

**HARM REDUCTION: GOOD PRACTICE IN ASIA**

**INTEGRATION OF HARM  
REDUCTION INTO ABSTINENCE-BASED  
THERAPEUTIC COMMUNITIES**

**A Case Study of We Help Ourselves,  
Australia**

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## PREFACE

The spread of HIV among drug users through the use of contaminated needles and syringes has been responsible for most HIV infections in many Asian countries. It is the major contributor to new cases and threatens the significant gains made in HIV prevention in others.

WHO and the United Nations' support for evidence-based responses, i.e., a “harm reduction”-based response, is clear. Developing such a response as part of an integrated prevention, treatment, and care response will be critical to overall success in minimizing the impact of HIV and AIDS in Asia and achieving the goals of Universal Access by 2010.

Harm reduction is itself a comprehensive package—of information, education, access to the means of prevention (needles and syringes, condoms) and to an expanded range of drug dependence treatment options. This package works best if outreach is a key method of service delivery and if a supportive legislative and regulatory environment exists. The *Harm Reduction: Good Practice in Asia* series aims to document examples, to illustrate what is already being done, to recognize the work of many people, and to share these experiences with others who are trying to do the same work in their own unique social, cultural, and national contexts.

This particular case study looks at how one therapeutic community has come to terms with HIV and its implications for drug-dependent people working towards a drug-free lifestyle. In doing so, the case study addresses the accusation that there is a dichotomy between abstinence and harm reduction. No such dichotomy exists, as this case study shows.

## ACKNOWLEDGEMENTS

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## ABBREVIATIONS

AA	Alcoholics Anonymous
CEIDA	Centre for Education and Information on Drugs and Alcohol, Sydney, New South Wales, Australia
HIV	human immunodeficiency virus
IDU	injecting drug use
IDUs	injecting drug users
MMT	methadone maintenance treatment
NA	Narcotics Anonymous
NSP	needle and syringe programme
NSW	New South Wales
SWOT	strengths, weaknesses, opportunities, threats
TC	therapeutic community
WHO	World Health Organization
WHOS	We Help Ourselves
WPRO	The Regional Office for the Western Pacific

## EXECUTIVE SUMMARY

In many countries in Central, South, and South-East Asia, the HIV epidemic is being driven by injecting drug use (IDU). Harm reduction programmes aim to reduce the transmission of HIV among injecting drug users (IDUs). Harm reduction is not opposed to the traditional abstinence goal of drug treatment services. Rather, harm reduction complements abstinence-based approaches by providing IDUs with the knowledge and tools to stay HIV-negative until they can achieve and maintain abstinence.

Therapeutic communities (TCs) have traditionally provided abstinence-based services for drug users. However, with the advent of HIV, some TCs have moved towards offering HIV education and making condoms and sterile needles and syringes available to their clients. One organization that has taken these steps is We Help Ourselves (WHOS), a drug treatment service operating several TCs in Australia. WHOS began to offer harm reduction services to clients in the 1980s and continues to do so today.

The process by which WHOS incorporated harm reduction into its abstinence-based programme can be conceptualized by using the “stages of change” of the trans-theoretical model: pre-contemplation; contemplation; preparation; action; and maintenance. Treatment services in the pre-contemplation stage are yet to consider the possibility of incorporating harm reduction into their programme. Those in the contemplation stage are aware of HIV among their client group and are willing to explore options for preventing further HIV transmission. Organizations in the preparation stage are taking steps to introduce harm reduction strategies, and those in the action stage have implemented harm reduction. Finally, treatment services in the maintenance stage are evaluating their harm reduction strategies and disseminating the findings.

The experiences of WHOS have provided several lessons for the drug treatment community:

### **1. Organizations for IDUs need to consider their role in HIV prevention**

The advent of HIV has dramatically increased the risks associated with injecting drug use. Organizations that try to help IDUs must think about what kinds of activities they can undertake with their clients to help prevent the spread of HIV between IDUs and into the wider community.

### **2. A balance between abstinence and HIV prevention can help deal with the reality of relapse**

While the best way to avoid drug-related harms like HIV is to abstain from drug injecting, the reality is that many clients of drug treatment services relapse. It is important to help IDUs achieve abstinence, but it is also important to ensure that they are aware of the risks of HIV and how they can protect themselves if they do relapse.

### **3. HIV prevention for IDUs can be addressed in many ways**

Efforts to reduce HIV infection can range from educating clients about HIV and how to protect themselves, to outreach and to making condoms and sterile needles and syringes available to clients as they need them. All efforts to prevent HIV are valuable and should be encouraged.

### **4. Drug treatment services can change their goals without compromising their values**

Abstinence and harm reduction are often presented as opposites or as conflicting approaches to drug use. In reality, abstinence-based organizations that implement harm reduction services find little conflict between the two approaches. Therapeutic communities can incorporate harm reduction while still promoting abstinence.

## **5. Change is more manageable if made gradually**

Careful guidance is needed to ensure that introducing harm reduction helps rather than hinders the service. Dividing the process of change into manageable steps (as in the previous section) and conquering each step before moving on to the next step will help ensure the success of harm reduction within a service.

## **6. Adding harm reduction to treatment services improves client outcomes**

Many therapeutic communities have found that making changes in their service in response to the threat of HIV has improved their ability to attract and retain drug users in treatment. Having more drug users in treatment decreases HIV transmission and leads to more clients completing treatment and remaining drug-free—the best outcome that could possibly be hoped for.

WHOS' journey from an abstinence-based therapeutic community to a harm reduction-based therapeutic community promoting abstinence is a case study of an organization transforming itself in response to the challenges of the HIV/AIDS epidemic. This case study shows clearly that the process of change, while rarely easy, can be managed. Change can produce many benefits for the organization, staff, and, above all, clients. Many drug treatment organizations have made the transition to harm reduction and few have regretted the change.

## 1. INTRODUCTION

### 1.1 HIV AMONG INJECTING DRUG USERS

An estimated 40 million people worldwide are infected with HIV.<sup>1</sup> While HIV continues to be most prevalent in Africa, it has caused a considerable epidemic in Eastern Europe and Central, South, and South-East Asia as well. One route of HIV transmission is via injecting drug use (IDU). Injecting drug users (IDUs) who share needles and syringes are at risk of contracting HIV and other infectious diseases. IDU accounts for 10% of HIV cases worldwide,<sup>2</sup> and is driving the epidemic in countries like the Russian Federation, Indonesia, and Viet Nam.<sup>3</sup>

HIV prevalence among IDUs is alarmingly high in some countries. In parts of China, up to 80% of IDUs are HIV-positive. In Indonesia, up to 40% of IDUs in Jakarta are HIV-positive, and prevalence in other areas is as high as 56%. Prevalence in Bangkok, Thailand, is estimated at 34%.<sup>4</sup> The table below shows the estimated HIV prevalence among IDUs in several East and Southeast Asian countries.

Estimated HIV Prevalence Among IDUs (%)

Country	Nationwide	Capital City	Other Places
China	Up to 80	Not known	1–84
Indonesia	15–47	15–40	16–56
Malaysia	10–40	Not known	18
Myanmar	37–63	39	7–92
Thailand	20–56	34	Up to 91
Viet Nam	Up to 89	3–14	14–64

Source: Aceijas et al. (2004).

High HIV prevalence among IDUs can serve as the entry point for a widespread, generalized epidemic if the virus is transmitted to non-injecting sexual partners and, in turn, to their children. In areas where many IDUs engage in sex work, the virus spreads very quickly to the wider community.<sup>5</sup> Therefore, to protect the community as well as high-risk groups, HIV among IDUs must be prevented.

### 1.2 The role of harm reduction in HIV prevention

Australia stands out as a country with low HIV prevalence, both overall and among IDUs. HIV prevalence among IDUs has remained below 2%.<sup>6</sup> The successful containment of HIV in Australia has been credited to early, pragmatic interventions that acknowledged the realities of both HIV and drug dependence.<sup>7</sup> At the centre of HIV prevention efforts in Australia have been harm reduction measures.

<sup>1</sup> Joint United Nations Programme on HIV/AIDS (UNAIDS) (2005)

<sup>2</sup> Aceijas et al. (2004).

