legislation (limitations on the permitted blood-alcohol concentration while driving), promoting alcohol-free environments (especially in schools, workplace and transport), restrictions on sale (opening hours and days of sale, types and locations of outlets), age limits (minimum age is most frequently 18 years old) and limits set on the maximum alcohol content of beverages.

Regulations vary between countries. Regulations regarding drinking and driving are generally more strict in Central and Eastern Europe than in

Western European countries. On the other hand, the restrictions on sale and limitations regarding alcohol content are generally more strict in Western Europe compared to Central and Eastern Europe. Not mentioned in this overview is the availability of treatment for problem drinkers in the various countries in the European region. Though it is believed that in most countries alcohol related treatment is available, we did not come across information which provides an overview of available treatment aims and modalities in the region.

In the literature search 7 articles were selected: 5 research articles and 2 review article. Five out of six research articles report about the evaluation of non-abstinence oriented brief interventions for problem drinkers, including a phone assisted self-monitoring and self-management programme (RES04), 3 programmes in a primary health care setting (RES14; RES18; RES19) and correctional driving-and-drinking training courses (RES30). In the other research article a comparison is made of different strategies with which general practitioners can be activated to conduct brief alcohol related interventions (RES16). The outcomes of these studies are neither positive nor negative. In the primary health care programmes, drinking behaviours generally improved, but no significant differences were found with behavioural changes in the control groups. In the phone-assisted programme, a positive effect was found on compliance, but no information is given on changes in drink behaviours among participants in the programme. Regarding the best strategy to approach GPs (in Denmark) chances of success to get GPs involved are highest when they are approached through the academic detailing; contact through telephone and direct mail appeared to be less successful (RES16).

In one review article the use and efficacy of anti-craving drugs was assessed (REV14). In contrast to the availability of substitution drugs for substances as heroin and tobacco, such a ‘magic’ drug which would substitute for alcohol and prevent alcohol craving, is not available yet.

However, drug research in the field of alcohol dependence does not look for substitution drugs, but seems to have a main interest in identifying pharmaceutical drugs which would decrease the desire to drink among alcohol dependent persons (which is not the same as drugs that could replace alcohol without leading to withdrawal symptoms). It appears that basic understanding of craving mechanism among alcohol dependent persons is still limited. Complicating factor is that effects of anti-craving (substitution) dugs are not easy to measure and compare, because different subtypes of alcoholism influence the intensity of alcohol craving. The best studies in this still experimental field, according to the author, are conducted among rats. A number of (mostly small scale) studies have been conducted among alcohol dependent human beings. Some preliminary positive results are found

(reduction of craving and alcohol drinking), among others with the drugs zimetidine, fluoxetine and citalopram; drugs which correct the limited serotonin uptake in the brain of alcohol dependent persons.

Conclusions on the efficacy of these drugs cannot be made yet; according to the author new bigger scale studies with better designs are needed to confirm these preliminary findings. Also, more research is needed on side effects and longer term effects of these drugs, as well as on applicability in

Illicit drugs

Risk or harm reduction interventions for illicit drug users have gradually spread all over Europe since the early eighties. Concerns for public health, related to the spread of HIV and hepatitis among injecting drug users, but also increasing public order problems in bigger cities in some of the Western European countries, has led governments to develop interventions and adopt programmes which primary aim is to reduce drug related harm. While two decades ago non-abstinence oriented approaches towards illicit drug use was still highly controversial and limited to specific interventions in the United Kingdom and the Netherlands (like substitution treatment and needle exchange programmes), the available risk reduction interventions have become more varied and practiced in more countries in Europe.

In spite of the increased variety in risk reduction interventions, most interventions are targeted at the more problematic and marginalized users of opiates. Substitution treatment and needle exchange programmes are still the most widely practiced interventions. Also other examples of risk reduction programmes are often targeted at heroin users, such as needle exchange programmes (RES29, RES31, INT28), safe drug use training and educational programmes, drug consumption facilities (REV04), the provision of filters to drug injectors (RES28), housing programmes for homeless drug users, hiv-testing (INT27) and hepatitis vaccination programmes. The interest to publish on risk reduction interventions targeted at users of cocaine (RES32), cannabis (INT06) and amphetamines (INT21) appears to be much more limited.

We did not find any publications on interventions targeted at users of substances as LSD, volatile substances, mushrooms and the so-called ‘smart drugs’.

Most described interventions provide information and education to drug users, often combined with outreach work and additional counselling, skill training and provision of harm reduction means (especially syringes and condoms, when the aim is reduction of HIV infection risks). The more comprehensive programmes, such as the low threshold

programmes in Italy and Ireland, also provide day care (i.e. a drop-in centre), substitution maintenance treatment, basic health care, social support (i.e. housing, jobs), psychological support, referral to higher threshold services and support for parents of drug addicts (INT12, INT13, INT14, INT19, INT26). It is not clear what the effect is of these low threshold facilities with multiple interventions, as evaluation studies are lacking. The same is true for outreaching interventions; assessments of the effect of outreach work are lacking.

Substitution drugs

The most widely described and evaluated intervention is the provision of substitution drugs to addicted heroin users. There exists a variety of substitution programmes with different substitution drugs, target groups and settings. Programmes have been evaluated in a number of countries. Substituted drugs include methadone, buprenorphine, codeine, morphine and heroin.

Many programmes have not well defined target populations, such as the programmes which are integrated within the low-threshold services and the provision of substitution drugs by general practitioners (RES09, REV03). Some studies and programmes have specifically defined target groups, such as pregnant women drug users (RES05, RES08), HIV infected drug users (RES26) and imprisoned drug users (REV06).

Overall, the studies on substitution programmes suggest a positive outcome for the drug users who receive substitution drugs. The programmes have resulted in a reduction of drug related harm on various indicators, such as reduction of overdoses (RES06, RES24), HIV incidence (RES04) and risk behaviours (RES03, RES13, RES25) as well as improvements in quality of life (RES11) and social functioning (RES03, RES12). Less obvious are the outcomes from studies in which differences in effect between substitution drugs are assessed, such as methadone and buprenorphine (RES01, RES02, RES05, RES25), methadone and morphine (RES08), methadone and codeine (RES10), methadone and prescribed heroin (RES12, RES23). Also outcomes from differences in dosing of methadone have been assessed; the studies indicate an improved effect from higher dosages of methadone on reduction of injecting frequency and HIV-incidence (RES24, RES26, RES27).

From the research data one cannot point out a ‘super’ substitution drug for heroin addicted drug users. All substitutes seem to have their own distinct advantages and disadvantages. Dependent on the target group and the specific aims one has with the substitution programme one may opt for a certain type, setting and implementation procedure for the provision of the drug.

Ecstasy: risk reduction at dance parties:

Relatively new are risk reduction interventions which are targeted at ecstasy users. In reviewed publications Ecstasy oriented interventions are described. The interventions are implemented in Germany (INT29), the Netherlands (INT02, INT29, INT30), the UK (INT04, INT29) and Italy (INT24). Providing information, counselling and doing outreach work at dance parties and in bars and discotheques are the core instruments used for risk reduction activities. Besides, in some countries (such as Germany, France, the Netherlands and Austria) on-the-spot pill testing is being implemented. Sometimes, like in the Netherlands, the testing is combined with warning campaigns in which through flyers and other means users are made alert on the (bad) quality of certain substances which are being sold. In Ireland, the UK and the Netherlands guidelines for party organisers and disco staff have been developed which promote 'safe house' conditions (INT02, INT29).

The publications regarding ecstasy are exclusively descriptive. No documentation is found in which the effect of these initiatives is assessed.

Multiple substances

Though most publications selected in this review relate to interventions and studies which are focused on a specific substance, some risk reduction interventions are not bound to a specific type of substance.

Though a multiple substance orientation is quite common in primary prevention (i.e. many school based prevention programmes deal with multiple substances), we could not find many publications with a risk reduction aim which are targeted on both licit and illicit substances. We only found one publication which describes a brief intervention which is aimed at encouraging self-controlled moderate substance use and which is offered to both problematic alcohol and illicit drug users (E08). In the publication no mention is made of the effect of the programme.

The Emergence of the Risk Reduction Concept in Europe and the difficulties encountered in implementing such programmes – definition of the concept

Peter Cohen (The Netherlands)

Risk reduction has always played a part in drug policies in Europe. The model for drug policy is, of course, alcohol.

Since the onset of the industrial society (mid 18th century) alcohol production and distribution has always been tied to quality controls, age and geographical limits. The same limitations have not been imposed everywhere. For example, the time limits of the English pub were never introduced in mainland Europe. In Holland, the age limit for buying alcohol is 16 years while in the USA it is often 21 years.

The purpose was to contain the risks of alcohol use, but the definition of those risks has changed with time and is different between cultures.

Different cultures construct different risk perceptions in relation to alcohol and legislation about alcohol control reflects those cultural differences.

The process of risk definition is very important and is probably the most important aspect of all drug control policies. I will try to illustrate this further.

In the very interesting reader about Harm Reduction, edited by Pat Erickson et al[1] the Introduction of the book divides the Harm Reduction paradigm into three major levels: conceptual, practical and political. At the practical level, harm reduction distinguishes itself from other approaches by putting the drug user at the centre and making it imperative that the co-operation of drug users in the making of programmes is guaranteed.

The relevance of this point is of course, that any definition of risk, and what to do about a risk, is carried out in co-operation with the group whose risks one tries to limit.

In one of the best research reports ever produced in the Netherlands, on ecstasy use in clubs, the authors state that the main object of the

[1] "Harm Reduction: A new direction of drug policies and programs" Patricia Erickson, Diane Riley, Yet Cheung, Patrick O'Hare. University of Toronto Press 1997

research is “the analysis of causes of incidents and accidents at large scale house parties” (page 10)[2].

The methodology of this investigation allowed for very extensive interviewing during house parties, carried out by people who were accepted as part of the group.

Later, this Ecstacy use investigation by the University of Utrecht was followed by a larger and very interesting project to evaluate one form of risk reduction at large house parties - the first aid booth.[3]

The researchers found many different problems at parties – both major and minor - related to the use of dance drugs. They also discovered how the people in the first aid booths were assisting with these problems. One of the conclusions was that the booths were mostly organised in such a way that the drug users trusted those who ran the booths and they went there with their problems.

Another important finding was that, when the police went to dance halls and started to search the young people who were waiting to get in, many would swallow all the drugs they had, in order to avoid detection. This caused problems e.g. aggression, panic attacks etc.

So, the definition of risk - who defines, who gains - is the crux of all risk reduction programming and the main criterion that distinguishes good harm reduction from all other policies is the concept that **risk reduction should be defined and executed in the interests of the group who are at risk**.

Where does this lead?

I would like to develop three points:

1) Risk reduction is a way of approaching drug policy issues, it is not a programme.
2) Risk reduction defends the interests of people irrespective of their social status.
3) Risk reduction programmes are futile if the people at risk do not see the risks as risks.

[2] “Ecstasy in het uitgaanscircuit” Goof van de Wijngaart et al CVO University of Utrecht, 1997. (Ecstasy and partying)

[3] D. de Bruin, N. Maalsté, G. van de Wijngaart (1998). Goed fout gaan. Eerste hulp op grote dansevenementen. Utrecht: Centrum voor Verslavingsonderzoek, Universiteit Utrecht. (First aid at large dance parties)

1) Risk reduction is a way of approaching drug policy issues, it is not a programme.

The concept of risk is completely neutral in itself.

When a risk is defined, it is not clear what should be done. If decisions are taken with the view that one particular group has to benefit from the risk reduction - and not another - only then does risk reduction change from a neutral concept to a programme or approach. My view on risk reduction is that an analysis should be made of the risks from the perspective of the risk taker and not of his parents or the police.

