

# International Journal of Drug Policy

## How (not) to prove that drug checking services facilitate access to difficult-to-reach communities who use drugs, and (not) encourage drug initiation?

--Manuscript Draft--

<b>Manuscript Number:</b>	DRUGPO-D-22-66R1
<b>Article Type:</b>	Viewpoint
<b>Corresponding Author:</b>	paul calle Ghent University Faculty of Medicine and Health Sciences: Universiteit Gent Faculteit Geneeskunde en Gezondheidswetenschappen Ghent, BELGIUM
<b>First Author:</b>	Paul Calle
<b>Order of Authors:</b>	Paul Calle

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60  
61  
62  
63  
64  
65

**Declaration of interests**

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests:

**Ethics approval**

The authors declare that they have obtained ethics approval from an appropriately constituted ethics committee/institutional review board where the research entailed animal or human participation.

The authors declare that the work reported herein did not require ethics approval because it did not involve animal or human participation.

**Funding sources**

This research received funding from the following sources

(Please insert all funding source details including grant number(s) and who provided financial support for the conduct of the research and/or preparation of the article and briefly describe the role of the sponsor(s), if any, in study design; in the collection, analysis and interpretation of data; in the writing of the report; and in the decision to submit the article for publication).

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60  
61  
62  
63  
64  
65

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Dear editor,

I want to submit a revised version of my response letter entitled “How (not) to prove that drug checking services facilitate access to difficult-to-reach communities who use drugs, and (not) encourage drug initiation?” (DRUGPO-D-22-66).

First of all, I want to thank you for the constructive criticism. Below I describe how I dealt with the comments.

Feedback 1: “hard to reach”

Doing research on hard to reach populations is indeed difficult, all the more since there is no universally accepted/applicable definition of “hard to reach”. I do not have a particular definition either. In my response, my main objective is to stress that the authors could have constructed a better data set by including a lot more questions on characteristics that are associated with difficult to reach communities who use drugs. To clarify this issue, the text was adapted: “Importantly, no data were collected on several characteristics associated with difficult-to-reach populations: mental illness and/or addiction not in contact with mental health services or addiction care facilities, low income, unemployed, homeless, asylum seekers, language barriers or no access to the internet. With other words, the questionnaire used was of little value, and the answers to the two relevant questions asked (i.e. the level of education and migration background) provide some evidence that the bigger part of the participants does not belong to a difficult-to-reach subgroup.”

Feedback 2: “in-depth interviews”

I fully agree that there are many different methods and research techniques to (try to) assess difficult to reach populations. However, in the particular setting of the study of Koning et al. (i.e. a pen-and-paper questionnaire on the occasion of a visit to the local DCS), it seems to me that the best way to reach well-founded conclusions are more questions and more detailed questions. To moderate the insistence on “in-depth interviews” the text was adapted in both paragraphs.

First, for my concerns about the authors’ conclusion about drug checking services as facilitators for access to difficult to reach drug users, I left out the sentence “The only way ... is an in-depth interview” in the above mentioned adapted version.

Second, for my concerns about the authors’ conclusions about the effects of DCS on drug initiation, I nuanced my point of view by changing “the only way” to “a good way”. To stress that my suggestions to adapt the scientific methods only apply to this particular study, I added “for the authors”, “their DCS”, “in the surveyed group” and “their clients”. These adaptations lead to “Anyway, a good way for the authors to find out more about the extent of the impact of their DCS on (the initiation of) drug use in the surveyed group is an in-depth interview of their clients.”

Minor comment 1:

In the second paragraph “doing the effort to” is replaced by “going to the effort to”.

Minor comment 2:

For the last sentence of the original version, I tried to stay as close as possible to the conclusions of Koning et al. For clarity, I rephrased this sentence to “In summary, the authors have an interesting set of data on DCS clients, but these data do not support their conclusion on the possibilities to facilitate access to difficult-to-reach communities who use drugs. Neither do they have reliable data to state that it is unlikely that DCS encourage drug initiation or increase the intention to use a drug never used before.”

Dear editor,

In the September issue of *International Journal of Drug Policy*, Koning et al. concluded from a questionnaire among clients of fixed-site drug checking services (DCS) in the Netherlands that DCS can be a valuable tool as they facilitate access to more difficult-to-reach communities who use drugs. In my opinion, they have no data to support this conclusion. On the contrary, they report that 76.1% of the participants were enrolled in or had completed university education. With this level of education, one may take for sure that these DCS clients have the skills to find reliable information on the ways to mitigate the risks involved with party drug use, implying that they are aware of the harm reduction measures or deliberately chose to ignore them. Consequently, this is not a difficult-to-reach community; for these 76.1% the added value of a DCS consultation is generally speaking limited to the information on the dose and purity of the drug provided. The authors also mention that people with a migration background were underrepresented. Importantly, no data were collected on several characteristics associated with difficult-to-reach populations: mental illness and/or addiction not in contact with mental health services or addiction care facilities, low income, unemployed, homeless, asylum seekers, language barriers or no access to the internet. With other words, the questionnaire used was of little value, and the answers to the two relevant questions asked (i.e. the level of education and migration background) provide some evidence that the bigger part of the participants does not belong to a difficult-to-reach subgroup.