<sup>3</sup> Central and Eastern European Harm Reduction Network (CEEHRN) (2002); Joint United Nations Programme on HIV/AIDS (UNAIDS) (2005).

<sup>4</sup> Aceijas et al. (2004).

<sup>5</sup> Joint United Nations Programme on HIV/AIDS (UNAIDS) (2005).

<sup>6</sup> National Centre in HIV Epidemiology and Clinical Research (2005).

<sup>7</sup> Wodak (1995); Wodak and Lurie (1997).

### 1.2.1 What is harm reduction?

The term “harm reduction” is used by different people to mean different things; hence the confusion about what it is. In a general sense, harm reduction is the management of risks associated with dangerous activities. In relation to drug use—including legal drug use—its aim is to reduce the negative consequences of such use. Consider motor vehicle accidents as an analogy. Car accidents can result in deaths and injuries, just as drug use can result in deaths and the spread of infections. The most obvious solution to the problem of car accidents would be to stop people from driving cars in the first place. Clearly, that would be extremely difficult to do. So, while engineers and designers work to improve cars so that they are less likely to crash, seat belts have been introduced to protect motorists if an accident does occur. Seat belts are thus a way of reducing the risks associated with driving. In the same way, harm reduction approaches to drug use reduce the risks and harm associated with the use of psychoactive substances.

Harm reduction approaches are often perceived to be opposed to abstinence-based approaches to drug use, and sometimes even to condone drug use. This is not the case. Rather, as shown below, abstinence falls within the hierarchy of harm reduction goals.

<b>Harm Reduction Hierarchy</b>	
(1)	Don't use drugs.
(2)	If you use drugs, don't inject.
(3)	If you inject drugs, use sterile injecting equipment and never share injecting equipment.
(4)	If you use non-sterile equipment and share equipment, use bleach to clean equipment between injections.

(See <http://www.ceehrn.org/index.php?ItemId=4805> for more information)

Thus, harm reduction complements abstinence-based drug treatment approaches by providing IDUs with the knowledge and tools to stay healthy and alive until they are able or willing to achieve abstinence. Abstinence remains the most effective way of reducing the negative consequences of drug use. For IDUs who cannot remain abstinent, harm reduction measures like methadone maintenance treatment and needle and syringe programmes can reduce the negative consequences.

### 1.2.2 Methadone maintenance treatment

Methadone maintenance treatment (MMT) is a pharmacotherapy-based treatment option for heroin users. Methadone acts as a substitute for heroin, thus preventing cravings and withdrawal. By removing the urge to use illicit drugs, MMT allows IDUs in treatment to leave that chaotic life behind, reconnect with family, and find employment. There is strong evidence that MMT reduces illicit drug use and drug injecting,<sup>8</sup> and thus lessens the likelihood of HIV transmission among IDUs. MMT also reduces crime<sup>9</sup> and incarceration of injecting drug users.<sup>10</sup> Methadone has been listed by the World Health Organization as an essential medicine in the treatment of drug dependence. For more information about MMT, see Appendix 1.

<sup>8</sup> Sullivan et al. (2004).

<sup>9</sup> Lind et al. (2005).

<sup>10</sup> Dolan et al. (2005).

### 1.2.3 Needle and syringe programmes

Needle and syringe programmes (NSPs) provide sterile needles and syringes and other injecting equipment to IDUs. Condoms and education in safer injecting and HIV prevention are also often provided. In addition, NSP workers refer IDUs into drug treatment. A large body of evidence demonstrates that NSPs prevent HIV transmission and have no negative impact on the community. NSPs are cost-effective,<sup>11</sup> do not encourage drug use,<sup>12</sup> and can create links between drug users and drug treatment services.<sup>13</sup> For more information about NSPs, see Appendix 2.

## 1.3 Abstinence-based approaches to drug dependence

Traditional abstinence-based approaches to drug dependence aim to stop drug use permanently. But few clients achieve abstinence, at least in the short term, as many abstinence-based services have acknowledged more recently. It is just as important to provide harm reduction services to clients who may relapse soon after leaving treatment. There are two main types of abstinence-based approaches to drug dependence: self-help groups and therapeutic communities (TCs).

### 1.3.1 Self-help groups

Self-help groups meet regularly to support one another towards the goal of achieving or maintaining abstinence. The most common self-help groups are Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). In 2005, there were more than 21,500 registered NA groups in 116 countries.<sup>14</sup> The AA/NA approach views alcohol or drug dependence as a disease for which there is no cure, only recovery. Following the “12 steps” can assist recovery (see Appendix 3). Sponsors play an integral part in NA. These are former drug users who mentor and support new members of the group who may be vulnerable to relapse.

Self-help groups do not consider themselves to be treatment services. This, in combination with the strict policy of anonymity, means that there has been very little research evidence around their effectiveness. Some studies have found that attending AA or NA meetings weekly can help users to maintain abstinence, especially if used in conjunction with other more formal treatments (Fiorentine & Hillhouse, 2000). AA and NA can be useful for helping drug users to form new, non-drug using social networks that support their abstinence goal.

### 1.3.2 Therapeutic communities

The therapeutic community (TC) is a treatment approach where clients live in small, structured communities. TCs were originally developed for the treatment of psychiatric patients. The first TC for drug users, Synanon, was established in the United States in 1958. The Synanon treatment approach was based on the principles of AA and employed recovered problem drinkers and drug users. The goal was to encourage psychological and lifestyle changes that would help clients maintain their new-found abstinence.<sup>15</sup>

<sup>11</sup> Commonwealth of Australia (2002).

<sup>12</sup> World Health Organization (2005).

<sup>13</sup> Hagan et al. (2000).

<sup>14</sup> [www.na.org](http://www.na.org)

<sup>15</sup> Gowing et al. (2002).

TCs today typically have a highly structured environment in which clients are considered members of a treatment community rather than patients. Most are staffed by a mix of professionals and ex–drug users. The treatment approach is based on peer support. Clients are expected to contribute both to the general running of the community, for example, by completing household chores, and to their own recovery, by actively participating in group and individual therapy.<sup>16</sup> Many TCs encourage attendance at AA or NA meetings to introduce clients to support networks outside the TC. Under the traditional TC model, the desired outcome for clients is complete abstinence from all drugs.<sup>17</sup>

The effectiveness of TCs is difficult to measure, as the services provided vary widely from one TC to another. What is known is that longer stays in treatment produce better outcomes.<sup>18</sup> The Australian Treatment Outcome Study (ATOS), an ongoing study of different drug treatment approaches, found that former TC clients who had abstained from heroin for two years stayed in treatment for a mean of 58 days, compared with only 28 days among those who had relapsed.<sup>19</sup>

A systematic review of the literature on TCs concluded that the approach does benefit some clients with drug and alcohol problems. However, the review noted that there has been less research than expected, and encouraged all TC practitioners to undertake high-quality research into their programmes, and to evaluate the programmes.<sup>20</sup>

## 1.4 The role of therapeutic communities in HIV prevention

The emergence of HIV among IDUs has caused some therapeutic communities to reconsider their abstinence-only focus.<sup>21</sup> These TCs have begun to integrate harm reduction services into their abstinence-based treatment programmes.<sup>22</sup> Under this treatment model, harm reduction and abstinence-based approaches to drug use are regarded as complementary. Abstinence is still valued, but harm reduction is also considered a valid goal. European TCs in particular have recently adopted this integrated model.<sup>23</sup> This shift has been described as a move from a goal of “abstinence only” to one of “abstinence eventually”.<sup>24</sup>

Pre-dating this recent shift by almost 20 years, a group of TCs in New South Wales, Australia, has been offering harm reduction services including HIV education, overdose prevention and education, condoms, and needle and syringe programme services since 1986. We Help Ourselves (WHOS) was among the first TCs in Australia, established in 1972 by a group of drug- and alcohol-dependent individuals who were disillusioned by the poor quality of drug dependency treatment available and were determined to improve this situation. In the beginning, WHOS focused on abstinence for its community members. However, the emergence of HIV in IDUs in the mid-1980s led to a shift in focus that included harm reduction. The following chapters examine how harm reduction was successfully incorporated into the abstinence-based service offered by WHOS.

<sup>16</sup> Gowing et al. (2002).

<sup>17</sup> Marlatt, Blume, and Parks (2001).