At this stage the direction taken could lead anywhere, as long as the risk taker is in agreement. Every group, every context, needs its own analysis and without the people (drug users) themselves, a good programme will not exist. Once a programme is seen as successful by drug users, it could develop into an approach that supports such a risk reduction, e.g. first aid booths in dance halls.

First aid booths may work in Holland, but would they in Sicily?

This is what I mean by "Risk reduction is not a programme, ,just an approach".

2) Risk reduction defends the interests of people irrespective of their social status

Often it is seen that low social status is the reason for not designing meticulous strategies. For example, in the USA prison system, where violence from guards towards prisoners often goes unpunished, prisoners with drug problems are dependent on outside help for risk reduction[4].

Risk reduction in these prisons is necessary, but does not happen, because prisoners, in general, have a very low status in the USA.

The best risk reduction would be individual cells for prisoners and not to be subjected to prison gang violence. From the perspective of prisoners much would be gained if they could file complaints against violent guards or fellow inmates.

People working with those in prison or drug users will often face the problem of the low social status of these groups. However, if risk

[4] Key Lee "A GUARD WHO HAS NEVER OWNED HIS CRIMES" and many others to be found on:http://www.angelfire.com/fl3/starke/

reduction became a serious issue, low social status would no longer be a barrier.

3) Risk reduction programmes are futile if those at risk do not see the risks as risks.

Imagine a risk reduction programme that defines party drug use as so risky it has to be censored. Many groups would support such a risk reduction programme but the impact of such action would be negligible and may even have a negative effect. The problem is that drug users at parties have a different view and do not see all drug use as risky.

To contest the views of the drug user at parties may be seen by majority groups or conventional politicians as very desirable, but their forms of risk reduction will not succeed. For serious risk reduction efforts to be successful policy makers will have to allow that their definitions of risk are not sufficient. Without serious, systematic and efficient research into the risks as seen by the drug user, such policies are pointless.

Specific problems related to alcohol or drug consumption and driving

Michèle Muhlmann-Weill (France)

Psychotropic substances are products which, even in very small doses can affect the way the brain functions. Although for a long time the word “drugs” was restricted to illegal substances and other products used for purposes other than those originally intended, such as medicines, ether, adhesives and other solvents, today the tendency is to use the term **psychoactive substances**, covering products available over the counter such as alcohol, or prescribed as medicines.

The effects vary depending on the individual: age, sex, physical characteristics or mental state, the method of consumption – oral ingestion, smoking, inhalation, mucosal absorption or injection - users’ state of health and lifestyle and the pharmacokinetic properties of the substance. Once it has been absorbed, it crosses the blood-brain barrier and reaches the brain, modifying the way it works, affecting vigilance and the cognitive, sensory and psychomotor functions which are essential for driving a vehicle. The effects of alcohol on a person’s ability to drive have been well known for a long time but in view of the increase in consumption, diversification of substances and multi-drug use, it is essential in the interests of public health and safety to identify more accurately the specific properties of each class of products in order to take the appropriate protection measures.

Epidemiological and experimental studies have confirmed that psychotropic substances seriously affect a person’s ability to drive. This research needs to be followed up more thoroughly in order to compare the effects of products used together, or in conjunction with alcohol, in order to assess the residual effects of the absorption of certain products and the neurological harm in the long-term or after withdrawal.

The consumption of psychoactive substances, which is very widespread in a recreational rather than problematic (addiction) context, must be better identified in order to put in place socially acceptable risk reduction measures.

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Overview of developments in risk reduction aiimed at synthetic drug users

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Introduction

'Synthetic' drugs such as amphetamine, ecstasy (MDMA), GHB and LSD are psychoactive substances derived from ingredients that are non-natural. 'Synthetic drug use' often refers to drug taking by young people and 'club-going' populations in the nightlife context. Within this context synthetic drugs are usually used in combination with other (non-synthetic) drugs, including alcohol, cannabis and cocaine. This paper will focus on risk reduction interventions in response to synthetic drugs (and non-synthetic drugs) used by young people in the nightlife context.

The paper will briefly describe the nature and extent of drug use in general populations of young people and 'club-going' populations. Risk reduction interventions will then be categorised, described and illustrated, with the aid of examples, from HIT – a Liverpool drug communication organisation, the UK and other parts of Europe. The provision of services for drug users with serious problems will also be discussed. Conclusions will then be drawn about the most common intervention targeting drug users in the nightlife context and recommendations made.

The nature and extent of drug use by general populations of young people and club-goers

Young people in the UK are more likely than most other young Europeans to use illegal drugs (Hibell et al, 2000; EMCDDA, 2000). Growing survey evidence of an increase in drug use among young people through the 1990s, combined with the findings of qualitative studies, suggest that the status of drugs has shifted from being an 'exception' to the 'norm' - drugs are now an accepted part of everyday activity among contemporary British youth. It is currently estimated that 50-65% of young Britons aged 16 – 24 years old will have tried illicit drugs and 20-25% will be occasional or regular users (Measham et al, 2001; Ramsey and Partridge, 1999). A significant proportion of this drug taking is located within lifestyles linked to club culture.

Participation in 'nightlife', or club and bar culture, has become an increasingly central feature of consumer youth culture. Recent figures suggest that the UK's official 4,000 nightclubs attract 16 million visits a year and that one in two 18-24 year olds are regular clubbers - these

figures exclude a wide range of other venues in which 'clubbing' takes place (Measham et al, 2001). A number of factors have contributed to this growth in club culture and consumer 'nightlife'. However, a key contributory factor in the UK was the evolution of 'dance culture' from the 'Acid House' phenomenon of the late 1980s (Garratt, 1998). Dance culture has not been confined to the UK. Over 2,500 participants in a recent study of nightlife in nine European cities explained their motives for involvement (Calafat, 1998). In order of priority, the key reasons given were to: meet friends, listen to music, escape daily routine, dance, look for a partner, look for sex and take drugs. However, despite the lower priority accorded to illicit drugs in this list, and the fact that alcohol is by far the favoured 'nightlife' drug, clubbing has provided a key context for access to and experimentation with drugs over the past decade. Club culture has produced a group of regular club drug users who, albeit a minority of those involved in this social activity, are among the most experienced drug users (Measham et al, 2001).
Risk reduction interventions

Risk reductions interventions targeting drug users in the nightlife context can be categorised as follows: (1) Inter-personal approaches including outreach, peer-led initiatives, user advocacy, crisis intervention and first aid. (2) Mass communication approaches including leaflets, posters, the Internet, paid advertising and media advocacy. (3) Pill testing and early warning systems. (4) Environmental approaches and the law.

Inter-personal approaches

A wide range of inter-personal approaches including counselling, information and advice, outreach, peer-led initiatives, user advocacy, crisis intervention and first aid are delivered on a 'face-to-face' basis to young people and/or club-going populations. In the UK a small number of drug services have specifically targeted young people using dance drugs such as ecstasy. Crew 2000, Edinburgh and Lifeline, Manchester provides user-friendly counselling, information and advice from city centre 'shop-front' premises. They also provide, when appropriate, important referral links to specialist services. Some agencies have provided similar services on an outreach basis in clubs. Crew 2000, Lifeline and others such as Jellinek Prevention Institute, Amsterdam through the peer-led Unity project, have delivered interventions by a combination of paid staff – often with a familiarisation with the 'club-scene' – young people and drug users. It is argued that peer-led initiatives are effective in making contact and being perceived as credible with young drug users in the nightlife context.

First aid and crisis intervention is provided in some clubs, raves and outdoor festivals in Europe. Such services are provided in a range of ways including the deployment of para-medics in clubs (Cream,

Liverpool) and outreach workers from drug services and peer-led initiatives (Crew 2000, Edinburgh (www.crew2000.co.uk); Unity, Amsterdam (www.euro.net/unity); and Eclipse, Hamburg (www.eclipse-online.de). The European Basics Network (www.basics-network.org) is an association of dance drug user groups from six countries which aims to reduce risks associated with dance drugs. During the summer of 2002, Basics will provide drug awareness and crisis intervention services at festivals throughout Europe.

The main emphasis of interpersonal interventions by drug services and peer-led or user-led services is on reducing the health risks of drug taking. However, some groups have taken on a wider advocacy role that has encompassed health issues, legal rights and human rights. The Committee for Recreational Drug Use, Amsterdam and the Dance Drug Alliance, UK have advocated that taking illegal drugs should not lead to social stigmatisation. It is argued that reducing stigma and prejudice will lead to health problems being tackled in a more pragmatic, realistic and effective way.

Mass communication approaches

Mass communication approaches including leaflets, posters, the Internet, paid advertising and media advocacy are utilised across Europe. HIT, Liverpool and Lifeline, Manchester were the first agencies in the UK to produce honest, useful and culturally recognisable drugs information for ecstasy users in the early 1990s (Henderson, 2000; McDermott, 1993 and Shapiro, 1999).

Liverpool was one the first British cities to respond to the growing use of ecstasy and other 'dance drugs' in the 1990s from a public health perspective. Very little was known about the effects associated with the use of MDMA in this setting and a majority of drug services were ill-equipped to respond to (and frequently unaware of) the potential needs of a whole new generation of 'recreational' drug users.

'Chill Out - A Raver's Guide' produced in 1991 was designed in the style of the flyers distributed to advertise 'rave' events. It was one of the first of its kind to attempt to communicate health messages to a growing number of young people becoming involved in the scene. The leaflet's producers, HIT (then Mersey Drug Training and Information Centre), aimed to build on the increased acceptability of pragmatic approaches to reducing drug related harm resulting from the key policy concern **of** the day – the reduction and containment of HIV infection amongst injecting drug users. HIT developed 'Chill Out' by tapping into the emerging culture and reviewing the latest research (which, at that time, was sparse). Familiarity with the culture's codes, drug taking etiquette, local and national infrastructures and movers and shakers formed the

basis for providing basic information on the effects of drugs commonly used on the club scene and on potentially associated problems. 'Chill Out' was positively received amongst its target audience locally and by the national youth style press. Its broader public reception was, however, more hostile - the campaign made front-page local and national tabloid news, prompting calls for its withdrawal.

However, despite the above controversy, approaches that seek to be credible with the target audience are endorsed and funded on a routine basis by government agencies in the UK and other countries. Huge quantities of leaflets, booklets and posters have been designed and distributed by government agencies, drug services, police and peer-led/user-led services to young people. Paid advertising in style-magazines, TV, radio and billboards, media advocacy and the Internet are also utilised in many countries.

An important aspect of mass communication approaches is the identification of the target audience by a range of factors including age, drug-taking behaviour, sexuality, sexual behaviour and travel**.**

The Department of Health, England ran a national advertising campaign to raise awareness of ecstasy and other drugs among a general population of young people during the early part of 2002. Paid advertising in lifestyle appropriate magazines, radio commercials and a website were used. An aim of the campaign was to increase awareness of, and calls to, the National Drugs Helpline.

Camden and Islington Health Promotion Service, London have produced booklets targeting gay men. The visual style and language is designed to be recognisable by gay men.

Studies of the association between drug taking, including ecstasy and GHB, and sexual behaviour (Clarke et al, 2002 and Henderson, 2000) and an increase in sexually transmitted infections in North West England (www.phls.co.uk) provided a basis for protecting the health of young drug takers by focusing on sexual behaviour. HIT's *Protection* campaign emphasised the interconnectedness of drug and sexual risk taking behaviour and involved distributing *Sex booklets* and condoms to dance-drug users (Henderson, 2002).

With the emergence of international nightlife resorts such as Ibiza, HIT and Liverpool John Moores University have identified increased risk factors for your British drug users holidaying in Ibiza (Bellis et al, 2000). These include increased frequency of drug taking, higher temperatures, language problems, the absence of free drinking water and problems of accessing acute medical services. HIT has produced leaflets specifically in response to the needs of young people holidaying in Ibiza.