Another issue raised by Koning et al. concerns the impact of a DCS on the intention to start using party drugs or to use a drug never used before. As only 0.7% of the DCS clients indicated that they never had used before any of the 20 popular party drugs studied (including cannabis), the authors concluded that it is unlikely that DCS encourage the first use of drugs. The authors also collected data on lifetime and last year prevalence, and time since first use of 20 popular party drugs. These data were analysed according to previous use of the submitted drug and other party drugs. As most of those who submitted a sample of a drug they had never used before were not naïve when it came to other drugs, the authors concluded that it seems unlikely that clients will experiment with a new type of drugs solely because of the possibility to have it checked at a DCS. In my opinion, both conclusions on the impact of a DCS on drug use are just speculations, or simply wrong. Why not take into account the possibility that a drug-naïve client going to the effort to provide her first MDMA pill to a DCS, will only take this pill after confirmation by a DCS of content and dosage, or that the first pill ever ingested was provided to DCS by someone else? And is it unsound to assume that an experienced party drug user who never used e.g. 2C-B before, will only swallow his first 2C-B pill after a DCS check? As shown in Table 1, 48% of the 52 clients providing 2C-B to the DCS had never used this drug before, suggesting that at least some of them want the confirmation of the 2C-B presence. Anyway, a good way for the authors to find out more about the extent of the impact of their DCS on (the initiation of) drug use in the surveyed group is an in-depth interview of their clients.

In summary, the authors have an interesting set of data on DCS clients, but these data do not support their conclusion on the possibilities to facilitate access to difficult-to-reach communities who use drugs. Neither do they have reliable data to state that it is unlikely that DCS encourage drug initiation or increase the intention to use a drug never used before.

Dear editor,

In the September issue of International Journal of Drug Policy, Koning et al. concluded from a questionnaire among clients of fixed-site drug checking services (DCS) in the Netherlands that DCS can be a valuable tool as they facilitate access to more difficult-to-reach communities who use drugs. In my opinion, they have no data to support this conclusion. On the contrary, they report that 76.1% of the participants were enrolled in or had completed university education. With this level of education, one may take for sure that these DCS clients have the skills to find reliable information on the ways to mitigate the risks involved with party drug use, implying that they are aware of the harm reduction measures or deliberately chose to ignore them. Consequently, this is not a difficult-to-reach community; for these 76.1% the added value of a DCS consultation is generally speaking limited to the information on the dose and purity of the drug provided. ~~Furthermore, he authors also mention that people with a migration background were underrepresented. Importantly, the authors mention that as no data were collected on several characteristics associated with difficult-to-reach populations: mental illness and/or addiction not in contact with mental health services or addiction care facilities, low income, unemployed, homeless, asylum seekers, language barriers or no access to the internet. e presence of psychiatric disorders (including addiction) were collected~~ With other words, the questionnaire used was of little value, and the answers to the two relevant questions asked (i.e. the level of education and migration background) provide some evidence that the bigger part of the participants does not belong to a no conclusions can be drawn regarding this often difficult-to-reach subgroup. ~~The only way to find out whether or not a client belongs to a difficult to reach subgroup is an in-depth interview.~~

Another ~~iss~~ue raised by Koning et al. concerns the impact of a DCS on the intention to start using party drugs or to use a drug never used before. As only 0.7% of the DCS clients indicated that they never had used before any of the 20 popular party drugs studied (including cannabis), the authors concluded that it is unlikely that DCS encourage the first use of drugs. The authors also collected data on lifetime and last year prevalence, and time since first use of 20 popular party drugs. These data were analysed according to previous use of the submitted drug and other party drugs. As most of those who submitted a sample of a drug they had never used before were not naïve when it came to other drugs, the authors concluded that it seems unlikely that clients will experiment with a new type of drugs solely because of the possibility to have it checked at a DCS. In my opinion, both conclusions on the impact of a DCS on drug use are just speculations, or simply wrong. Why not take into account the possibility that a drug-naïve client ~~g~~oing to the effort to provide her first MDMA pill to a DCS, will only take this pill after confirmation by a DCS of content and dosage, or that the first pill ever ingested was provided to DCS by someone else? And is it unsound to assume that an experienced party drug user who never used e.g. 2C-B before, will only swallow his first 2C-B pill after a DCS check? As shown in Table 1, 48% of the 52 clients providing 2C-B to the DCS had never used this drug before, suggesting that at least some of them want the confirmation of the 2C-B presence. Anyway, ~~a goodthe only way for the authors~~ to find out more about whether or not the extent of the impact of their DCS ~~a DCS has an impact~~ on (the initiation of) drug use in the surveyed group is an in-depth interview of their clients.

In summary, the authors have an interesting set of data on DCS clients, but the ~~se~~ data do not support their conclusions ~~s~~ on the possibilities to facilitate access to reach difficult-to-reach

communities who use drugs. Neither do they have reliable data to state that it is unlikely that subgroups and an unlikely impact of DCS encourage drug initiation or increase the intention to start using party drugs or to use a drug never used before.