<sup>18</sup> Simpson, Joe, and Brown (1997).

<sup>19</sup> Darke et al. (in press).

<sup>20</sup> Lees, Mannings, and Rawlings (2004).

<sup>21</sup> Broekhaert and Vanderplasschen (2003).

<sup>22</sup> Broekhaert and Vanderplasschen (2003); Kellogg (2003); Marlatt, Blume, and Parks (2001).

<sup>23</sup> Broekhaert and Vanderplasschen (2003).

<sup>24</sup> Kellogg (2003).

## 2. THE INTEGRATION OF HARM REDUCTION INTO ABSTINENCE-BASED THERAPEUTIC COMMUNITIES: THE EXPERIENCE OF WE HELP OURSELVES

The following information was collected via semi-structured interviews with key stakeholders in Sydney, NSW. Key stakeholders included:

Garth Popple, Executive Director of WHOS, 1986 to present

Bill Robertson, HIV/Infectious Disease worker, WHOS, 1990–1994

Peter Todaro, Area Co-ordinator HIV/AIDS, Central Sydney Area Health Service, 1996–2000, and Harm Reduction Manager, WHOS, 2000

Michael MacAvoy, Director, Drug and Alcohol Directorate, New South Wales Department of Health, 1988–1994

Stuart Riley, Policy Analyst, Drug and Alcohol Directorate, New South Wales Department of Health, 1990–1994

Rigmor Berg, AIDS and IDU Education Co-ordinator, Centre for Education and Information on Drugs and Alcohol (CEIDA), Sydney, New South Wales, 1987–1988.

Relevant reports, minutes of WHOS Board of Directors meetings, conference abstracts, and presentations were also examined. The information gathered is presented here as a historical account of the change in the WHOS service model from an abstinence focus to a harm reduction focus.

### 2.1 1985–1986: Preparing the organization

HIV infection first appeared among IDUs in Sydney and Melbourne in 1985.<sup>25</sup> Of 2,624 new HIV diagnoses in Australia in 1986, 131 (5%) were related to injecting drug use.<sup>26</sup> Also in 1986, the Executive Director of WHOS, Garth Popple, noticed an increase in the number of HIV-positive clients presenting to WHOS. What is worse, clients known to be HIV-negative left the service only to return later as HIV-positive.

Of great concern at that time was the potential for HIV to spread rapidly among IDUs as it had in countries with more advanced epidemics than Australia.<sup>27</sup> Fifty-eight per cent of IDUs presenting to a detoxification unit in New York in 1984 were HIV-positive,<sup>28</sup> and so were 53% of the residents of an Italian TC in 1984/85.<sup>29</sup> The few HIV-positive IDUs in Sydney could easily transmit the virus to their injecting and sexual partners, leading to a similarly high prevalence. This was demonstrated by a study that identified the sexual and injecting partners of an HIV-positive IDU in Sydney.<sup>30</sup> The diagram below, taken from Blacker et al. (1986), shows the relationships between the index case (marked with an “x” in the diagram) and his injecting and sexual partners.

<sup>25</sup> Arachne and Ball (1986); Blacker et al. (1986).

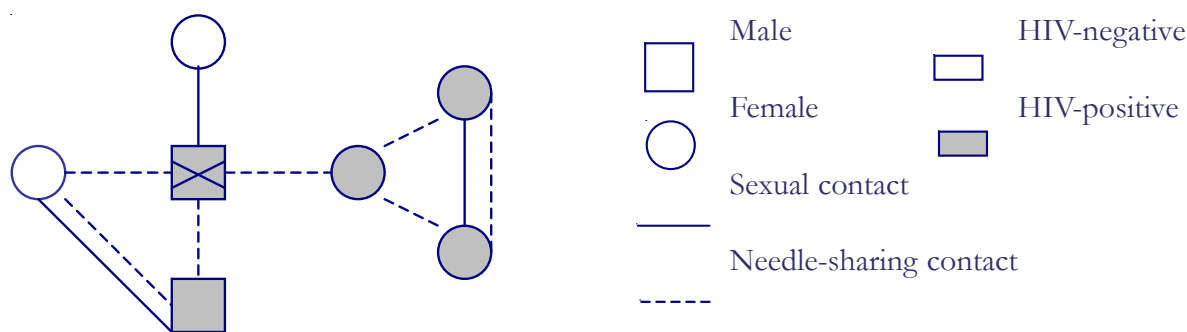
<sup>26</sup> National Centre in HIV Epidemiology and Clinical Research (1996).

<sup>27</sup> Arachne and Ball (1986); Blacker et al. (1986).

<sup>28</sup> Spira et al. (1984).

<sup>29</sup> Ferroni et al. (1985).

<sup>30</sup> Blacker et al. (1986).



Of five injectors traced, four were HIV-positive. One male and one female injecting partner of the index case were HIV-positive. Two injecting partners of the HIV-positive female also tested HIV-positive.

In addition to this contact-tracing study, general prevalence studies were showing a rapid increase in HIV prevalence among Sydney's IDUs. The contents of syringes returned to an NSP in December 1986, when tested, revealed an HIV prevalence of 1%.<sup>31</sup> A second, similar study in August 1987 found that the prevalence had increased to 3%.<sup>32</sup> A sampling of IDUs in December 1987 showed another increase, to 9%.<sup>33</sup> Clearly, urgent action was needed to prevent HIV transmission among networks of IDUs in Sydney.

In 1986 We Help Ourselves had a strong focus on abstinence. However, only 5%–10% of its clients completed the programme. That meant that most of the clients of WHOS could not or would not achieve or maintain abstinence. They left the programme and returned to injecting drug use, thus risking contracting HIV. The Executive Director believed that treatment services for IDUs had a responsibility to assist these clients as well as those who were able to maintain abstinence:

*“Are we here to help the drug-dependent or only those who do it our way?”*

-Executive Director, WHOS, 2005

Moreover, some argued that services with an exclusive abstinence focus would contribute to the spread of HIV among IDUs. Because these services did not provide HIV education and preventive tools like condoms and syringes, clients would remain unaware of the risks of HIV and how they could protect themselves from it. Drug treatment services, they added, had a responsibility to provide IDUs with education, condoms, and syringes to prevent the spread of HIV. The Executive Director of WHOS agreed. He called this “common sense” approach “risk prevention”, and began to consider the possibility of integrating HIV prevention services like education, condoms, and needle and syringe provision into the abstinence-based WHOS therapeutic communities.

The Executive Director was aware that the long-held aims and priorities of the service would have to be reassessed. WHOS in 1986 aspired to have drug-free clients—its aim was “abstinence only”. But this service approach did not meet the needs of the significant number who relapsed into drug use and had received no assistance to keep them from contracting HIV or other infections. By focusing solely on abstinence, WHOS was failing many of its clients.

<sup>31</sup> Wodak et al. (1987).

<sup>32</sup> Wolk et al. (1988).

<sup>33</sup> Wolk et al. (1990).

For the Executive Director, to reassess the priorities of WHOS was to acknowledge the threat posed by HIV:

*“Do we continue following our existing approach or do we deal with reality?”*

-Executive Director, WHOS, 2005

The reality was that not many were willing or able to abstain. Some clients were leaving WHOS and engaging in HIV risk behaviours. Also, despite the rules, clients were using drugs and having unprotected sex and were thus at risk of HIV even while in the TC. Finally, even clients who completed the programme and were able to abstain could relapse at a later stage and also risk being infected with HIV. The Executive Director believed that preventing HIV among current and former clients should be as high a priority as helping clients to become drug-free; that is, the organization should shift towards an “abstinence eventually” goal. He noted:

*“You might take three or four attempts at treatment before you get drug-free,  
but once you’re HIV-positive, you’re positive.”*

-Executive Director, WHOS, 2005

Aware that some key stakeholders would be concerned about the implications of introducing harm reduction into WHOS, the Executive Director engaged in consultation and consensus building. This took time but was necessary. Senior WHOS staff, the Board of Directors, and clients were told about the HIV situation in the world, in Australia, and within WHOS. These key stakeholders were encouraged to consider the evidence and apply a decision-making process known as a SWOT analysis.