Pill testing and early warning systems

Ecstasy (MDMA) – usually tablets, sometimes capsules and occasionally powder – is often contaminated with other substances or comprises no 'drug' content whatsoever. In response to this and publicised ecstasy related deaths in some countries, some organisations have advocated for, and provide, pill testing and early warning messages about dangerous 'pills'. There are a number of ways that pill testing and early warning systems are delivered.

The Drug Information Monitoring System (DIMS), supported by the Dutch Government routinely tests 'ecstasy pills' off-site in laboratories; places the results in a database with information about the size, shape, weight and appearance of the pill; and provides warning notices to drug agencies and ecstasy users at clubs and raves. (DIMS, 1998). In Austria, the *Check It! Project* provides quick laboratory testing facilities using gas chromatography on-site at large raves by a mobile-testing machine.

Onsite testing occurs on a sporadic basis in Netherlands, Austria, France and German (De Jong, 2001). The most common method employed is the 'Do-it-yourself' colour reaction kit (e.g. The 'E-Z Test). A small part of a tablet is shaved-off and exposed to a formaldehyde and sulphuric acid solution. Depending upon the substance, a colour change in the solution occurs. The change in colour over a specified time period is then compared with a chart that matches different colours with specific drugs i.e. MDMA, MDEA, MDA, MBDB, 2CB and amphetamine. As well as this method being used on-site in clubs by a range of health agencies, it is also used on an individual basis by drug users. The 'E-Z test' kit is available via mail order and on the Internet. 'Colour-reaction testing' may improve 'consumer safety – albeit on a 'better than nothing basis' and initiate contact between health agencies and drug users. However, some commentators have expressed concerns about the value of such testing methods. The kits will not detect potentially harmful substances; they don't inform the user how much of a psychoactive substance is present in a pill; and thus may create a false sense of safety in some users (Winstock et al, 2001).

Environmental approaches and the law

Broader public health and environmental approaches including developing codes of good practice in clubs and focusing on the wider-night-time environment are important risk reduction strategies. The risks to drug users derive not just from the individual reactions to a specific substance(s) but from the environmental context in which it is taken. The majority of deaths in the UK associated with ecstasy have been attributed – in part – to the hot club environment, energetic dancing for

long periods, the poor availability of water and the absence of first aid facilities. Some cities have adopted 'Safer Dancing Guidelines' that provides Codes of Good Practice for clubs. These may include measures to prevent overcrowding; to provide air conditioning, free drinking water and first aid; to provide health and safety training for club staff; and to ensure clubs have clear procedures and protocols for dealing with emergencies. (London Drug Policy Forum, 1997)

The wider night-time environment where a club is located may also threaten a young person's health. Interventions designed to improve late-night transport and reduce aggression and violence may significantly protect the health of young drug users.

The enforcement agenda and the role of the police can enhance and diminish risk reduction interventions in the night-time environment. There are different drug laws and enforcement priorities across Europe and within individual countries. The police can, and do, make significant contributions to risk reduction by supporting some of the interventions described in this paper and ensuring that the night-time environment is a safe place to go out in. However, it has been argued that the police in the UK are in a difficult situation. They have neither the resources nor inclination to enforce the drug laws (Measham, 2001). Should they prioritise dance drugs over other forms of drug taking? Should they target individual users or target dealers? How do they deal with the organised crime associated with 'club-land'? How can they best protect the health of club-goers? The response of the police to these scenarios is currently mixed in the UK. A senior policeman from London suggested that arresting people who take ecstasy and cocaine at the weekends is a waste of time whilst the same police force employed sniffer dogs to target individual drug users in Soho, London (The Face, 2002). A result - often unintended – of policing in this context is the potential consequences of dispersing 'the problem' underground, thus making risk reduction interventions more difficult to carry out.

Managing serious drug problems

The vast majority of young people taking drugs in the night-life context are unlikely to experience significant health problems over a long term period. Serious acute medical problems are also, on a population basis, rare. However, some young people do experience problems with their drug use such as anxiety and depression. A recent study in Manchester, England reported that 23% of a sample of club-goers had presented to their General Practitioner with symptoms linked to alcohol or drugs. Many did not disclose that their problems might be associated with their substance use (Measham et al, 2001). In the UK, there is a questionable role for conventional drug services in responding to the future needs of a new generation of drug takers – simply because most

drug services were established to provide services to heroin users. An aspect of risk reduction is to refer individuals with serious problems to appropriate services. In this context, this is likely to mean acute medical services, primary care, specialist mental health services and drug services responsive to younger non-opiate using people. Clearly, there are important implications for the future commissioning and delivery of services.

Conclusion

The most widespread response to synthetic drug use is the provision of information about drug-related risks and risk reduction practices to target audiences of young people. A range of inter-personal and mass communication methods provides this. Broader environmental approaches involving night-time venues and statutory agencies can significantly enhance these interventions.

Interventions should include drug specific *and* broader health related components such as sexual health. Measham and colleagues have suggested a three-legged agenda to risk reduction information: the *night out agenda* which includes advice about alcohol, drug combinations, looking after friends and travel plans; the *recovery agenda* which includes dealing with and reviewing tiredness, mood swings and impact upon work or education; and the *broader health agenda* relevant for the small but important number of people with emerging problems linked to drug use. (Measham et al, 2001). Communicating with club-goers needs to be done in a way that acknowledges and encompasses cultural norms. Government advice in the UK states, '*The credibility of the message, medium and its content is critical and should be matched to the needs of the target group*.' (Home Office, 1998).

This paper set out to describe the main interventions in response to drug use in the night-time context. It did not aim to report on the effectiveness of such interventions. However, it must be recognised that the evidence base for the majority of interventions described is currently limited. Process, outcome and impact evaluation is not done as a matter of routine. This situation is not unique to drugs and risk reduction. Health promotion in response to other risk taking behaviours is also not routinely evaluated. HIT and other organisations have tried to evaluate risk reduction interventions - often on a tight budget (e.g. www.hit.org.u/protectionreport.pdf). In the UK, The Drugs Prevention Advisory Service – a government agency – has sought to provide guidance and create a 'culture change' to ensure that some evaluation, however limited, is a core part of an intervention. Initiatives like these and ways of communicating good practice must be encouraged.

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Tailored feedback and alcohol use

Andrée J. van Ems (The Netherlands)

Introduction

This paper is about a new qualitative approach for reducing hazardous drinking - a project from the National Institute for Health Promotion and Disease Prevention (NIGZ).

One of the tasks of the NIGZ is to carry out the National Alcohol Prevention Campaign:
"DRANK maakt meer kapot dan je lief is", which means: Drinking can break your heart. In this campaign we are dealing with three target groups:

Young people (15-25 yrs)
Students (university)
Adults (especially men between 35-55 yrs).

At the beginning the campaign was focused on young people, but in 1998 (van Gorp) research showed that of those adult men and women who drink alcohol, a substantial number are drinking above sensible limits. We define sensible limits as fewer than 21 standard units a week for men, and fewer than 14 standard units a week for women. A standard unit contains 10 grammes of alcohol.

In the Netherlands approximately 15% of the population do not drink alcohol.

On the slide you can see that of those men between 35 and 45 years of age who are drinking alcohol, more than 40% are drinking above sensible limits.

Women drink a lot less than men. But you can see that 25% of the women between 35 and 45 years of age are drinking too much.

Until now we have tried by quantitative methods to reduce the risk of hazardous drinking. Television, radio spots, brochures were used as a means to inform people about the risks of drinking above sensible limits. In this way a lot of information was disseminated, but there was no change in behaviour.

Research (Alcohol Alert, 1999, 2000) showed that advice and minimal interventions by therapists can be effective in reducing risky or hazardous drinking. However, we know that not many people, even

those with real alcohol problems go to specialist services or to see their general practitioner. In our view people who are drinking in a risky manner, and who do not have big problems, do not need to see a specialist.

We asked ourselves how we could reach, in a more personal way, large groups of people who are drinking above sensible limits.

Computer tailoring

In the last decade computer-generated tailored health messages have been developed to assist the public on matters like smoking and the consumption of fat and vegetables. (Brug, 1997, Dijkstra, 1998).

A definition is given by de Vries and Brug (1999): Computer tailoring is the adaptation of health education materials to one specific person through a computerised process. Although much research has to be done concerning the question of WHY computer tailoring is effective, we do know that it is effective in reducing, for example, smoking and the intake of fat, compared with general health education or even self-help materials. During the last two years we have developed a computer system the use of which can give tailored feedback to alcohol users. The aim of this feedback is to make people aware of their drinking patterns and to reduce risky drinking.

How is tailoring done?

Tailored messages (advice/recommendations) require the following:

- Screening on individual characteristics that are relevant to a person's behaviour (in our case, drinking alcohol). This is done by a self-test or questionnaire.
- Message library with all the health education messages that may be needed.
- An algorithm, or set of decision rules that evaluates the screening and then selects messages tailored to the individual.
- A channel to deliver these messages to the user, e.g. a letter

Questionnaire

The questionnaire for alcohol use has now been developed and tested. We decided to make a special website for this tailored feedback, on which people can anonymously complete the questionnaire. In addition they receive advice online immediately. They can choose to print out the information, or have it sent in a pdf or html format by email. Because we want the advice to be as personal as possible we have also chosen a design for the website that can be adapted to the preference of the

user. As well as this, banners will be used to seduce people from other websites to have a look at www.drinktest.nl - a football banner will be used to represent sport. Going directly to the site there will be a neutral page which is shown on the slide. On this first page the user can type in their favourite alcoholic beverage, eg beer.

The questionnaire which will appear is designed in the form of a beer page. In fact there are two questionnaires.

The first questionnaire is very short and, apart from some basic questions, eg sex and age, only three questions are asked:

- Weekly alcohol consumption

Idea from the individual about the quantity of his/her alcohol use (very little/very much)

Changes in the individual

By combining these questions, a preliminary recommendation is generated. In this message people are given information about their drinking patterns, and what are sensible limits. People who are drinking above sensible limits are encouraged to fill in the rest of the questionnaire which is unnecessary for those who are already drinking sensibly. This response is given in the style of the individual's favourite beverage.

In the second part of the questionnaire there are three types of questions.
Personal circumstances, for example, pregnancy or suffering from heart or vascular disease
Pros and cons of drinking less alcohol, for example:
If I drink less alcohol, relaxing would be more difficult
Questions about self-efficacy in possible high-risk situations for drinking
There are two types of situations: social situations, e.g. being at a party and negative emotional states, e.g. feeling down.

This is followed by 32 multiple choice questions. In practice it takes about ten minutes to complete the questionnaire. The individual is offered advice on all relevant subjects:

Examples of subjects:
Alcohol and health
Alcohol and traffic
Alcohol and pregnancy
Pros and cons of alcohol
Drinking with others

www.drinkest.nl forms the first part in a stepped care approach. People who want more than advice can go to another website where they can follow a self-help programme: how to drink less. This site is being developed by the Trimbos Institute in co-operation with the NIGZ and the Jellinek.

Evaluation of the effects of www.drinktest.nl is now taking place. We are planning to launch the site in Autumn 2002.

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Education by Peers and Field Workers

Ragnhild Bruun (Norway)

Introduction

My name is Ragnhild Bruun. I am 22 years old and I come from Oslo, Norway. I used drugs for about three years and for the past two years have been a volunteer in a project called FUTURE. My presentation is about this project as a method of risk reduction.

Risk reduction

Firstly, I would like to say something about how I understand the term "risk reduction" and why I think it is important. In the **UNDCP** *Demand Reduction Glossary* "risk reduction" is described as "policies or programmes that focus on reducing the risk of harm from alcohol or other drugs". This is also my understanding of the term.

