COST-EFFECTIVENESS is not a dirty word

A 'very modest proposal' says the author. Others may see it as an unholy descent from saving lives, to saving money. Welfare benefit gained per £ spent is the issue, outreach work the example.

James Les Kay

ANXIETY ABOUT HIV infection has been coupled with the long-standing awareness that only a minority of injectors are in touch with any helping service. As one solution to this problem, 'outreach' has become the buzz word in the drugs field. Last year the Advisory Council on the Misuse of Drugs argued:

Outreach workers can [contact] drug misusers who may not otherwise seek help, for instance, young drug misusers, drug misusing prostitutes, occasional drug misusers and amphetamine misusers.[1]

The smallest sensible unit for outreach work would be two workers attached to a community-based team. Even if the salaries were modest and support services budgeted at rock bottom, it is difficult to see how such a pair of workers could be funded for less than £25,000 a year. Established as a separate team with their own administrative support and offices, costs could shoot up to £40,000. An ambitious target would be for them to bring an extra 5-600 new clients into contact with services over three years.[2]

It is now relatively simple to calculate the range of costs for each of these clients (see table): at the most optimistic, £125 per client; at the most pessimistic, £240 per client.

Another way to address the problem of injectors not yet in contact with services would be to cut out the middle person — in this case, the outreach worker — and substitute direct economic incentives to drug users themselves. The medium for an incentives strategy could be needle exchange clients. They are in a sort of limbo between those trying to stop using drugs and those out in the community with no intention of doing anything about their drug use.

Needle exchange clients could be offered money to bring their friends into contact with our services. An offer of £10 cash per new contact would result in a rapid influx of hitherto unseen drug injectors. We could then offer each of these new contacts £5 for listening to a short presentation on safer injection techniques promoting the needle exchange service.

This very modest proposal has the great beauty of being the most cost-controlled service one could imagine. If the incentives strategy failed, it would cost almost nothing. Costs are incurred only to the extent to which it succeeds in attracting clients — and these will never be more than £15 per client plus minimal servicing costs. In contrast, if outreach workers fail to make any new contacts they still cost the full budget allocation from day one.

It might be thought that £10 is not much of an incentive — but this is £10 per client. If a drug user were energetic enough to bring in ten, they would be going away with £100. They would have earned it. If £10 was not enough £20, £30, or even more could be offered — as long as the fee stayed under about £100 per new contact, it could still be guaranteed to be cheaper than the outreach option.

Without some such attempt to calculate the costs and benefits of different ways of providing this sort of service, it seems difficult to justify new expenditure on as vague a concept as outreach work.

Counter-counterarguments

☐ The first argument against such a strategy might be that it would be difficult to administer. Certainly there would need to be very clear rules for managing a system which hinged on handing out cash. Ensuring there was no time when significant amounts of cash were held would mean repeated visits to a nearby bank, but it ought to be possible to make such arrangements fairly easily. No worker should be left operating solo in such a setting — but that shouldn't be happening anyway.

It would also be necessary to have some way of checking that new contacts were not just passers-by press-ganged into service as imaginary injectors. But this is not a new problem for needle exchanges: staff there routinely seek evidence of injection, either by inspection of injection sites or through a brief discussion assessing how much the client knows about methods used for preparing and injecting drugs.

There are genuine organisational problems to be overcome in ensuring the smooth, argument- and corruption-free dissemination of cash in return for contact. I cannot believe these would defeat the imagination of staff currently deployed in services such as needle exchanges.

The economics of outreach

Outreach method	Yearly cost	Cost over 3 years	Clients reached	Cost per client
Outreach team:				
optimistic estimate	£25000	£75000	600	£125
pessimistic estimate	£40000	£120000	500	£240
Needle exchange clients	Dependent on performance			£15?

1. Advisory Council on the Misuse of Drugs, *AIDS and Drug Misuse*. Part 1, HMSO, 1988.
2. This target is based on discussions with fieldworkers and some managers of drug services. The consensus was that my 'target' was very optimistic.
3. Nurco D.N., "Drug addiction and crime, a complicated issue", *British Journal of Addiction*. 1988, 82(1).
Parker H. *et al*, *Living with Heroin*. Open University Press, 1988.

The author has worked for many years in drugs training for the Lifeline Project in Manchester, which he recently left to help form NETWORK ADA. He can be contacted on 0706 828963.

☐ A more principled objection might be that it is immoral to pay drug users cash which they would in all likelihood spend on drugs. This would be a peculiar position to adopt when drugs and free needles are already being handed out as an incentive to make contact. Set against it is the fact that, if we were not paying drug users, many would raise the cash by victimising the local community. The link between acquisitive crime and illicit drug use has been well established in recent years.[3]

Are we morally secure in ignoring the rise in burglary rates due to injecting drug use, not to mention the health risks from needle sharing? Might we be more righteous in the long run if we were to offer financial incentives to drug users to encourage contact with services? If they use those incentives to further their drug use, so what? — they were going to continue using and sharing anyway. These are not new moral dilemmas. In educational work it has long been argued that a harm-minimising strategy should override moral fastidiousness.

☐ Another argument is that the contrast with outreach work is false — that the aims of outreach work are not to bring drug users into existing services, but to create an entirely new type of service operating out in the community and responsive to the needs of that community.