“SWOT” stands for “strengths, weaknesses, opportunities, and threats”. SWOT analysis enables decision-makers to arrive at a course of action appropriate for a given time. The steps in SWOT analysis are as follows:

- (1) Determine the **strengths** of the proposal.
- (2) Determine the **weaknesses** of the proposal.
- (3) Consider the **opportunities** that could be provided by the proposal.
- (4) Consider any potential **threats** to the success of the proposal.

An external facilitator works with stakeholders over one or two days to develop all four variables and assist the group in reaching an informed and rational decision. A short example of a SWOT analysis of the possibility of incorporating harm reduction measures into the programmes of therapeutic communities is presented below.

### Sample SWOT Analysis

- (1) The *strengths* of the proposal could include increasing client retention and minimizing the spread of infectious diseases like HIV.
- (2) The *weaknesses* of the proposal could include the possibility that providing syringes might increase drug injecting.
- (3) The *opportunities* provided by the proposal could include building staff capacity by providing training in harm reduction and protecting the wider community by containing the HIV epidemic.
- (4) The *threats* to the proposal could include client, staff, or governmental opposition to harm reduction.

The Board of Directors and other key stakeholders came to agree that the strengths and opportunities of the proposed changes outweighed the weaknesses and threats. They concluded that integrating harm reduction into WHOS TCs was likely to benefit clients.

The Executive Director was also gathering support from outside WHOS. Among the supporters of the plan to introduce harm reduction were the NSW Department of Health and the Centre for Education and Information on Drugs and Alcohol (CEIDA) in Sydney. CEIDA provides workforce development activities to workers in the drug and alcohol field. Support also came from former clients of WHOS, which has a strong tradition of involving successfully recovered former clients in both the Board of Directors and in more informal decision-making roles. Many of these former clients were now working in the harm reduction field, providing HIV education to drug users and working in needle and syringe programmes (NSPs). These former clients were strongly supportive of the idea of integrating harm reduction into WHOS. They saw no conflict between harm reduction and abstinence, preferring to consider harm reduction as an important step on the road to abstinence.

While the Board of Directors and ex-clients agreed that harm reduction could benefit the clients, some WHOS clinical staff, however, remained committed to the original, abstinence-only philosophy. What was particularly challenging to them was the proposed change from one clear treatment goal—abstinence—to a more complex set of goals that included reducing harms associated with drug use and unsafe sex (on and off the premises), as well as abstinence. The Executive Director presented harm reduction to his staff as an exercise in risk management that would benefit clients, and urged them to consider the evidence for this novel approach to service provision for IDUs.

In 1986, when WHOS was making these organizational changes, staff training in harm reduction was rare. As an alternative to training, staff members were encouraged to join the management committee of a drug user organization or organizations that focused on infectious diseases. Drug user organizations are staffed by current and former drug users who educate other drug users and provide services such as drop-in centres and NSPs. These organizations are based on the idea that the best people to educate and inform drug users are other drug users—a process called peer education. One drug user organization is the New South Wales Users and AIDS Association (NUAA). NUAA was established to provide peer education in HIV prevention to IDUs. The organization receives funding from the NSW Department of Health. Other services provided by NUAA include NSP, a drop-in centre, the *User's News* magazine, and education in preventing hepatitis C and drug overdose. NUAA also makes representations to the Government on issues of concern to drug users.<sup>34</sup> Spending time at NUAA exposed WHOS staff to different ways of thinking about drug use and harm reduction.

<sup>34</sup> New South Wales Users and AIDS Association (NUAA) (2004).

## 2.2 1987–1990: Implementing harm reduction

Starting in 1987 and 1988, CEIDA provided much of the HIV information and education materials to be used at WHOS. CEIDA produced guidelines on HIV prevention, testing, and support and assisted WHOS in establishing HIV education groups for clients. Also at this time, bowls of condoms were placed in all toilets for WHOS residents. There was concern that sexual activity in the TC would increase; that did not happen.

### Will Providing Condoms Increase Sex in the TC?

Providing condoms in TCs commonly raises concerns of increased sexual activity. Evidence now shows that providing condoms in prisons<sup>1</sup> and schools<sup>2</sup> does not lead to an increase in sex in these institutions. Neither was there an increase in sexual activity in the TCs of WHOS. It is safe to assume that providing condoms will not increase sexual activity in TCs.

<sup>1</sup> Dolan, Lowe, and Shearer (2004).

<sup>2</sup> Kirby (2002).

No records of the number of condoms made available or the number taken were kept. Keeping records may have discouraged clients from taking them. It was important that clients knew that the condoms were freely available and not monitored, and that they would not be punished for using them.

It soon became clear that integrating harm reduction into WHOS involved a great deal of work. A staff member to coordinate all harm reduction activities was needed. In 1990, WHOS received funding from the NSW Department of Health to hire someone to work full-time on the harm reduction project. Clearly, the introduction of harm reduction into the service had not reduced the ability of WHOS to attract funding; in fact, funding bodies appreciated the courage with which WHOS faced criticism and made changes in its service in response to the threat of HIV.

The new “HIV/Infectious Disease Coordinator” was given authority equal to that of the Treatment Coordinator, in recognition of the importance of the coordination role. An important message was sent to both staff and clients: harm reduction was firmly integrated into WHOS and was just as important as the abstinence-based treatment programme.

From the early 1990s, the WHOS harm reduction programme consisted of the following: HIV counselling and testing; individual and group education sessions; outreach; and condom and needle and syringe provision.

### *HIV Counselling and Testing*

To be diagnosed with HIV can be devastating. Clients being tested for HIV must receive counselling before and after the test;<sup>35</sup> otherwise, they can become destructive and engage in high-risk behaviours during this vulnerable time. The HIV/Infectious Disease Coordinator implemented pre- and post-test counselling for all WHOS clients who requested an HIV test. If necessary, counselling could also be provided between the testing and the release of the results, and clients could rely on the Coordinator to accompany them to the testing clinic. The identities of HIV-positive clients were kept confidential.

To further ensure confidentiality, WHOS now uses external sexual health services for HIV counselling and testing.

### *Individual and Group Education*

Education groups for WHOS clients focused at first on HIV prevention. These groups discussed the transmission of HIV, safe injecting practices including the use of bleach to clean syringes, and strategies for achieving more regular use of condoms. Two separate HIV education programmes were developed—one for women clients and one for men, partly because of the different risks and experiences of women and men in relation to sexually transmitted HIV. For example, there are more women than men sex workers, a high-HIV-risk occupation.

After successfully running HIV education groups, the HIV/Infectious Disease Coordinator introduced a relapse prevention group. This group taught clients how to avoid situations that might lead to relapse, and how to cope if they did relapse. Instead of cutting themselves off from treatment after a relapse, out of shame, clients were encouraged to see a relapse as a setback, not a failure, and to remain in treatment.

Group sessions were also held in WHOS' "halfway houses" for clients who had completed the programme but were not yet ready to live outside a supportive environment. These sessions provided skills for coping with the "real world" without using drugs.

### *Outreach*

WHOS staff had often expressed concern about clients who were discharged from the TC before completing the programme. In an effort to address these concerns, the HIV/Infectious Disease Coordinator implemented an outreach service, particularly for clients who were HIV-positive or engaging in high-risk behaviours. The outreach programme would keep clients alive and as healthy as possible until they could abstain from drugs.

The HIV/Infectious Disease Coordinator maintained contact with high-risk clients after they left the WHOS programme, whether they had completed it or not. These clients were taught safer injecting and sexual practices. They also learned that they could return to WHOS any time they wished to make another attempt to achieve abstinence. The outreach service was particularly important in letting clients know that the TC respected and cared for them, no matter what.

### *Condoms and Needle and Syringe Programmes*

From 1990, WHOS made condoms and "safe kits" available to all clients. Each kit contained three full sets of injecting equipment (needles and syringes, spoons, swabs, cotton, sterile water, and a syringe disposal box), three condoms, three sachets of lubricant, and information cards about hepatitis C, HIV, and drug treatment services.



*A WHOS safe kit, with information leaflets, three sets of injecting equipment, condoms, lubricant, and syringe disposal container (“fupack”)*

Safe kits were placed in all toilets in WHOS. They were also offered to residents who chose to leave the programme. As with the condom distribution programme, no formal records of the number of kits dispensed were kept.