When I introduce parents to the project and educate them about drugs there are those who are sceptical of the concept of risk reduction. They think it is a way of accepting substance abuse. They tend to the view that risk reduction is saying yes to drugs, condoning its use or sending the wrong message to young people who are already using illicit drugs or considering whether to use them. This is understandable. However, I think it is important to acknowledge the fact that there will always be people who choose to use drugs. It is simply unrealistic to believe otherwise. Since there will always be people making that choice, it is very important to be able to reach them, and to try as far as possible to prevent or reduce the attendant social, physical and psychological problems. The crucial question in this connection is - how do we reduce the risk of harm? I am here to talk about a project that aims at risk reduction and prevention of substance use among young people who participate in the house/techno youth culture. The emphasis will be on risk reduction.

The name of the project is FUTURE. It is run under the auspices of *Uteseksjonen* and based there. *Uteseksjonen* is the outreach section of the Department for the Prevention and Treatment of Drug and Alcohol Problems (*Rusmiddeletaten*) in Oslo. There are three other FUTURE projects in Norway. I will limit my presentation to the FUTURE project in Oslo.

How FUTURE started

FUTURE is the continuation of a project called *Stopp Dopet, Ikke Dansinga*. Translated into English, this means, *Stop the Drugs, Not the Dancing.* In 1994/1995, a social worker named Elin Halvorsen Ringstad started working at *Uteseksjonen.* She had been a part of the growing house culture in Oslo. She and another social worker decided to target the subculture and develop methods to gain access to it. This was at the time when the subculture was closed. They started outreach work at rave and house parties. They met two men, a DJ and a party organiser, who were concerned about developments in the sub-culture in relation to substance use/misuse. The two men had already started making flyers, which gave tips on how to avoid such side effects of stimulant-based drugs as heat stroke and exhaustion. These flyers had a risk reduction profile. The two men were well known in the sub-culture. They knew the sub-cultural jargon and behavioural traits intimately. This was very important for the project. The men and the two social workers started working together to prevent and reduce the use of drugs at dance or music events. They called the project *Stop the Drugs, Not the Dancing***.** The social workers then met four youths who had problems with drugs. When the social workers asked them what they could do to help them, they answered that they wanted to work like the social workers, on a voluntary basis. This was the beginning of the party or dance patrol as a drug prevention method. The fact that the two men (DJ and party organiser) who had originally started working with the social workers were well regarded in the sub-culture was very important. Their position in the sub-culture made it possible for them to function as conduits for new norms and values. Others with similar positions in the sub-culture were eventually recruited to join them.

In 1999, the project changed its name, partly because the original name triggered off resistance from the target group. For them the catch phrase "*Stop the Drugs*" was too provocative and moralising. This seemed to scare off the very people with whom we wished to establish contact. The volunteers decided that the new name should be FUTURE. Elin H. Ringstad is now working full-time at Uteseksjonen as project manager.

Who are the volunteers in FUTURE?

Today, there are about 60 volunteers and 5 social workers in FUTURE. The number of volunteers could be higher, but since some of the volunteers need to be given professional help by the social workers, we now operate with a waiting list. Presently, we only accept new members in August and January. The volunteers are aged between 17 and 25 years. The average age is around 20.

The majority of volunteers have personal drug experience, mostly with the so-called 'rave drugs' such as amphetamines, ecstasy, cocaine and GHB. The use of cannabis and benzodiazepines is also common. To become a member of FUTURE, you must have the motivation or wish to stop using drugs. We do not demand that you are "clean" when you join. Therefore, some of our volunteers still use drugs. The volunteers have different drug careers in relation to use and non-use. This is an advantage, because someone who has not been using drugs for two years has lots of experience to offer someone who has just stopped using or is trying to. It is quite common in FUTURE for volunteers to openly talk about the psychic/psychological problems they have e.g. anxiety, depression and so on.

There are also volunteers who have made the choice not to use drugs and who just want to do something for others. They make up about one fifth of the group. This mix is very important for the project. The non drug-using volunteers help to introduce some stability to the group and they also help to remove any stigma that might otherwise be associated with membership in FUTURE. These non drug-using volunteers have very strong opinions about drugs and function as good role models for the rest of the group. They play a central role in educating their peers in how to lead a life without drugs. For example, they contribute to discussions about what drug free people talk about, what they do when they are bored, how they manage to say NO when offered drugs and so on. You can call this the self-help aspect of FUTURE. FUTURE helps its members to reflect on their attitudes to drugs, to talk about their problems openly with the feeling that they are being listened to and understood, not misunderstood or prejudged. It is my view that this is very important in social work with young people.

What does FUTURE do?

FUTURE's main task is to help young people who are in involved with youth environments which have a permissive attitude to drugs. Our target group is young people between 15 and 25 who use stimulant-based drugs. We use different methods in order to reach them. The following are some of those methods.

Brochures

One of the things FUTURE does is to produce brochures about illicit drugs. These brochures are intended for people who are already using drugs or who are at risk of starting. Our brochures contain factual information on how the various drugs work, the feelings associated with them, their short and long-term effects and how to avoid and reduce these effects. For example, in our brochure about ecstasy we address how the highs and lows associated with the drug unfold, and how this

could be a frightening experience. We do this to prepare users for these experiences. The brochure on ecstasy also contains information about how to avoid heat stroke and exhaustion, warnings about mixing ecstasy with alcohol and information about suspicious pills and capsules, with suggestions as to appropriate dosage. Before we produce brochures, we consult our volunteers. We consider them the experts since they have first hand knowledge about the effects of the drugs. In the brochures we use both "street" and professional terms. The volunteers are also responsible for the layout of the brochure. This gives credibility and ensures that they are not seen only as propaganda to scare young people away from drugs. We have brochures about ecstasy, amphetamines, cocaine, GHB, cannabis and benzodiazepines. We are currently working on a new brochure about cocaine and are planning another on mushrooms. These two drugs are becoming more and more popular among the target group. It is important to point out that FUTURE has a strict policy against distributing its brochures at elementary schools or youth clubs because of the fear that they might be seen as an invitation to use drugs, thus defeating the purpose.

We also have a brochure especially prepared for parents. This contains information on how to identify the symptoms and behavioural traits that are commonly associated with the use of stimulant-based or rave drugs and how parents who are suspicious that their son/daughter is using drugs, can take up issues relating to drug use with the young person. It also contains information about how to make the best of the situation if one's child is using drugs.

Stands

To hand out these brochures to our target group, we have to be where they are. To do this, FUTURE sets up stands at every big dance or music event. Nowadays large music events are not so common. So, we have started targeting nightclubs where we know the use of rave drugs is widespread. We set up stands at these clubs and volunteers man the stands, but there is always at least one social worker present. Young people who need professional help are referred to the social worker. There are also four volunteers who are charged with special responsibilities. These volunteers have been with FUTURE for many years and are experienced and reliable.

We hand out several things from a typical FUTURE stand. We know that people who use rave drugs often do not eat much and so are undernourished. This is because stimulant-based drugs reduce the feelings of hunger and pain. So we hand out fruits and lollipops - the lollipops are very popular. This is because rave drugs induce lots of muscular activity in the jaws and the lollipops give users something to do. We also hand out condoms, as we know that a lot of people while

under the influence of drugs and alcohol have unprotected sex. And of course, we hand out our brochures and flyers. They contain information, also, about our other activities. I'll say more about that later.

Some of the boys in FUTURE take pictures with digital cameras at these dance events. We download these onto a computer and show them on a big screen using a laser projector. We know that most of the young people are very fond of watching themselves on a big screen and for that reason they flock to our stand.

Most of our volunteers are very creative. They give free body paint to those who want it. All of this helps us reach a lot of young people who participate in this youth culture. We are well known and accepted in this youth environment. In fact, some youths do not know much about the happenings on the rave/techno scene before FUTURE came into the picture. Others cannot imagine a dance event without the presence of FUTURE. In their minds, FUTURE is part and parcel of these music or dance events.

The main idea behind having these volunteers working at the stands is to ensure that there is, if you like, a youth-to-youth communication. If the person you are meeting is the same age as yourself, then it is much less intimidating to make contact than it would be if that person were your parents' age. As I mentioned above, many FUTURE members had used rave drugs before and they meet young people with whom they are already acquainted. Hence our message becomes much more credible and reliable when these young people know that WE know what we are talking about and we also communicate this to them in 'their language' - a language they can understand. It therefore becomes easier to win their trust. Most of our members were recruited this way. They would meet us at music events and think it would be interesting to be a member of FUTURE. Then three, or maybe, four months later, they would be the people handing out fruit and brochures and recruiting new members. This way the process comes full circle.

We have rules and regulations that our volunteers have to respect when they represent FUTURE. These rules and regulations are made by FUTURE and are constantly reviewed. First of all, you have to abstain from drugs for at least one month before you can represent or work for FUTURE. Secondly, you cannot use drugs or alcohol while working for FUTURE. To become a member of FUTURE, you have to sign a declaration to uphold the Norwegian law on confidentiality. Any information given by members of FUTURE or by participants at dance events is strictly confidential. This is to encourage their trust and to ensure that they talk openly about their problems.

All FUTURE members are obliged to undergo courses that equip them with the skills they need in order to work at stands. We learn how to give first aid, how to handle conflicts and how to avoid them by using body language and so on. We are also taught the physical effects of drugs by a doctor from the Institute of Forensic Medicine.

Courses

We try to plan some activities that are attractive to our members so that they can have something else to do in their spare time other than using drugs. We call these activities 'courses'. This is because the word 'course' is not so intimidating and binding as the word 'school'. Hence we prefer 'DJ-course' to 'DJ-school'. The courses are effective ways of reaching our target group. These courses are designed by some of our volunteers so that they often match the interests of those we are trying to reach. The courses are user-run and the focus is on personal resources. Everyone is good at something and to let the volunteers plan and participate in something they are interested in has a positive impact on their self-esteem. We have organised courses in reading Tarot Cards, in belly dancing, interpretation of dreams and in astrology. We are currently running two courses: a DJ-course and a course in sewing and design. We also have two dance groups which meet once a week.

The DJ course, the dance groups and the sewing and design course are all very popular and with good reason. The DJ has the highest status within the rave culture, followed by the dancers. Our DJs and dancers perform at large dance or music events. This is very important; they return to the culture after quitting drugs and being even cooler than they were before. They also design and sew their own costumes - even the boys.

Every summer, there is a large event called The Summer Parade in Oslo. The Summer Parade is a big techno parade where a lot of buses/trailers drive through the principal streets of Oslo with people dancing on top and around them. It is similar to the Love Parade in Germany. Last year, FUTURE had two buses on which our own DJs played and our dancers danced. We made our own costumes. It was a major hit! FUTURE and Uteseksjonen attracted a lot of attention and this boosted the confidence of the participants.

Discussions with Parents

A lot of parents contact Uteseksjonen because they fear or suspect that their children are taking drugs. If this turns out to be the case, we offer them a 'parent talk'. A social worker and a member of FUTURE usually talk with the parents and their son or daughter. It is our view that having a youth, who has been through a similar experience, might help shed

more light on the issue under discussion and make it possible for both the parents and the young person to consider the other side of the story. To participate in a talk like this as a volunteer you have to be clean for at least a month. It is the social workers who decide which volunteer will participate.

Lectures

We also give lectures to parents at school meetings, to nurses and teachers as well as other professionals who work with young people with drug problems. We do not give lectures to young people. The fear, again, is that such lectures might be seen as an invitation to use drugs especially when given by volunteers with plenty of resources. The main reason we give so many lectures is that FUTURE members have first-hand knowledge about these drugs. It also helps them to see their own use differently because of the diverse type of questions they are asked. Being able to transform something you are deeply ashamed of to something positive and valuable has positive effects on their self confidence. It feels good to know that even though you have caused your family, friends and yourself so much pain, you are still worth something.