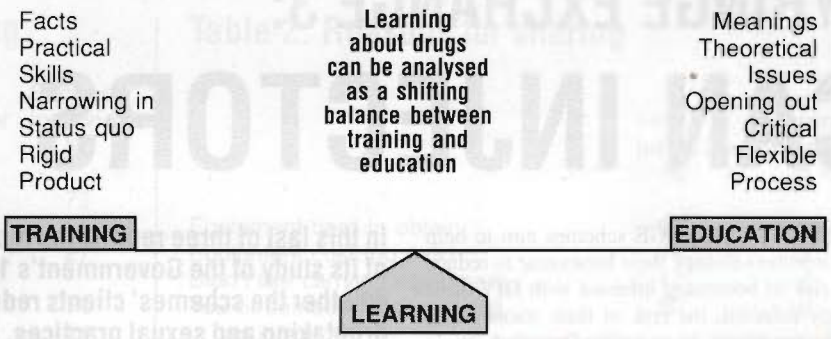
This may be a sensible objective for outreach work. But it is not how new outreach services have recently been justified. Demands for these services clearly originate in the threat of an epidemic of HIV disease. The case has been persuasively made that the objectives of abstinence-orientated drug services have to give way to the priority of curbing HIV infection. Opportunities to encourage safer drug use (ie, no longer sharing needles) can only occur if drug users are brought into contact with the advice, persuasion and resources available at services such as needle exchange schemes.

By definition, the *sine qua non* of harm-reduction services is their ability to contact those at greatest risk. Outreach work may be justifiable in its own terms — but it becomes an important part of the response to HIV only to the extent to which it succeeds in reaching those parts which other services have not.

THERE IS NOTHING new about offering drug users payment to cooperate with drug services. It is a well-established tradition in research in America. In north-west England a recent series of user interviews in the evaluation of Lifeline's comic earned participants £10 an hour. The system worked without any serious problems.

The idea of economic incentives ought to appeal to those of a Thatcherite persuasion — though this is probably the reason why it will get a 'no' from people who only need to think that it smacks of capitalism, to know that they oppose it.

A final argument in favour of at least attempting this incentives approach is that it would be very cheap to launch. If it proved unsuccessful, the experiment would have cost very little. The idea could be introduced on a pilot basis for a few months with only one or two thousand pounds in the kitty. Perhaps the best way to test the validity of arguments for and against this strategy would indeed be to launch it on just such a pilot basis, and see what happens next. ■



SKILLS or ISSUES?

The nature of drug training

Is it drug training workers need — or drug education? Decide for yourself what learning about drugs should really be about.

Dave Macdonald

THE TERM 'training' makes me feel uncomfortable, evoking images of dogs being trained to sit, or soldiers trained to kill. It implies obedience, and that there is a 'right' and a 'wrong' way of doing things. In reality, what's called 'training' often lies somewhere on a continuum between training and education, and not at either extreme. In the drugs field, as elsewhere, learning processes have to be an appropriate mix between training and its opposite and contradictory concept, education (see diagram).

☐ Training is about looking at facts and providing practical skills for dealing with them. It is more rigid than education, often being based on the status quo and promising an end-product, ie, the trained or skilled worker: "Training involves a *narrowing down* of the consciousness to master certain techniques or skills." (Peter Abbs, *Guardian*, 5 January 1987.)

☐ Education, on the other hand, looks at the meanings behind the facts and the issues that arise from them, as well as the facts themselves. Ideally it should be a critical, flexible process valid in itself whether or not there is an end-product such as practical skills or qualifications: "Education is an *opening out* of the mind which transcends detail/skill and whose movement cannot be predicted". (*op cit.*)

From these definitions it is clear that what many people bring to a learning event on drugs is their experience of training, not education. This may be their experience of the British school system, which increasingly fits the criteria for training rather than education, or of professional training in, for example, social work, teaching or medicine. As a result they expect to be provided with the facts about drugs and drug users and the practical skills to deal with them — end of story.

Education by itself is as useless as training by itself in helping people to cope through their learning about drug problems. It can be so woolly that it never tackles the issues it discusses in a practical sense. Certainly it is bad practice to send someone away from a learning event without some enhancement of their skills.

If education is emphasised rather than the training product, people may initially feel de-skilled and *less* able to cope, because they feel their existing knowledge base and skills are inadequate, and no new skills have been learnt. They may feel personally challenged or criticised. However, their competence will eventually be enhanced as they discover how to adapt their *existing* skills to the issues that emerge during the learning experience — learning *how* to solve their problems rather than just what the solutions are.

Indeed, many educational models assume that learning is a process filled with tension and conflict. It seems essential, then, that this experience should be conducted within a context of maximum safety and support and with evaluation and follow-up built in. This is particularly true, for example, of the new courses we are organising for drug workers in Scotland. These workers are increasingly having to work with HIV-positive clients, and need help with sexuality and sexual counselling, pregnancy counselling, bereavement and loss.

THE BEST SKILLS to help people come to terms with the many facets and complexities of the 'drug problem' may be those of education itself — to be flexible and critical, to examine the issues, and to maintain an open mind. After all, the 'drug problem', like education itself, is a phenomenon the movement of which cannot always be predicted. ■

The author is a Training Organiser with the Drugs Training Project at Stirling University, Scotland's national drug training organisation. The Project can be contacted on 0786 73171.

I have refrained from giving in-depth examples of training and education in the drugs field. Readers should consider for themselves whether the model described makes sense. If you are a participant, do you feel you are experiencing a balanced approach that meets your needs? If you are a helper, are you clear where you and your course stand on the education/training continuum, and how you fit this to the needs of the course participants?