*“All we know is that we get, say, 500 a year, and we’ve got 450 now, so 50 have gone out....Whoever took them needed them.”*

-Executive Director, WHOS, 2005

WHOS staff worried that providing condoms and injecting equipment might send conflicting signals to clients. Some clients indeed said they were confused: sex and drug use were not allowed, but condoms and syringes were. The HIV/Infectious Disease Coordinator explained that while there were rules, not everyone followed them all the time. WHOS wanted the clients to be prepared, to avoid HIV and other infectious diseases. Besides, the Coordinator pointed out, just because condoms and syringes were available didn’t mean they had to be used. Abstaining from sex and injecting drug use despite the availability of condoms and syringes became a lesson for clients in coping with risky relapse situations.

Most clients responded positively to the introduction of harm reduction strategies once they saw how helpful the strategies were. They realized that WHOS was a non-judgemental environment committed to ensuring the health and safety of clients. WHOS did not experience a drop in admissions after it introduced harm reduction; rather, as word spread, more IDUs sought treatment at WHOS.

### Will Providing Syringes Increase Drug Injecting in the TC?

It is commonly thought that providing needles and syringes will encourage drug use. On the contrary, research shows that needle and syringe programmes in the community do not encourage increased drug injecting.<sup>1</sup> Nor do they encourage non-injecting drug users to begin injecting.<sup>2</sup> Finally, providing injecting equipment does not affect drug users' motivation to seek treatment or reduce drug use.<sup>3</sup> It is reasonable to assume that making sterile injecting equipment available will not encourage TC residents to inject drugs.

<sup>1</sup> Hartgers et al. (1989); Watters et al. (1994).

<sup>2</sup> Guydish et al. (1993).

<sup>3</sup> Bluthenthal et al. (2001).

### 2.3 1991–2006: Evaluating and disseminating harm reduction at WHOS

Services provided must be evaluated to ensure the effective use of scarce resources. WHOS carried out informal evaluation and also commissioned an external research organization to do a formal evaluation. Some evaluation activities became part of standard organizational procedures. Data on the ethnic background, housing status, employment history, and treatment history of all clients were gathered during the standard admission interview. At discharge, the length of stay and reason for discharge were recorded.

The simple evaluation activities of WHOS showed positive changes after harm reduction was integrated into the service. Programme completion and client retention rates increased. In 1986, 4.4% of clients completed the programme. In 1988–1991, after harm reduction was introduced, the proportion increased to 11.5%. The median length of stay was just 4 days in 1986 but went up to 17 days between 1987 and 1991.<sup>36</sup>

This increase in client retention is especially important, as a longer stay is associated with improved treatment outcomes.<sup>37</sup> There was also a large decrease in the number of clients leaving against staff advice. In 1985, 92% of clients who were discharged left against the advice of staff. By 1988–1991, the percentage had decreased to 40%.<sup>38</sup>

In addition to an increase in the number of clients achieving abstinence, reductions in risk behaviours were recorded. Of 159 WHOS clients surveyed in 1997/98, on admission 26% reported practicing unsafe sex and 14% reported sharing needles and syringes. Eighteen months later, the corresponding figures were 19% and 5%.<sup>39</sup>

These data show that after harm reduction was introduced to WHOS, client retention and programme completion increased—contrary to what some had feared. Furthermore, clients' HIV risk-taking behaviour was reduced.

<sup>36</sup> Swift et al. (1993).

<sup>37</sup> Simpson, Joe, and Brown (1997).

<sup>38</sup> Swift et al. (1993).

<sup>39</sup> We Help Ourselves (WHOS) (1998).

Despite the success, however, WHOS' recent changes caused some uneasiness in other drug rehabilitation services. There were even those who suggested that WHOS should be dropped from the Australasian Therapeutic Communities Association, the peak representative body for TCs in Australia. WHOS used the data from its evaluation projects to address this opposition. The evidence was clear and convincing: harm reduction had had positive effects on WHOS. While some resistance to harm reduction in TCs may remain, WHOS is still a member of the Australasian Therapeutic Communities Association, and the Executive Director of WHOS was its president for several years.

Convinced of the value of the new service model, the Executive Director of WHOS and his colleagues set about spreading their knowledge. This involved attending national and international conferences, making presentations, and joining drug and alcohol advisory committees. In this way, other professionals were exposed to the concept of integrating harm reduction into abstinence-based treatment services.

The following is an abstract of a paper presented at the 20th World Federation of Therapeutic Communities Conference, 2003, by the Executive Director of WHOS, Garth Popple.

### **Harm Reduction and Abstinence-Based Drug Treatment: Irreconcilable Opposites or Partners There for the Making?**

Are harm reduction and abstinence-based drug treatment irreconcilable? In 1986, our abstinence-based residential therapeutic community considered the emerging HIV epidemic and the rapidly increasing deaths from drug overdose. We decided the best response was to help our clients protect themselves, including providing access to condoms and sterile needles and syringes. We initially referred to these changes as "common sense", but later found that others called it "harm reduction". Now, a decade and a half later, with HIV as the biggest global public health threat since the Black Plague, numerous abstinence-focused drug treatment centres around the world do not provide the information or the means for drug users to avoid HIV/HCV infection or drug overdose, in particular during their stay in treatment.

AIDS forced us to understand that abstinence and harm reduction are not polar opposites: abstinence is part of harm reduction. It took the terrible AIDS epidemic to reaffirm to us that our clients don't get better according to the practitioner's timetable. The reality is that relapse happens. It's our responsibility to give them a safe environment to recover in, and the information and a safer means to protect themselves, other users, their partners, and the wider community.

Drug treatment is an evolving science, and rehabilitation centres and TCs are not all the same. To think so is a mistake that can lead to a polarization that can damage the field. It was imperative that we developed and established new partnerships. We are 100% for harm reduction and 100% for our clients' right to strive for abstinence.

In summary, WHOS was able to integrate harm reduction into its abstinence-focused therapeutic community without impairing the service. The Board of Directors of WHOS was quick to see the advantages of taking a "risk management" approach to HIV and drug use among clients. Staff members were reluctant at first to move away from the "abstinence only" goal, but as they discussed and examined the evidence for harm reduction they, too, came to realize that abstinence would still be valued as one of a range of potential outcomes for clients. No Board members or staff resigned from WHOS over the changes in policy and practice.

Some feared that the move would cost WHOS funding support for its services. This was not the case. In fact, after implementing harm reduction WHOS received more funding from the NSW Department of Health. Others expected clients to be unhappy with the changes. On the contrary, the clients appreciated the fact that WHOS was helping them to remain healthy and safe, despite their failed attempts to achieve abstinence. WHOS continued to attract clients and open new TCs incorporating harm reduction principles.

## 2.4 We Help Ourselves today

We Help Ourselves now operates five therapeutic communities for people with drug and alcohol dependencies. WHOS New Beginnings is for women only, and WHOS Metro is only for men. The other three TCs cater to both women and men. The Methadone to Abstinence Residential TC is specifically for clients who wish to stop methadone maintenance treatment. All WHOS TCs operate under the following mission statement, which specifically acknowledges the importance of harm reduction to WHOS services:

*“To foster personal growth within a drug free therapeutic program. This is complemented by incorporating the concepts of Harm Minimisation for substance misuse/abuse, including the spread of communicable diseases, for example HIV/HCV.”*


-We Help Ourselves mission statement

The current WHOS harm reduction programme is the We Help Ourselves HIV/AIDS Infectious Disease Service. Its aim is to minimize the spread of HIV and other communicable diseases among alcohol and other drug users, particularly injecting drug users. The service works with clients and staff of WHOS and also provides an outreach service to former clients. The objectives of the service are:

- (1) To provide education in HIV/AIDS and other infectious diseases, using groups and one-on-one strategies for clients in residence, and on an outreach basis for injecting users who may not be in contact with health services.
- (2) To conduct relapse and overdose prevention activities, using groups and one-on-one strategies targeting clients in residence and on an outreach basis.
- (3) To provide options that promote access to a drug-free lifestyle and HIV/infectious diseases treatment and support.
- (4) To integrate a harm minimization approach into drug treatment services.
- (5) To oversee and maintain standard infection control guidelines in all WHOS facilities.
- (6) To provide harm minimization activities to increase knowledge of safer practices and thus decrease risky practices.