Conclusion

The project FUTURE focuses on both risk reduction and drug abuse prevention. We could not have done just one of them. Working to reduce the risk of harm among young people who use stimulant-based drugs automatically leads to drug abuse prevention. This is because our volunteers also function as role models for young people who may not have any drug experience. When they are out doing drug prevention work eg giving lectures, they learn more about the risks that they will put themselves into if they choose to use drugs. This way, the drug prevention work they carry out reduces the risk of harming themselves when they use drugs. They have learned about the short and long-term effects of these drugs in order to give lectures to others. They also share this information with their friends in their youth environment. It is probable that this will have a preventive and a risk reducing effect on their environment.

Comprehensive policies and integrated approaches - the example of the city of Rotterdam

Wouter de Jong (The Netherlands)

Abstract

Risk reduction strategies regarding substance use are often considered from the perspective of single organisations, which undertake activities and services in order to reach and influence the behaviour within quite often pre-defined target population(s). Risks are defined in terms of substance use related consequences for the individual and his/her direct surrounding.

A different level on which one can consider risk reduction strategies is the level of the municipality. Substance use related issues and challenges on a municipal level are for example the maintenance of safety and public order in the city, the control of infectious diseases and the encouragement of multi-sectoral co-operation (between police, drug agencies, the public prosecutor's office, the agencies for the homeless and the (mental) health care institutions).

In recent years the city of Rotterdam has made a strong effort to develop an integrated approach towards substance use risks by finding a balance between public health, social care and public order policies. The primary aim of the Rotterdam approach is the reduction of social harm and the prevention of marginalisation, which is, related to substance use problems. The key word of the Rotterdam approach is inter-sectoral collaboration on various levels of policy development and implementation. This has resulted in a number of co-operative initiatives and programmes. First evaluations show promising outcomes, which could hardly be realised without the co-operation between the various sectors and organisations involved.

Risk reduction in the night time environment National and international considerations

Mark A. Bellis, Karen Hughes & Helen Lowey (United Kingdom)

The two main themes of the presentation are that:

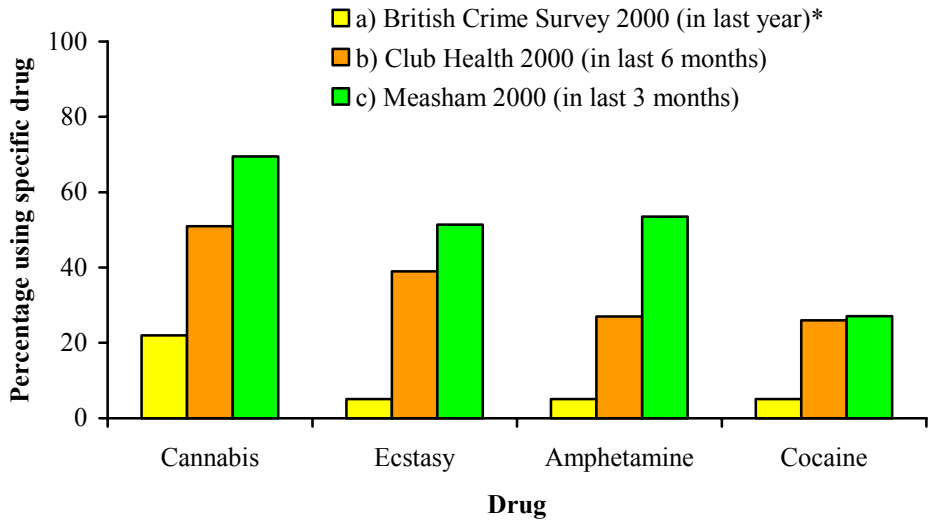
The night time environment can be altered in order to reduce the risk associated with the consumption of substances. In other words, we can develop a healthy settings approach to the night time environment.
Because of the nature of clubbing and rise in international dance music tourism (individuals going on holiday abroad specifically to visit night clubs) we now need an international response to reducing risks to health associated with night life.

Throughout these we consider substance use in its broader sense including legal drugs such as alcohol and tobacco. If justification is needed for this, in the UK alone up to 33,000 people die of alcohol related effects each year (Alcohol Concern, 1998) and 120,000 deaths are attributed to smoking (around 13 per hour) (Department of Health, 1998). However, certain types of drug use (e.g. ecstasy) have a particular relationship with club culture.

The relationship between clubbing and the use of illicit drugs is now well established (Measham et al., 2001). In Figure 1, we can see levels of cannabis, ecstasy, amphetamines and cocaine use in:

a) the general population from the British Crime Survey, 2000 (Ramsay et al., 2001)
b) a sample of young people travelling to an international dance resort from Club Health (Bellis et al., 2001) and
c) a group of UK club goers from a Dancing on Drugs survey (Measham, 2000).

Figure 1. Substance use in the general UK population and the club-going population.



**Age range: 16-29, except Measham, 15-57 (mean age=22.8)*

In the case of ecstasy, around 5% of individuals in the general population consumed ecstasy in the 12 months prior to the survey, whereas around 40% of individuals who travelled to an international dance resort consumed ecstasy in the six months prior to their trip abroad. Among the club goers surveyed in the UK, around 50% had consumed ecstasy in the last three months before the survey.

In the UK, recent reports of ecstasy deaths have acknowledged the relationship between the environment and the negative effects of drug use. For example, reports of ecstasy-related deaths indicate that external factors contributed to the individual's death:
"The most likely cause of death is heatstroke. The temperature in the club was thought to be 40°C" (Burke, 2001).
"Lack of adequate ventilation on a hot night with an inadequate supply of cold water" (Bowcott, 2001).

In other words, there is a growing recognition that the night club environment has a significant effect on the level of harm that is related to drug consumption. Most often, considerations of the environment have focused on the need for cool areas (i.e. 'chill out' areas) (Webster et. al., 2002) and adequate access to cold water in order to reduce the risk of over heating and dehydration. However, there are other areas in the night time environment where risks associated with substance use can be reduced (Table 1).

Table 1. Some Key Environmental Areas where Risk can be reduced

Buildings	**Ventilation and temperature**
Chill Out Areas to Cool Down	Smoking
Safe stairways and stairwells	Heat
Good lighting	*Water Availability*
Access to telephones	**Safe Sex**
Safe electrical Systems	Condoms availability
Noise	Health promotion
Staff and Training	**Access and Exit**
Door Staff	Fire Exits
Bar Staff	Emergency Services
First Aid	Crowd Control
Testing	***Night-time environment***
Pill Testing	*Licensing hours*
Breath Testing	*Public transport routes*

The design of the night time venue itself is important, for example, reducing the number of dark and secluded areas can reduce levels of drug dealing. Night clubs are often packed with electrical equipment and adequate safety measures should therefore ensure that the risks of fire are minimised. At the same time, issues such as over crowding and visible fire exists are vital if generally disorientated people (often through dance and substance use) are to escape a burning building (Calafat et. al., 2001; Webster et. al., 2002).

Equally, staff training in terms of crowd control and first aid is important. Both these elements should incorporate an understanding of adverse drug related effects. Other issues include:
Licensing hours and how they may result in large numbers of intoxicated, disorientated individuals leaving night time venues and gathering in the streets at the same time.
Excessive music volumes within clubs, which may lead to hearing damage.

Provision for safe sex including access to condoms (i.e. recognising the link between sex, alcohol and other substance use).

Testing initiatives, such as breath tests and consideration of pill testing.
Transport provision to move drunk and drugged people quickly and safely away from clubs at the end of an evening.

It is useful to provide some recent examples to illustrate some of the risks associated with these issues. In 1999, a report identified a clubber falling to his death in a Manchester night club after showing off to some friends (Manchester News, 2001). More recently another person died in a club as a result of a conflict with door staff, again after falling down stairs (Mendick, 2001). The importance of properly trained door staff cannot be over emphasised; properly trained door staff should be able to reduce harm rather that inflict it. A similar example of this behaviour occurred when an individual was left brain damaged after a fight with a night club bouncer (BBC News, 1998). These events illustrate the importance of training door staff to minimise harm and to deal effectively with inebriated individuals.

The relationship between violence and substance use in the night time environment is strong. Around 19% of all violence in the UK occurred outside a pub or a club, while 40% of violent incidents were related to alcohol and 18% to drugs (Ramsay et al., 2001). In addition, around 5,000 people in the UK are attacked with pint glasses every year, many of whom are scared for life (Deehan, 1999). In other words, controlling the paraphernalia used to consume alcohol (i.e. glasses and glass bottles) can be an important step in minimising harm relating to substance use. Some organisations are running campaigns in order to reduce this risk. For example, HIT, a harm reduction organisation based in Liverpool, UK (Figure 2) is running the Crystal Clear Campaign to reduce glass-related injuries by:
raising awareness of bottle and glass related injury.
encouraging patrons to leave glasses and bottles inside clubs.

Figure 2. Crystal Clear Campaign

Some effects on health in night clubs are perhaps less obvious. For example, noise levels in clubs can reach 120 decibels (Royal National Institute for Deaf People, 1999) while in the workplace it is recommended that individuals wear ear protectors if subjected to prolonged exposure to noise levels over 90 decibels (Health and Safety Executive, 1999). Some reports suggest that just one evening in a night club can leave people with severally damaged hearing (Walsh, 2000). Therefore, with the recent escalation in clubbing, substantially more young people will be exposed to excessive noise levels that could damage their hearing. The Medical Research Council Institute of Hearing Research found that 66% of club goers reported temporary hearing problems after attending a night club (Smith and Davis, 1999).

Sometimes the answers to problems such as noise are relatively simple. The distribution of earplugs inside clubs for instance may help protect hearing (Thyssen 2001). In some parts of England, lollipops have been handed out by the police to people leaving night clubs to reduce shouting and noise pollution in the surrounding environment (BBC Devon, 2001).

These examples are important in identifying a broader settings approach to health in the night time environment. This clearly includes substance use but also addresses its interaction with other elements that make up the night time environment. Often, through this approach, new and interesting solutions to risk reduction can be developed which, having had the input of a wider group, are more likely to be accepted. Furthermore, many groups who have important roles in the night time environment (Table 2) may be unwilling to talk specifically about drug issues but will engage in discussions on broader health issues.

Table 2. Some Partners in Improving Night Time Health – through a Settings Approach

Night-Life Industry	Health Agencies
Club and bar owners	Substance use services
Staff (door and bar)	- alcohol
Event promoters	- tobacco
Clubbers	- drugs
Authorities	Sexual health services
Police	Youth services
Emergency Services	Environmental health services
Local Authorities	**Others**
Politicians	Travel and tourism

International aspects of night life related harm are becoming more important, as every year we see an increase in travel abroad particularly among young people (Figure 3). Major event organisers now hold club nights across a range of continents meaning young people travel more frequently to experience the dance culture. As a result of the international nature of clubbing and because young people are travelling to international resorts to participate in night life, tour and travel operators have become key players in reducing risk for clubbers. One cause for concern is the link between sexually transmitted infection outbreaks and young people mixing in resorts abroad (Cook et. al., 2001). However, there are many reasons why clubbing abroad may present additional risks to health (Table 3). These include:

- unknown geography, language and location of health services,
- unknown quality of drugs purchased from unfamiliar dealers,
- differences in the size of drink measures,
- hotter climates which increase the risk of dehydration (and gastro-intestinal infections, which also cause dehydration) and,
- unfamiliar access to condoms and unknown levels of sexually transmitted infections.