The following activities are carried out under the HIV/AIDS Infectious Disease Service programme:

- (1) HIV/AIDS education groups for clients. These groups for women and men meet weekly in all WHOS facilities.
- (2) Relapse prevention and drug overdose education groups. These groups meet regularly in WHOS facilities and on an outreach basis.

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- (3) Staff training in harm reduction. All staff are expected to be familiar with harm reduction principles.
  - (4) Condoms and needle and syringe provision. Condoms and safe kits are offered to residents leaving the service. Safe kits contain needles and syringes, swabs, spoons, cotton, sterile water, a syringe disposal container, condoms, lubricant and information. Syringe disposal units are also available in all WHOS bathrooms.
  - (5) Outreach service to former clients. This service promotes safer sex and safer injecting to former clients. Through the outreach service, clients who are currently injecting keep in contact with treatment services.
  - (6) Amnesty management. Group or one-on-one meetings give opportunities to discuss violations of the rules in the TC. No punitive action is taken as a result of information shared at these groups. Amnesty management provides WHOS with valuable information for planning and implementing the harm reduction programme.

### 3. THE INTEGRATION OF HARM REDUCTION INTO ABSTINENCE-BASED THERAPEUTIC COMMUNITIES: STAGES OF CHANGE

The process by which WHOS integrated harm reduction into their abstinence-based therapeutic communities, as presented above, can be conceptualized in a manner familiar to many drug treatment professionals—as a “stages of change” model. In this section, the steps an organization takes in moving towards harm reduction are presented using the famous stages of change: pre-contemplation; contemplation; preparation; action; and maintenance. Abstinence-based therapeutic communities can use this section to identify the stage their organization is at and plan the incorporation of harm reduction measures into their service.

#### 3.1 Pre-contemplation

Organizations in the pre-contemplation stage are yet to consider the possibility of integrating harm reduction into their therapeutic community. There may be individual staff members with an interest in harm reduction. They may wish to encourage colleagues to move towards contemplation by raising HIV issues at staff meetings and other forums.

#### 3.2 Contemplation

In the contemplation stage, organizations are aware of HIV among their clients and are concerned about preventing its further spread. Organizations in the contemplation stage may wish to consider if they have a role to play in helping their clients avoid HIV until they are willing or able to achieve abstinence. Staff should familiarize themselves with the concept of harm reduction and evidence supporting this approach. If possible, they should visit and observe harm reduction services like needle and syringe programmes in action. They should develop connections with local harm reduction networks or drug user organizations. They should learn about the extent of HIV among clients and options for addressing HIV in the client group. The option of HIV education is widely acceptable; condom and needle and syringe provision is more controversial, but also very important. Organizations that review the evidence and decide to incorporate harm reduction into their current services should then move into the preparation stage.

#### 3.3 Preparation

Organizations that make a commitment to harm reduction have reached the preparation stage. Strong leadership from a harm reduction advocate within the organization is vital at this stage. This person will be needed to prepare staff, key stakeholders, other service providers, and clients for the changes that are to be implemented. This may require reassessing the aims and priorities of the service, including preparing new mission statements or other documents. Meetings with staff, official bodies that oversee the treatment service, other drug treatment service providers, and current and potential clients are recommended. In some areas, it may also be helpful to meet with police or other law enforcement authorities. At these meetings, the arguments for harm reduction should be presented and any concerns that are raised should be discussed. The meetings should identify and build on common ground; for example, all parties might agree that controlling the HIV epidemic is important. With this as a starting point, different strategies for preventing HIV transmission, including both abstinence-based and harm reduction approaches, should be discussed. Rational decision-making should be promoted by using tools like SWOT analysis, as described above. It may be helpful to talk about shifting the organization from the aim of “abstinence only” to the aim of “abstinence eventually”.<sup>40</sup> This stage may take some time, but efforts to prepare the organization and others for change will benefit the future operation of the service.

<sup>40</sup> Kellogg (2003).

In addition to consulting with other relevant parties, all organization staff should undergo training to understand the philosophy of harm reduction, the effectiveness of different harm reduction measures, and ways of providing HIV education and other harm reduction activities. A variety of training packages are available for this purpose. Before and after the training, there should be an assessment of knowledge of and attitudes towards HIV, injecting drug use, and harm reduction. Comparing scores on the pre- and post-assessments will provide data on how much the staff members have learned from the training. Drug treatment services could also consider inviting HIV-positive IDUs to speak to staff about their lives and how harm reduction services help drug users. Guest speakers can be contacted through organizations like AIDS councils, community-based harm reduction services, or drug user groups.

Before moving into the action stage, organizations must ensure that implementation strategies are in place. These define what is going to be done, how it is going to be done, and who is going to do it. Having these plans in place before taking action will help minimize any unexpected events. An evaluation strategy should also be drafted. This should define the kinds of questions to be answered (e.g., Has client retention improved?) and the types of data to be collected from clients.

### **3.4 Action**

In the action stage, organizations act on decisions made in the earlier stages. The organization implements the harm reduction measures deemed appropriate. Where several changes are being made, it may be easier to introduce one harm reduction strategy at a time. For example, an organization might start with an HIV education programme. After staff and clients have adjusted to this, the organization might then consider condom or needle and syringe provision.

If funds are available, it can be useful to hire a dedicated harm reduction worker to oversee the implementation and everyday operation of harm reduction activities. Part of this worker's role can be to ensure that staff and clients understand why harm reduction has been incorporated into the service and to provide ongoing services and staff training.

### **3.5 Maintenance**

Organizations in the maintenance phase have implemented harm reduction and should now undertake evaluation projects. Both harm reduction and abstinence aspects of the organization's treatment programme should be evaluated. Evaluating the effectiveness of the programme ensures that scarce resources are being used appropriately. Regular programme evaluations also ensure that high standards are maintained, and can provide feedback for further improving programmes. Outcomes to measure might include reductions in risk behaviours and drug use, increases in client retention and treatment completion, and improved physical and mental health of clients.

Findings from evaluations should be widely disseminated to guide other drug treatment organizations. Research papers should be prepared for publication in peer-reviewed journals. Findings should be presented at drug or HIV-related conferences (funding for at least part of travel and conference registration costs can often be applied for). Information can also be disseminated by giving presentations at other drug treatment services and inviting drug treatment professionals to visit and observe the harm reduction programme in action.

Finally, organizations in the maintenance stage should ensure that all their staff members engage in regular training and professional development activities. These may include formal training programmes, attendance at meetings of professional societies, or visits to other agencies working with drug users.

## 4. LESSONS LEARNED

The experiences of We Help Ourselves in transforming itself from an abstinence-based therapeutic community to one successfully incorporating harm reduction while still promoting abstinence provide a case study of how a drug treatment organization can change its goals in response to the changing needs of clients. This case study provides a number of lessons for therapeutic communities and other drug treatment organisations working in the age of the HIV/AIDS epidemic:

### 1. Organizations for IDUs must consider their role in HIV prevention

The advent of HIV has dramatically increased the risks associated with injecting drug use. Drug injecting is now far more dangerous not only for drug injectors but also for their communities. Organizations that try to help IDUs have to think about what kinds of activities they can undertake with their clients to help prevent the spread of HIV between IDUs and into the wider community.

### 2. A balance between abstinence and HIV prevention can help deal with the reality of relapse

While the best way to avoid drug-related harms like HIV is to abstain from drug injecting, the reality is that many clients of drug treatment services relapse. Some relapse very soon after starting treatment; others complete treatment and are drug-free but relapse days, weeks, or months later. Thus, while it is important to help IDUs achieve abstinence, it is also important to ensure that they are aware of the risks of HIV and know how to protect themselves if they do relapse.

### 3. HIV prevention for IDUs can be addressed in many ways

Efforts to reduce HIV infection can range from educating clients about HIV and how to protect themselves, to outreach and to making condoms and sterile needles and syringes available to clients as they need them. All efforts to prevent HIV are valuable and should be encouraged.

### 4. Drug treatment services can change their goals without compromising their values

Abstinence and harm reduction are often presented as opposites or as conflicting approaches to drug use. In reality, abstinence-based organizations that implement harm reduction services find little conflict between the two approaches. Both have the welfare of the drug user as the number-one priority. Both agree that abstinence from drug use is the best way to avoid drug-related harms like HIV. Therapeutic communities can incorporate harm reduction while still promoting abstinence.

### 5. Change can be more manageable if done gradually

Therapeutic communities wishing to incorporate harm reduction into their service model need a strong advocate for their cause within the organization. In some cases, managers will provide leadership to bring about change. In other cases, agency staff will need to work together to create change from the bottom up. In all cases, careful guidance is needed to ensure that introducing harm reduction helps rather than hinders the service. Dividing the process of change into manageable steps (as in the previous section) and conquering each step before moving on to the next will help ensure the success of harm reduction within a service.

### 6. Adding harm reduction to treatment services improves client outcomes

Different clients of therapeutic communities have different needs and different ideas about what they expect from treatment. Most clients, if asked, would say they wish to abstain from drug use. However, many clients will relapse during or after treatment, placing themselves at risk of HIV. TCs must also address the needs of these clients by providing them with the knowledge and tools to remain HIV-negative.

Many TCs have found that making changes in their service in response to the threat of HIV has made them better able to attract and retain drug users in treatment. Having more drug users in treatment decreases HIV transmission and leads to more clients completing treatment and remaining drug-free—the best outcome that could possibly be hoped for.

#### **4.1 Conclusion**

WHOS' journey from an abstinence-based therapeutic community to a harm reduction-based therapeutic community promoting abstinence is a case study of an organization transforming itself in response to the challenges of the HIV/AIDS epidemic. This case study shows clearly that the process of change, while rarely easy, can be managed. The process of change is best achieved by identifying common ground between different viewpoints and taking small steps.

To best serve their clients, therapeutic communities must consider their needs. In the age of the HIV/AIDS epidemic, these needs include knowledge and tools to protect against HIV infection. Integrating harm reduction into abstinence-based therapeutic communities can produce many benefits for the organization, its staff, and, above all, its clients.

## REFERENCES

Aceijas, C., Stimson, G.V., Hickman, M., Rhodes, T., on behalf of the United Nations Reference Group on HIV/AIDS Prevention and Care among IDU in Developing and Transitional Countries. Global overview of injecting drug use and HIV infection among injecting drug users. *AIDS*, 2004, 18:2295–2303.

Arachne, J., Ball, J. AIDS and IV drug users: The situation in Australia. *Australian Drug and Alcohol Review*, 1986, 5:175–185.

Blacker, P., Tindall, B., Wodak, A., Cooper, D. Exposure of intravenous drug users to AIDS retrovirus, Sydney, 1985. *Australian and New Zealand Journal of Medicine*, 1986, 16:686–690.

Bluthenthal, R.N., Gogineni, A., Longshore, D., Stein, M. Factors associated with readiness to change drug use among needle exchange users. *Drug and Alcohol Dependence*, 2001, 62: 225–230.

Broekhaert, E., Vanderplasschen, W. Towards the integration of treatment systems for substance abusers: Report on the Second International Symposium on Substance Abuse Treatment and Special Target Groups. *Journal of Psychoactive Drugs*, 2003, 35(2):237–245.

Central and Eastern European Harm Reduction Network (CEEHRN). *Injecting drug users, HIV/AIDS treatment and primary care in Central and Eastern Europe and the Former Soviet Union*. Lithuania: CEEHRN, 2002.

Commonwealth of Australia. *Return on investment in needle and syringe programs in Australia*. Canberra: Commonwealth Department of Health and Ageing, 2002.

Darke, S., Williamson, A., Ross, J., Teesson, M. Residential rehabilitation for the treatment of heroin dependence: Sustained heroin abstinence and drug-related problems two years after treatment entrance. *Addictive Disorders and Their Treatment* (in press).

Dolan, K., Lowe, D., Shearer, J. Evaluation of the condom distribution program in New South Wales prisons, Australia. *Journal of Law, Medicine and Ethics*, 2004, 32.

Dolan, K.A., Shearer, J., White, B., Zhou, J. Wodak, A.D. Four-year follow-up of imprisoned male heroin users and methadone treatment: Mortality, re-incarceration and hepatitis C infection. *Addiction*, 2005, 100:820–828.

Ferroni, P., Geroldi, D., Gallic, C., Zanetti, A.R., Cargnal, A. HTLV-III antibody among Italian drug addicts. *Lancet*, 1985, 2(8445):52–53.

Fiorentine, R., Hillhouse, M.P. Drug treatment and 12-step program participation: The phenomenal growth of an important resource. *Journal of Substance Abuse Treatment*, 2000, 18(1): 64–74.

Gibson D.R. Two- to seven-fold decreased risk associated with use of needle exchange. In: *University of California Third Annual Conference on AIDS Research in California, 17th Annual AIDS Investigators' Meeting*. San Francisco, 2000.

Gowing, L., Cooke, R., Biven, A., Watts, D., on behalf of the Australasian Therapeutic Communities Association. *Towards Better Practice in Therapeutic Communities*. Bangalow: Australasian Therapeutic Communities Association, 2002.

Guydish, J., Bucardo, J., Young, M., Woods, W., Grinstead, O., et al. Evaluating needle exchange: Are there negative effects? *AIDS*, 1993, 7:871–876.

Hagan, H., McGough, J.P., Theide, H., Hopkins, S., Duchin, J., Alexander, E.R. Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors. *Journal of Substance Abuse Treatment*, 2000, 19(3):247–252.

Hartgers, C., Buning, E.C., van Santen, G.W., Verster, A.D., Coutinho, R.A. The impact of the needle and syringe-exchange program in Amsterdam on injecting risk behaviour. *AIDS*, 1989, 3:571–576.

Hurley, S.F., Jolley, D.J. Effectiveness of needle-exchange programs for prevention of HIV infection. *Lancet*, 1997, 349:1797–1800.

Joint United Nations Programme on HIV/AIDS (UNAIDS). *UNAIDS/WHO Policy Statement on HIV Testing*. Geneva: UNAIDS, 2004.

Joint United Nations Programme on HIV/AIDS (UNAIDS). *AIDS Epidemic Update*. 2005. Accessed online at [http://www.unaids.org/Epi2005/doc/report\\_pdf.html](http://www.unaids.org/Epi2005/doc/report_pdf.html)

Kellogg, S.H. On “gradualism” and the building of the harm reduction–abstinence continuum. *Journal of Substance Abuse Treatment*, 2003, 25:241–247.

Kirby, D. The impact of schools and school programs upon adolescent sexual behaviour. *Journal of Sex Research*, 2002, 39(1):27–33.

Lees, J., Mannings, N., Rawlings, B. A culture of enquiry: Research evidence and the therapeutic community. *Psychiatric Quarterly*, 2004, 75(3):274–294.

Lind, B., Chen, S.L., Weatherburn, D., Mattick, R. The effectiveness of methadone maintenance in controlling crime: An Australian aggregate-level analysis. *British Journal of Criminology*, 2005, 45(2):201–211.

Marlatt, G.A., Blume, A.W., Parks, G.A. Integrating harm reduction therapy and traditional substance abuse treatment. *Journal of Psychoactive Drugs*, 2001, 33(1):13–21.

Marlatt, G.A., Blume, A.W., Parks, G.A. Integrating harm reduction therapy and traditional substance abuse treatment. *Journal of Psychoactive Drugs*, 2001, 33(1):13–21.

Metzger, D.S., Woody, G.E., McLellan, A.T., O'Brien, C.P., Druley, P., et al. Human immunodeficiency virus sero-conversion among intravenous drug users in- and out-of-treatment: An 18-month prospective follow-up. *Journal of Acquired Immune Deficiency Syndrome*, 1993, 6:1049–1056.

National Centre for HIV Epidemiology and Clinical Research. *Australian HIV Surveillance Report*, 12(2):11. Sydney: National Centre for HIV Epidemiology and Clinical Research, 1996.

National Centre for HIV Epidemiology and Clinical Research. *Australian NSP Survey National Data Report 2000–2004*. Sydney: National Centre in HIV Epidemiology and Clinical Research, 2005.