Figure 3: Holidays taken abroad by GB residents (Office for National Statistics, 2001)

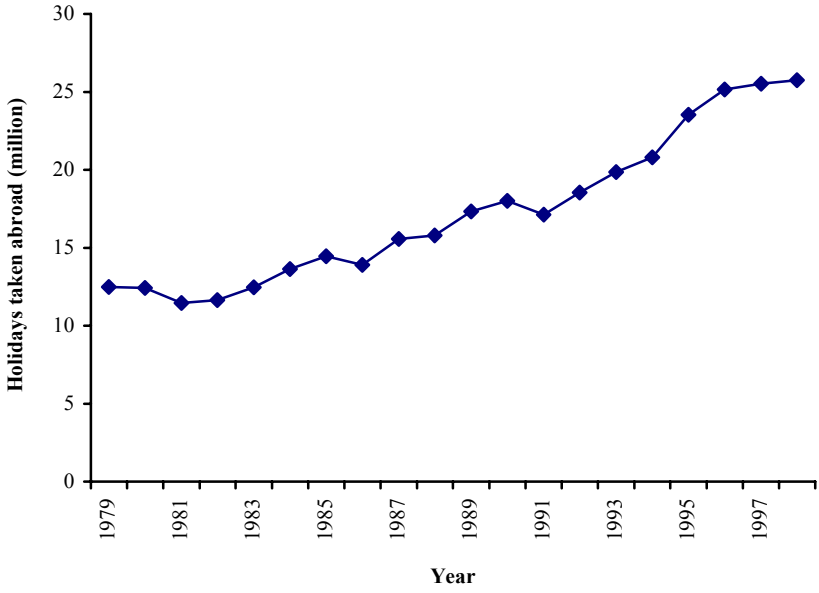


Table 3. Some elements leading to increased risk associated with nightlife abroad

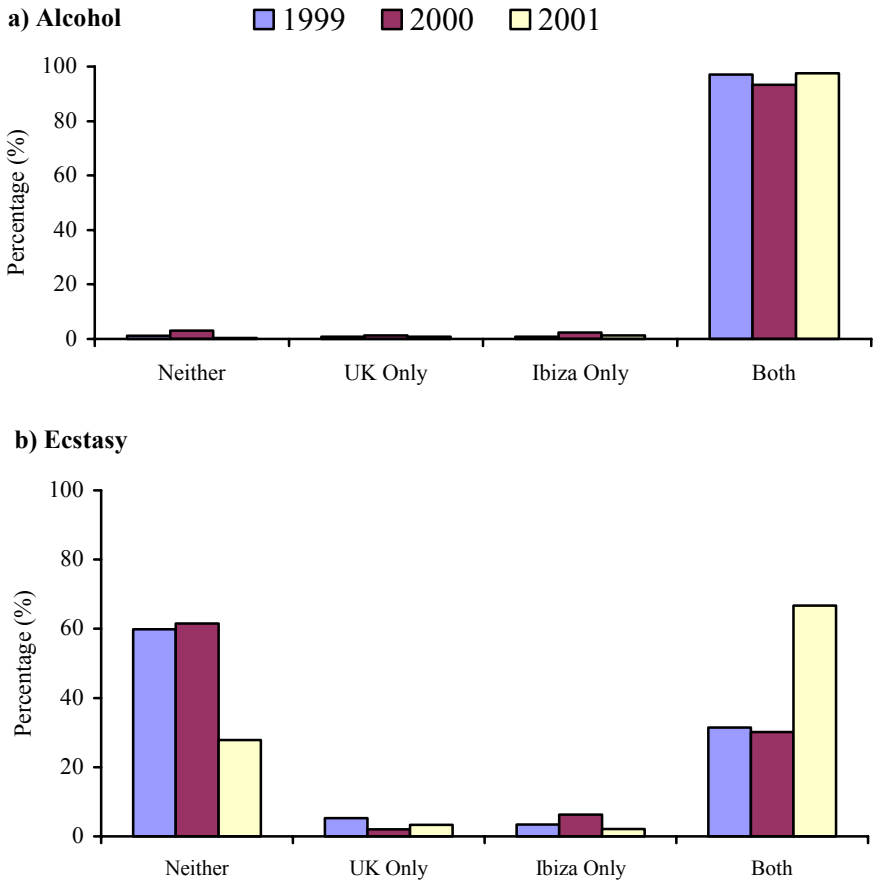
Environment is Unknown	**Dehydration**
Geography	Hotter climates
Language	Gastro-intestinal infections
Location of services	Temperature related increase in neurotoxicity
Legislation	**Sexual Health**
Opening hours	Unknown access to condoms
Drink-driving limits	Unknown levels of HIV and other STIs
Drugs	**Social**
Unknown suppliers	Reduction in social constraints
Counterfeits	Little or no work pressures
Emergency Services	**Alcoholic Drinks**
Sometimes restricted access	larger measures

The remainder of this paper will deal specifically with increased risks associated with another element of travel abroad - reduced social constraints while on holiday and how they effect substance use.

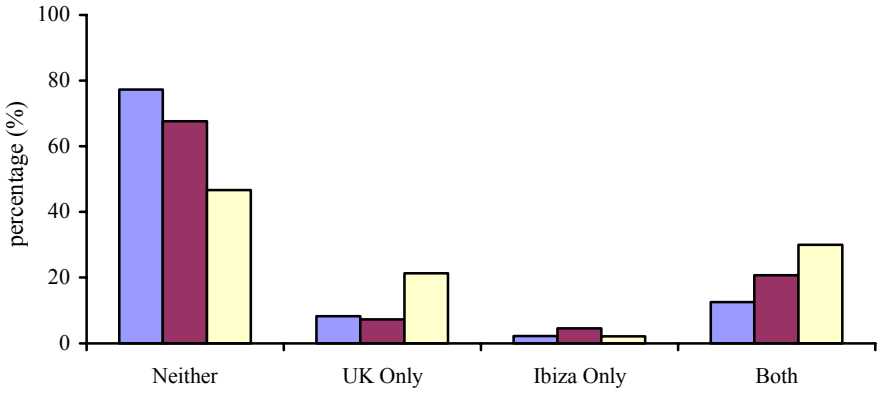
Ibiza is generally recognised to be one of the major international countries for dance music tourism and also one of the first locations where dance music and ecstasy use as a recreational combination emerged. It has an endemic population of around 80,000 but a throughput of over 1.5 million people (Instituto de Estudios Turisticas, 2000). Vast numbers of these young people visit the large clubs on the island which have capacities up to 10,000 people per night and stay open all night (BBC Radio 1, 2002). In order to study changes in risk behaviour of young people visiting Ibiza a three year study was undertaken during 1999, 2000 and 2001 (Bellis, M.A. et.al, 2001). Sample sizes were 1000, 500 and 750 in each year respectively and compliance was over 85% for each year. Surveys were undertaken at Ibiza airport between July and September (as individuals were waiting to return to the UK) and questions addressed drug use and sexual behaviour while in Ibiza and during the six month period prior to visiting the island. Here we present preliminary analyses.

Figure 4 shows the proportion of individuals who use alcohol, ecstasy and/or cocaine in (i) neither UK nor Ibiza (Neither), (ii) in the UK only, (iii) in Ibiza only or (iv) in both Ibiza and the UK (Both). It can be seen that the vast majority of people use alcohol both in Ibiza and the UK and there has been very little change in levels of its use (around 95%) over the three year period. Similarly, for ecstasy, individuals either use the substance in both Ibiza and the UK or not at all, with very few individuals using in Ibiza only or the UK only. This implies that ecstasy is easily available in Ibiza with supply not being a limiting factor. Furthermore, there has been a large rise in the consumption of ecstasy in Ibiza during 2001. The reasons for this are discussed later. Finally, for cocaine there is still a significant group of people who are only using cocaine in the UK but not in Ibiza. This may imply that supply of cocaine is still a limiting factor in the international resort. Over the three year period there has been a steady rise in the number of individuals using cocaine, from 22.8% of individuals having used cocaine in either location (Ibiza or UK) in 1999 to 53.3% having used in either location in 2001.

Figure 4. Substances used in Ibiza and UK

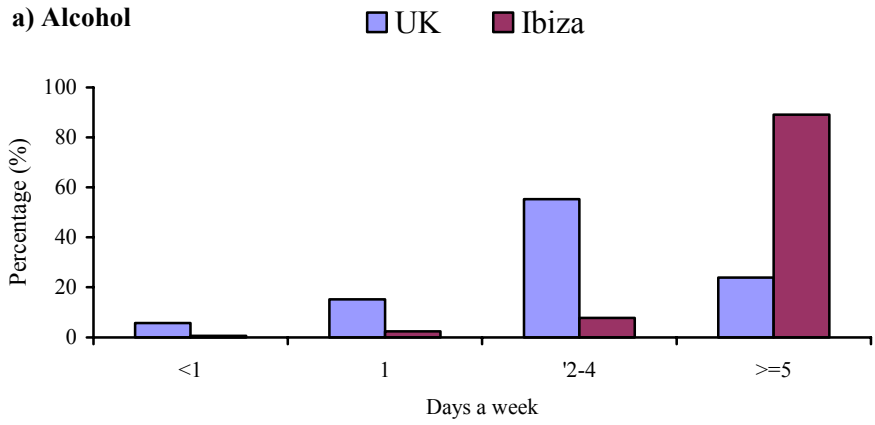


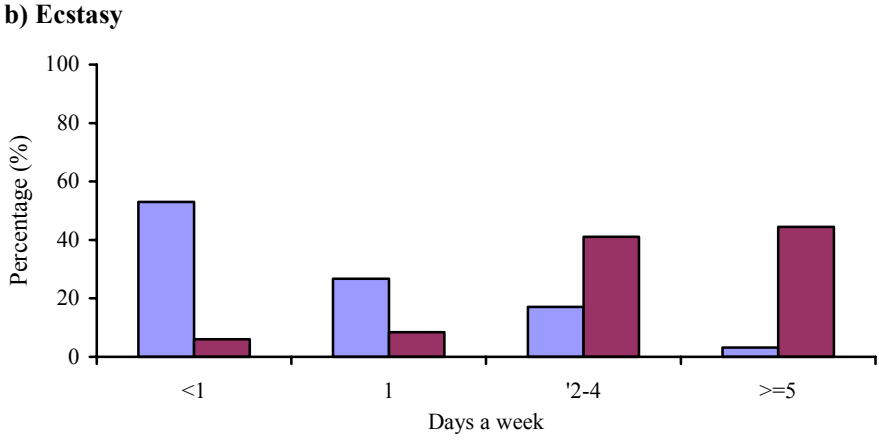
c) Cocaine



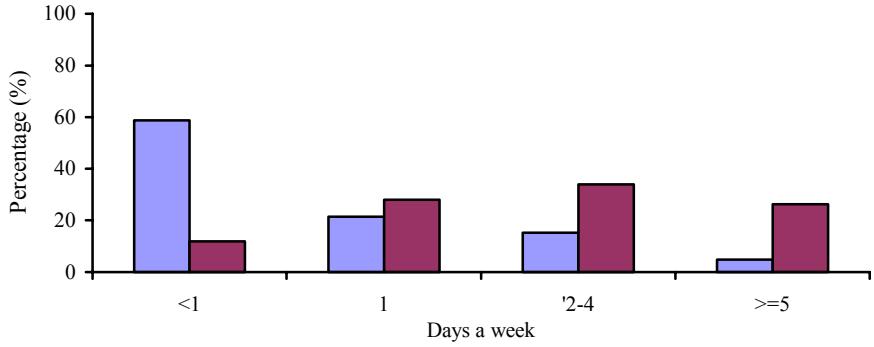
Changes in the way individuals use drugs are equally as important as numbers using. Limiting analysis to only those individuals who used each substance in Ibiza and the UK (i.e. Both), we compared the frequency (days a week) that individuals used alcohol, ecstasy and/or cocaine (Figure 5). For alcohol, 24% of users consumed alcohol five or more days a week in the UK, which rose to 90% whilst in Ibiza. For ecstasy only 3% of individuals who used ecstasy in the UK used it five or more days a week. In contrast in Ibiza, nearly half of the same users were taking the drug five or more days every week. A similar pattern of change can also been seen for cocaine.

Figure 5. Frequency of substance use in Ibiza and UK





c) Cocaine



Inevitably the frequent use of different substances means that a larger number of individuals are using more than one substance during their stay in Ibiza (excluding alcohol and tobacco). The increase in ecstasy and cocaine use seen in 2001 means that over the three year study period, levels of multiple substance use (during a holiday in Ibiza) have increased. Currently we know little about what effect consuming illicit drugs five or more times a week (even for a one or two week period each year) has on peoples' health. This type of behaviour (combined with the almost ubiquitous consumption of alcohol) also raises other questions in terms of the effects of a cocktail of substances being taken over a 7–14 day holiday period.

Why has ecstasy risen so steeply in 2001 among those visiting Ibiza? In 2001, the UK media highlighted a "get tough" approach to drug use aimed at clubs in Ayia Napa, Cyprus (Gillan, 2001). Ayia Napa is another popular dance music tourist resort for the UK population. By analysing our data we identified that the proportion of individuals visiting Ibiza in 2001 who had previously visited Ayia Napa had doubled, indicating that some individuals may have switched from Ayia Napia to Ibiza as the resort of choice for their holiday in 2001. This effect was not seen in people previously visiting other popular tourist resorts. We analysed the drug taking characteristics of this group and found they were significantly more likely to be ecstasy users ($p<0.05$; data not shown). In other words a change in drug policy in Ayia Napa may have caused significant numbers of ecstasy users to change their holiday destination from Ayia Napa to Ibiza. The implication is that unilateral changes in drugs policy may move individuals to other international night resorts that provide a more favourable environment for enjoying drugs and clubs.

An international approach to risk reduction in the night time environment involves developing international access to health related information on different countries environments. One mechanism for this is web sites, and some excellent examples of sites already exist providing information on safety and night life (www.dansesafe.org; www.ravesafe.org). Additionally, it is important that international health information materials are designed to address the types of substance use behaviour when taken while abroad. By working with HIT the results of our research have been used to create new literature, which is targeted towards young people going on holiday. This informs people about types of substance use and dangers associated with nightlife behaviour (in this case) specifically in Ibiza.

In summary, environment is a central issue for improving harm minimisation and risk reduction associated with substance use. Using the night club as a setting allows more groups to become involved in harm minimisation procedures and consequently more acceptable solutions to be developed. Club Health must be regarded as an international issue as young people are now travelling abroad more and for longer periods. As a result, international materials and initiatives need to be developed to address health promotion and health protection. Part of this process requires basic international standards of health for clubs to be developed (see www.clubhealth.org.uk). We still have relatively little information on the types of substance use behaviour that individuals undertake while on holiday abroad; with most studies focusing on average behaviour within the study population's own county. However, what research is available and that which becomes available in the near future should rapidly inform health promotion materials such as web sites and leaflets.

Whether clubbing has a positive or negative effect on health depends on how night life is managed not just by health services but by club owners, door staff, police and clubbers themselves. Managed well, clubbing can help regenerate night-life economies, provide a release from stress, a place to socialise and even an enjoyable form of exercise. Managed badly it can lead to alcohol related violence, damaged hearing and in some cases result in death from drugs and other causes.

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Description of programmes set up in the framework of a risk reduction policy

Benjamin Perasović (Croatia)

Risk (harm) reduction in the area of drug use other than by injection comprises a wide spectrum of policies and activities. Sociologists refer to contemporary society as the "society of risk", hence it is not surprising that risk reduction has many forms, from production (economy) and ecology to health or traffic. However, in the area of drug use the most present problem is that of use by injection and as a result of heroin use, programmes such as needle exchange have become synonymous with harm reduction and risk reduction strategies.

We can, of course, talk about drug use and risks in two ways; one is to start from the fact that drugs are used and to discuss the risks that come as a result of that use, whilst the other is to consider the use itself as the greatest of risks and, consequently, to consider the reduction of demand or supply as the most effective way to reduce risk.

In the past few decades, many outreach, low threshold strategies have been developed in western Europe, enabling risk reduction activists to come to even those users who are otherwise difficult to reach because they are out of the system. Also, the use of methadone as a means to cease heroin use (gradually reducing the quantity) or simply for maintenance has become generally accepted in the official policies of all European countries.

Occasional campaigns for the integration of addicts into society aim to reduce risk by a certain normalisation, at least in special zones or neighborhoods. For quite some time, especially in Germany, the Netherlands and Switzerland, risk reduction includes also opening drop-in centres and consumption rooms in which addicts are also able to receive first aid. However, the majority of these programs refer to the use of heroin and occasionally cocaine.

The best known programmes for risk reduction in the area of drug use other than by injection are undoubtedly those addressing clubbers, night-life actors, the rave scene, etc. We already have ten years of experience in this area, from the first information on the effects of MDMA served to the rave population in simple, understandable language to all kinds of interventions performed today so as to reduce risk on the wider party, club or "recreational drug use" scene. In this scene, there are risks which are not related to the use of a drug, such as problems of the conditions of a party (the number of people, possibility to move, drinking water, air circulation), which become more

pronounced under the presumed influence of the drug. The main actors of risk (harm) reduction are non-governmental organisations (NGOs), sometimes within the system, but predominantly with unstable sources of financement.

To what extent are such informative and educational programmes, including pill testing on party events in some western European countries, in conflict or opposition with supply and demand reduction programmes? This is a classic question that is often posed when discussing harm and risk reduction initiatives. Supply reduction in principle does not interfere with these initiatives, though there were cases in eastern Europe when a police raid and a fear of a detailed search at the entrance to the club made many people swallow more drugs then they actually intended to. Messages such as “Less is more” have thus become unusable.

In countries where pill testing is not tolerated, there could be other ways of cooperation between the police and NGOs, especially if there are some poisonous materials in the pills. Getting information from well-established rave scene channels is necessary in such cases.

Demand reduction is, naturally, an area quite distinct from the reduction of risk or harm incurred by presumed use of drugs. However, the two spheres can be connected. The experience of the Slovenian NGO **Drogart** demonstrates that one can successfully combine prevention with a specific target group (high school pupils) and classic harm reduction work at party events.

What are the elements of the best risk reduction programme in the area of night life, dance drugs and the rave scene?

Research

Research is a desirable basis of every good programme. It requires qualitative, ethnographic research, as well as quantitative methodology. Besides the rather general term “youth culture”, sociologists have until recently used the term subculture. Regardless whether we will use the term subculture, or as French sociologist Michael Maffesoli speaks about, “neo-tribes”, the research should encompass genuine movements on the scene of drug use. Youth subcultures are followed by various mystifications, which are both positive and negative. Negative mystifications are also known as “moral panic”, which is connected with stigmatisation and marginalisation of youth; subculture is necessarily presented as deviant and subcultural styles as unacceptable.

On the other hand, there are positive mystifications, which see subcultural actors as a resistance with the creative potential for social change. Here, we are not concerned with social paradigms but with the need to reject mystifications in favour of researching the genuine, everyday life of subcultural groups, especially when tied with various forms of drug use. For example, on the rave scene one might find hippies, punks and football hooligans, as well as the jet-set, all with their regional specific characteristics, slang and drug preferences, but only a careful ethnographic research establishes network and maps different from our expectations when thinking about superficial characteristics, symbols and meanings. Many common perceptions, such as the one on fixed pharmacological characteristics of a certain drug, the way it determines behaviour, or about certain types of social use, change depending on the practices of urban tribes and individuals in the past century. Good research, based on an understanding of subcultures and adolescent "worlds", can facilitate recognising the right target population and make later activities in harm and risk reduction initiatives easier, as well as serving evaluation purposes.

Informing

Informing pertains to objectively acquainting people with a certain drug, its characteristics, possible consequences and the ways to reduce risk and harm. There are medical, legal, as well as social aspects. The majority of information in this area is presented in a form understandable and acceptable to the target population, without moralising or judging, but primarily informing about short and long term effects, possibly followed by useful advice or simple and effective slogans that inform about risk reduction. Numerous organisations have been using flyers (a certain micro-media of the scene it addresses) as the most frequent way of spreading information, but web sites, permanent telephone lines, posters, brochures, etc. are not neglected either. Research can spot specific problems in a local context, but apart from providing information about drugs, their short and long term consequences, drug mixing and the problem of "coming down", the most frequent information it provides is about heat stroke, exhaustion and recuperation, the damage caused by standing close to the loudspeakers, dehydration, possible risks of traffic or information intended especially for women.

Education

Observing many similar risk/harm reduction programmes, we can conclude that education appears on two levels; first, the education of actors themselves, NGOs, volunteers and others participating in the programme. Education is conducted in seminars, lectures and workshops and it refers to disseminating knowledge about drugs, their

pharmacological characteristics and social types of use. Education is conducted by experts.

On the second level, education means deeper, longer and more complex processes of informing and interacting between a harm reduction actor (NGO) and the target population, so as to establish a solid body of knowledge about drugs and the possibilities to reduce risks. Some associations are active in risk and harm reduction among rave populations and they address the wider scene, regardless of the drug use, in an attempt to improve the conditions and communication among scene actors. For example, apart from publishing leaflets, brochures and flyers, the Croatian NGO Špica is releasing the PLUR magazine, which provides information about drugs and risk reduction, as well as providing a series of articles on the problems of the scene that have nothing to do with drug problem, but rather with the problems of music, money, commercialisation, solidarity, violence, relations with the police, etc.

In some countries, it is also customary for everyone working on a party to attend the first aid course, as well as a series of workshops on different types of overdose or other difficult states caused by drug use. In the work with volunteers, one usually uses the experiences of the sociology of small groups, as well as “peer education” heritage so far.

Field Work

In a good programme, field work always involves more than merely disseminating flyers and brochures. Face to face contact is sometimes more important (or needed) than anything else and specific conditions of a rave or a similar event make this contact very important. Hence, volunteers have to take part in workshops and undergo education and to completely understand the content and purpose of risk reduction activities in order to be successful in the direct spreading of the message. Field work includes information and education, first aid and often negotiations with the organisers of parties, the police and ER representatives. In one period of mass parties, the owners of clubs in Croatia (as well as in many other countries) used to close down the water supply in toilets so that thirsty ravers would pay for drinks at the bar. Given the poverty in this country, there is a high probability that clubbers have used amphetamines or ecstasy and, with a lack of air ventilation, the risks have been significantly increased.

Many volunteer groups wear easily recognisable T-shirts or ID cards around their neck during field work. Their activity is obvious and frequently commented by the target population. It seems important that these people usually consider themselves part of the same scene, music and dance, which makes the role model influence desirable.

Analysis of slang, knowledge about the main informal groups, their behaviour, dance style or music preferences, the latest trends in drug use can exert influence on the scene by pushing the image of over-drugged people who consume as much as three or six ecstasy tablets is undesirable and unacceptable for the majority of party scene members. This can be achieved if young actors of risk reduction come from the "inside", which enables them to impose themselves as actors of the rave (techno, house, trance) scene themselves.

Finally, let us take a closer look at an example of a risk reduction programme in Croatia. After the first risk reduction initiative was accepted in the mid 90s (together with the developed system of reducing supply, including all levels of prevention and treatment, this strategy has found its place in the national strategy against drug abuse), Croatia started with needle exchange, informative brochures and risk reduction in the area of heroin addiction. The NGO Špica, which focuses on risk/harm reduction on party scene and dance drugs, emerged several years later.