New South Wales Users and AIDS Association (NUAA). *NUAA Strategic Plan 2004–2007*. 2004. Available from [www.nuaa.org.au](http://www.nuaa.org.au)

Simpson, D.D., Joe, G.W., Brown, B.S. Treatment retention and follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors*, 1997, 11:294–307.

Spira, T.J., Des Jarlais, D.C., Marmor, M., Yancovitz, S., Friedman, S., et al. Prevalence of antibody to LAV among drug detoxification patients in New York. *New England Journal of Medicine*, 1984, 311:467–368.

Sullivan, L.E., Metzger, D.S., Fudala, P.J., Fiellin, D.A. Decreasing international HIV transmission: The role of expanding access to opioid agonist therapies for injection drug users. *Addiction*, 2004, 100:150–158.

Swift, W., Darke, S., Hall, W., Poppo, G. *Who's who? A report on the characteristics of clients seen at We Help Ourselves (WHOS) 1985–1991* (NDARC Technical Report No. 14). Sydney: National Drug and Alcohol Research Centre, 1993.

Watters, J.K., Estilo, M.J., Clark, G.L., Lorvick, J. Syringe and needle exchange as HIV/AIDS prevention for injection drug users. *Journal of the American Medical Association*, 1994, 271:115–120.

We Help Ourselves. *Annual activities report 1997–1998: HIV/Infectious Disease Education and Outreach Service*. Sydney: We Help Ourselves, 1998.

Wodak, A. Harm reduction: Australia as a case study. *Bulletin of the New York Academy of Medicine*, 1995, 72(2):339–347.

Wodak, A., Dolan, K., Imrie, A., Gold, J., Wolk, J., et al. Antibodies to the human immunodeficiency virus in needles and syringes used by intravenous drug abusers. *Medical Journal of Australia*, 1987, 147:275–276.

## APPENDIX 1: METHADONE MAINTENANCE TREATMENT

Methadone maintenance treatment (MMT) is a pharmacotherapy-based treatment for heroin dependence. Methadone is an opiate agonist. This means that methadone acts on the same receptors in the brain as heroin, thus reducing cravings for heroin. Methadone and a similar medication for heroin dependence, buprenorphine, are both listed by the World Health Organization as essential medicines. This emphasizes how important and effective methadone maintenance treatment is as a treatment option.

Methadone must be prescribed by a doctor, who takes into account how much heroin the patient has been using and how much methadone will be needed to counteract cravings for heroin. The effects of methadone last for 24–48 hours, so the patient needs only one dose in 24 hours. Instead of spending time seeking heroin, a patient on a stable dose of methadone can concentrate on everyday activities like working, studying, and caring for the family.

There has been a great deal of research into the effectiveness of MMT in treating heroin dependence. The following summary demonstrates the effectiveness of MMT in reducing HIV transmission, deaths, criminal behaviours, and imprisonment.

- 1) **MMT reduces HIV seroconversions:** A study comparing HIV-negative injecting drug users (IDUs) in and out of MMT found that after 18 months, 22% of those not in treatment had acquired HIV, compared with only 3.5% of those in treatment.<sup>41</sup>
- 2) **MMT reduces deaths.** The mortality rate of IDUs in MMT is one-third to one-quarter of that of IDUs not in treatment.<sup>42</sup> In a study of a randomized controlled trial of a prison-based MMT programme with 382 participants, none of the participants in MMT died. However, there were 17 deaths among participants not in MMT.<sup>43</sup>
- 3) **MMT reduces criminal offenses.** An Australian study reported that for every 100 people in methadone treatment per year, there were 12 fewer robberies, 57 fewer break-ins, and 56 fewer car thefts.<sup>44</sup>
- 4) **MMT reduces re-incarceration.** IDUs who receive MMT in prison and remain in MMT after release have reduced risk of returning to prison. In a four-year follow-up study, heroin users not in MMT had a re-incarceration rate of 97 per 100 person-years. Those in MMT for 8 months or longer had a re-incarceration rate of only 23 per 100 person-years.<sup>45</sup>

<sup>41</sup> Metzger et al. (1993).

<sup>42</sup> World Health Organization (WHO)/United Nations Office of Drugs and Crime (UNODC)/Joint United Nations Programme on HIV/AIDS (UNAIDS) (2004).

<sup>43</sup> Dolan et al. (2004).

<sup>44</sup> Lind et al. (2005).

<sup>45</sup> Dolan et al. (2005).

## APPENDIX 2: NEEDLE AND SYRINGE PROGRAMMES

Needles and syringe programmes (NSPs) provide sterile injecting equipment to injecting drug users (IDUs). They also often provide condoms and information and education about safer injecting, overdose prevention, and HIV prevention. Although there is a great deal of evidence that NSPs prevent HIV infections among IDUs, they are controversial. Some of the research evidence on NSPs is presented below.

- (1) **NSPs are cost-effective.** An Australian Government study reported that for a \$130 million investment between 1991 and 2000, an estimated 25,000 cases of HIV and 21,000 cases of hepatitis C were prevented, resulting in a saving of up to \$7.7 billion in treatment costs.<sup>46</sup>
- (2) **NSPs do not encourage drug use.** A World Health Organization review of the evidence regarding NSPs concluded that NSPs do not cause an increase in injecting drug use;<sup>47</sup> indeed, NSP attenders decrease the frequency of their injecting.<sup>48</sup>
- (3) **NSPs refer drug users to treatment services.** NSPs can also link drug users with other services, such as medical or drug treatment. A study in the United States found that NSP attenders were five times more likely to enter drug treatment than non-attending IDUs.<sup>49</sup>
- (4) **NSPs do not affect motivation for treatment.** NSPs do not reduce drug users' motivation to receive treatment, as shown by a study of the first NSP in Australia. The NSP was adjacent to a methadone maintenance clinic in inner Sydney, but an examination of urine samples of the clients of the methadone programme found no increase in illicit drug use compared with clients of another methadone clinic.<sup>50</sup>
- (5) **NSPs help prevent HIV transmission:** A large ecological study compared HIV prevalence over time between 29 cities with NSPs and 52 cities without NSPs. This study concluded that, on average, HIV prevalence among IDUs decreases by 5.8% per year in cities with NSPs. In cities without NSPs, HIV prevalence among IDUs increases by 5.9% per year.<sup>51</sup>

<sup>46</sup> Commonwealth of Australia (2002).

<sup>47</sup> World Health Organization (2005).

<sup>48</sup> Gibson (2000).

<sup>49</sup> Hagan et al. (2000).

<sup>50</sup> Wolk et al. (1990).

<sup>51</sup> Hurley and Jolley (1997).

## APPENDIX 3: THE 12 STEPS OF NARCOTICS ANONYMOUS

### NA Twelve Steps

1. We admitted that we were powerless over our addiction, that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God *as we understood Him*.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed, and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory and when we were wrong promptly admitted it.
11. We sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to addicts, and to practice these principles in all our affairs.

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## APPENDIX 4: USEFUL WEBSITES

**Asian Harm Reduction Network (AHRN):** AHRN aims to develop understanding of harm reduction in Asia by providing education, training and advocacy. URL: <http://www.ahrn.net/>

**International Harm Reduction Association:** An international network for harm reduction researchers and drug treatment professionals. URL: <http://www.ihra.net/>

Programme of International Research and Training (PIRT): **Training manuals and packages in harm reduction and writing articles for publication are available for free download.**

URL: <http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/page/PIRT>

**We Help Ourselves:** The website of the therapeutic communities presented in this book.

URL: <http://www.whos.com.au>

**Who's crazy?** A former drug user details how he moved from promoting abstinence to believing in harm reduction. After changing his personal philosophy, he worked to change the focus of his drug treatment organisation. Now retired, he ran a large outreach and needle and syringe programme service.

URL: <http://www.harmreduction.org/pubs/news/spring99/hsimpson.html>

**World Health Organization:** Listing of all WHO guidelines, training materials and research documents in the area of HIV/AIDS and injecting drug use. URL: <http://www.who.int/hiv/pub/idu/en>

**World Health Organization, Regional Office for the Western Pacific:** Website on harm reduction among injecting drug users with relevant publication, policy documents, data, meetings and events, collaboration centres, news.

URL: [http://www.wpro.who.int/health\\_topics/harm\\_reduction/](http://www.wpro.who.int/health_topics/harm_reduction/)