Since this is the first risk reduction NGO in the area outside heroin addiction and drug use by injection, there were fears that accepting its public work would lead to accusations about promoting drug use. However, the initiative was not denied and Špica's activities have not received a single negative article in the media. On the contrary, it has been receiving more financial and institutional aid.

Špica's research (which was only partly for evaluation purposes) demonstrated that its activities are know to 70% of the party scene's population. With its activities, flyer designs, web site and other means, Špica imposed itself as an actor on the scene itself and served as a certain bridge towards the institutions of the system. Through negotiations with party organizers, Špica managed to stop the practice of shutting down water supplies. Today, organisers predominantly invite Špica representatives on their own to make arrangements for info-stands, free drinking water, chill out spaces and other details. There is also cooperation with the institutions of the system and the trend of using extremely high amounts of drugs, which was evident before the arrival of this NGO for "a healthier subcultural scene", has been stopped, at least in the major clubs where Špica is active.

Fragmentation of contemporary society and the plurality of approaches are today's reality. Due to differences and specific characteristics of target groups, it is possible to achieve a national policy towards drugs that respects all aspects, including reduction of supply and demand, methadone and drug free treatment, as well as risk and harm reduction programmes, which presuppose the use of drugs.

The heroin scene and the party scene are significantly divided, but the fact is that one section of partygoers ended up addicted to heroin due to the practice of “coming down in the morning” with a line of smack. Risk reduction organisations have paid due attention to this problem.

Risk reduction programmes usually concentrate on two important areas – heroin (in western countries also cocaine) and the party scene (ecstasy, amphetamines). The latest developments in the filed of risk reduction in Croatia have demonstrated that various risk reduction initiatives are closely intertwined. A good example is a programme pertaining to AIDS and HIV infection. It is well-known that AIDS has changed many previously held positions and that it marked the beginning of a wider acceptance of risk and harm reduction strategies. AIDS prevention is a huge area unto itself but in many ways it is connected with the risks of drug use.

Let us look at two dimensions that emerge if we compare the main messages of AIDS prevention with the problem of drug use. One dimension is undoubtedly concerned with needle exchange programmes and reaching those who are outside the system and any form of treatment. However, the other dimension, such as campaigns for safe sex and use of condoms covers a much wider area than drug use by injection, wider even than the “youth culture”. Effective AIDS prevention programmes create a certain “group of rules” for risk reduction (similar to those for traffic safety) aimed at the entire population.

Nevertheless, it is not presumed that all the “tribes” in our fragmented urban world receive equally well messages aimed at the general population. Croatian research among the rave population demonstrated that those considered by sociologist to be the most urban population, the internet generation that should be informed and relatively responsible compared to their peers, have deep prejudices against the use of condoms! This fact resulted in gathering several actors and institutions of the society so as to approach the target population to reduce risks of HIV infection.

If a message aimed at everyone does not reach special groups, than it should be formulated so as to be acceptable to the target population. Actors of prevention agreed that Špica as an NGO active in risk reduction on a party scene should begin with AIDS prevention within its usual activities to inform and educate the rave and club scene.

Risk reduction programmes are clear and simple, as well as quite universal, but they always have to include the significance of the local context and the characteristics of the target population. By definition, risk and harm reduction work with target populations, which enables

tolerance and pluralism in its approach. Actors of demand, supply and harm reduction programmes can each work together in their own fields for the benefit of everyone.

Conclusions

Milan Krek (Slovenia)

What is risk?

Different people may have different view on risk, i.e., "my son use drugs" (mother's view of risk), "police will put me in prison" (user's view of risk), "do I find drugs in his pocket?" (police's view of risk), "do they make a trouble?" (politician's view of risk), "I hope, that he will not have an heroine overdose" (medical doctors view of risk), "I am afraid that your mother will find your heroin" (another drug users view on risk). All is relative, even perception of risk.

What is risk reduction approach?

Is it a part of drug policy or a general drug policy? What is the relation between risk reduction, drug demand reduction (DDR) and drug supply reduction? And finally, is it a political approach to drug phenomenon?

Risk reduction is *just an approach*. At this moment it is a part of drug policy in the DDR strategy mostly as a terciary prevention (HIV, hepatitis C, B etc..). But in the future it could be a drug policy and other DDR activities will be a part of risk reduction policy.

Drug supply reduction activities made risks for drug users(prisons, arresting, stigmatisation, unemployment,...). The drug suply reduction strategy should be change if risk reduction would become a leading policy.

Risk reduction should be oriented on the target groups; we need always analysis of risks from the consumers or target group of the programme.

- risk is a dinamic category

- risk reduction is not a program, but just an approach

The UNDCP glossary defines risk reduction as the policies or programmes that focus on reducing the risk of harm from alcohol, tobacco or other drugs
But risk reduction is not only "reduction of harm": EDDRA – EMCDDA describes "harm reduction" programmes as activities aimed at stopping harmful consumption practices or decreasing drug related social and health problems or death. It does not evisage a drug free status or reintegration of the users.

We know that risk reduction is a basic pillar or approach of the Pompidou Group, accepted on Ministerial Conference in Sintra (Portugal), October 2000. NGOs are also important organisations on the field of risk reduction, so we have to support NGO iniciatives and self-help groups.

Risk reduction is usefull not only for illegal drugs but also for the tobacco and alcohol, but some risk reduction activities could be contraproductive (light cigaretes). We could learn a lot about the risk reduction from the activities on alcohol and tobacco activities.

We need to improve the **research** in this field and to connect DDR and harm reduction strategy.

In a risk reduction programme there are four important fields of activity:
information
- education
- research
- evaluation

Looking at the scientific publications on this subject, one could remarks that terminology is not uniform: different people understand different thing under risk reduction. It is not clear what makes risk reduction different from supply reduction, DDR and harm reduction. We need more research on influence of risk reduction on DDR and drug supply reduction startegy and activities.

The preliminary report shows that there is not a lot of knowledge about the iunfluence of risk reduction activities and legitimacy of risk reduction strategy is not obivious and varies over time.

In general, specific bibliography is poor: there are articles on the field of alcohol and not so many on the field of tobacco. Many analyses were made for politicians and they are not put them in scientific revues. A possibility to improve that could be to set up a multidisciplinary research group in Pompidou group, which could support their research work, establish a research journal and a web site. Of course, special funds for research in risk reduction field would be necessary.

It would also be useful to learn from experiences of risk reduction activities in the field of legal drugs for planing activities on illegal drugs field.

One key subject is **"driving and drugs"**. Some studies show that 75% of drivers use the acohol and 5% heroin. Psychotropic substances influence decreasing the ability to drive. There are several results which

support this conclusion: under the influence of drugs the reaction time is more than three times longer, the perception of the reality changes, so drug use is a high risk for driver and other participants in traffic.

The new group of **synthetic drugs** produce new risks; they are often connected with new forms of dance music events (rave parties). Many times the use synthetic drugs is associated with alcohol, heroin, cocaine,... We need **new approach** to the problem, old methods are not effective: new activities, new methods.

Thinking on synthetic drugs and risks reduction, we have to consider:
- culture
- specificity of different drugs
- specificity of target groups
- credibility of the messages
- permanent evaluations of our work
- young people *"need"* the risk

Some interventions to reduce risk of synthetic drugs:
- outreach
- peer intervention: teaching people how the consequences of drug using looks like and, maybe, teaching them how to use synthetic drugs in a safer way
- user advocacy
- emphasis on improving knowledge and reducing risk communication by newspapers, internet, leaflets, pill testing
- safe environment for rave parties and other dance events (guidelines for clubs, with references to water supply, noise, temperature, access to public transports).

A presentation during the Seminar has shown us the *PC* **as equipment for education and risk reduction**. We find target group of people, we can give them interesting information and they can see what is good and what is not and all consequences: under the influence of information they can change their behaviour. It is a simple and effective method.

A **multisectoral approach**, promoting the cooperation between different professionals and sharing their responsibility must be aimed to influence attitudes and behaviours of both drug users and the community. A common strategy in Europe is necessary: risk reduction should be a part of national, city and local community strategy but also a part of the European drug strategy.

This two-days Seminar has given us the opportunity to exchange our experiences of risk reduction programmes, mostly based and inspired

by policies aimed to limit risks of the use of "legal" drugs, as alcohol and tobacco. Unfortunately, the amount of scientific research and publications on this field is small and should be encouraged. New drugs and new ways of drugs use require new approach and new methods to reduce associated risks.

As a general conclusion, let me say that **risk reduction activities are one of the most important strategies of intervention in the future**.

APPENDIX I

PROGRAMME

Thursday 21 February 2002

9.00 – 9.30 Registration of participants

Opening of the seminar

9.30 – 9.35 *Christopher LUCKETT*
Head of Division, Secretariat of the Pompidou Group
Welcome, introduction, practical information, history/context of the activity

9.35 – 9.40 *Patrick SANSOY*
Chargé de Mission à la Mission Interministérielle de la lutte contre la Drogue et la Toxicomanie, MILDT (France)
Welcome, introduction, history/context of the activity

Chairman for the half-day: Patrick SANSOY

9.40 – 10.00 Session 1:
The emergence of the risk reduction concept in Europe and the difficulties encountered in implementing such programmes – definition of the concept
Peter COHEN (Netherlands)

10.00 – 10.20 Session 2:
Description of programmes set up in the framework of a risk reduction policy
Benjamin PERASOVIC (Croatia)

10.20 – 11.00 Questions and discussion (as regards sessions 1 and 2)

11.00 – 11.30 Coffee break

11.30 – 11.50 Session 3:
Examples of risk reduction policy in Europe (all substances) – recent research in this field and analysis of the results of programmes aimed at substance users other than by injection
Wouter de JONG (Netherlands, Consultant)

11.50 – 12.15 Questions and discussion

12.15 – 14.00 Lunch break

Chairman for the half-day: Mari JÄRVELAID (Estonia)

14.00 – 14.30 Session 4:
Specific problems related to alcohol or drug use associated with driving
Michèle MUHLMANN-WEILL (France)

14.30 – 14.50 Questions and discussion

14.50 – 15.10 Session 5:
Overview of developments in risk reduction strategies aimed at synthetic drug users
Andrew BENNETT (United Kingdom)

15.10 – 15.30 Session 6:
Qualitative approaches: examples of specific risk reduction experiences with substances other than by injection (alcohol related issues)
Andree van EMST (Netherlands)

15.30 – 16.00 Questions and discussion (as regards sessions 5 and 6)

16.00 – 16.30 Coffee break

16.30 – 16.50 Session 7:
Laws and regulations
Bertrand LEBEAU (France)

16.50 – 17.10 Questions and discussion

17.15 *Reception (Blue Restaurant)*

Friday 22 February 2002

Chairman for the half-day: Bernard VANDENBOSCH (Belgium)

9.30 – 9.50 Session 8:
Education by peers and field workers
Ragnhild BRUUN (Norway)

9.50 – 10.10 Questions and discussion

10.10 – 10.30 Session 9:
Comprehensive policies and integrated approaches – the example of the city of Rotterdam
Wouter de JONG
Hugo VERPOORTEN (Netherlands)

10.30 – 10.50 Questions and discussion

10.50 – 11.20 Coffee break

11.20 – 11.40 Session 10:
Risk reduction in the night-time environment: national and international considerations
Mark BELLIS (United Kingdom)

11.40 – 12.00 Questions and discussion

12.30 – 14.00 Lunch break

Chairman for the half-day: Milan KREK, General Rapporteur

Special session: Summary and conclusions

14.00 – 14.20 Summary of the seminar
Milan KREK

14.20 – 14.40 Questions and discussion

14.40 – 15.00 Discussion and conclusions of the seminar
Led by the General Rapporteur

Close of the seminar

15.00 – 15.05 *Patrick SANSOY*

15.05 – 15.10 *Christopher LUCKETT*

APPENDIX II

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