Sarah Larney, Kate Corcoran, Alex Wodak and Kate Dolan, on behalf of the World Health Organization Regional Office for the Western Pacific

The integration of harm reduction into abstinence-based therapeutic communities: A case study of We Help Ourselves

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THE INTEGRATION OF HARM REDUCTION INTO ABSTINENCE-BASED THERAPEUTIC COMMUNITIES:
A CASE STUDY OF WE HELP OURSELVES

Sarah Larney, Kate Corcoran, Alex Wodak & Kate Dolan, on behalf of the World Health Organization Regional Office for the Western Pacific

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Garth Popple, Executive Director, We Help Ourselves (WHOS) 1986 – 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 Health, 1988-1994

Stuart Riley, Policy Analyst, Drug and Alcohol Directorate, New South Wales Health, 1990-1994

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

ABBREVIATIONS

AA	Alcoholics Anonymous
CEIDA	Centre for Education and Information on Drugs and Alcohol
HIV	Human Immunodeficiency Virus
IDU	Injecting drug use
IDUs	Injecting drug users
MMT	Methadone maintenance treatment
NA	Narcotics Anonymous
NSP	Needle and syringe program
NSW	New South Wales
SWOT	Strengths, weaknesses, opportunities, threats
TC	Therapeutic community
WHO	World Health Organization
WHOS	We Help Ourselves

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 programs aim to reduce the transmission of HIV among IDUs. Harm reduction does not oppose 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 are able to achieve and maintain abstinence.

Therapeutic communities (TCs) have traditionally provided abstinence-based services for drug users. However, with the advent of HIV many TCs have moved towards offering HIV education and making condoms and sterile needles and syringes available to their clients. One organisation 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 continue to do so today.

The process by which WHOS incorporated harm reduction into their abstinence based program can be conceptualised 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 program. Those in the contemplation stage are aware of HIV among their client group and are willing to explore options for preventing further HIV transmission. Organisations 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. Organisations for IDUs need to consider their role in HIV prevention
The advent of HIV has dramatically increased the risks associated with injecting drug use. Organisations 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. The reality of relapse: Balancing abstinence and HIV prevention
While the best way to avoid drug-related harms like HIV is to be abstinent from drug injecting, the reality is that many clients of drug treatment services relapse. 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 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 providing clients with education about HIV and how to protect themselves, through to outreach, to making condoms and sterile needles and syringes available to clients as they are needed. 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 organisations that implement harm reduction services find there is little conflict between the two approaches. It is possible to incorporate harm reduction into therapeutic communities while still promoting abstinence.

5. The process of change

Careful guidance is needed to ensure 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 to their service in response to the threat of HIV has improved their ability to attract and retain drug users in treatment. More drug users in treatment leads to decreased HIV transmission and increased numbers of 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 organisation 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 organisation, staff and above all, clients. Many drug treatment organisations have made the transition to harm reduction and few have regretted the change.

1. INTRODUCTION

1.1 HIV among IDUs

An estimated 40 million people worldwide are infected with HIV (UNAIDS, 2005). While Africa continues to have the highest prevalence of HIV of any region, the epidemics of Eastern Europe and Central, South and South-East Asia are considerable. 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. Worldwide, ten per cent of HIV cases have been attributed to IDU (Aceijas, Stimson, Hickman, *et al.*, 2004) and in countries such as the Russian Federation, Indonesia and Viet Nam, IDU is driving the epidemic (CEEHRN, 2002; UNAIDS, 2005).

HIV prevalence among IDUs is alarmingly high in some countries. In parts of China, up to 80% of IDUs are HIV positive. In Jakarta, Indonesia, up to 40% of IDUs are HIV positive and in other areas of Indonesia prevalence can be as high as 56%. Prevalence is estimated at 34% in Bangkok, Thailand (Aceijas, *et al.*, 2004). The table below shows estimated HIV prevalence among IDUs in several East and Southeast Asian countries.

Country	National (%)	Capital city (%)	Other sites (%)
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

Table 1: Estimated HIV prevalence among IDUs. Adapted from Aceijas *et al.* (2004)

High HIV prevalence among IDUs can serve as the entry point for a widespread, generalised epidemic if the virus is transmitted to non-injecting sexual partners and in turn, their children. In areas where many IDUs engage in sex work, the virus spreads very quickly from injectors to the wider community (UNAIDS, 2005). Preventing HIV among IDUs is thus essential for the protection of the whole community as well as high-risk groups.

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 consistently remained below two per cent (National Centre in HIV Epidemiology and Clinical Research, 2005). The successful containment of HIV in Australia has been credited to early, pragmatic interventions that acknowledged the realities of both HIV and drug dependence (Wodak, 1995; Wodak &

Lurie, 1997). At the centre of HIV prevention efforts in Australia have been harm reduction measures.

1.2.1 What is harm reduction?

The term "harm reduction" is used by different people to mean different things. This has led to confusion about what harm reduction is. In a general sense, harm reduction is about managing risks associated with dangerous activities. More specifically, it is an approach to drug use – including legal drug use – that aims primarily to reduce negative consequences. Consider motor vehicle accidents as an analogy to drug use and the aims of harm reduction. 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, this would be an extremely difficult outcome to achieve. So, while engineers and designers work to improve cars so that they are less likely to crash, seat belts have been introduced into cars to protect motorists in the event that 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 the opposite of abstinence-based approaches to drug use and sometimes even as condoning drug use. This is not the case. Rather, as shown below, abstinence falls within the hierarchy of harm reduction goals.

Harm Reduction Hierarchy

- Don't use drugs
- If you use drugs, don't inject
- If you inject drugs, use sterile injecting equipment and never share injecting equipment
- 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 further 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 are unable to remain abstinent, harm reduction measures such as methadone maintenance treatment and needle and syringe programs are ways to reduce 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 need to engage in a chaotic, illicit drug-focused lifestyle, IDUs in MMT are able to reconnect with family and find employment. There is strong evidence that MMT reduces illicit drug use and drug injecting (Sullivan, Metzger, Fudala, *et al.*, 2004), which in turn reduces the transmission of HIV among IDUs. MMT also reduces crime (Lind, Chen, Weatherburn *et al.*, 2005) and incarceration of injecting drug users (Dolan, Shearer, White *et al.*, 2005). Methadone has been listed by the World Health Organization as an essential medicine in the treatment of drug dependence. For further information on MMT, see Appendix 1.

1.2.3 Needle and Syringe Programs

Needle and syringe programs (NSPs) provide sterile needles and syringes and other injecting equipment to IDUs. Condoms and education about safer injecting and HIV prevention are also often provided. NSP workers also refer IDUs into drug treatment. A large body of evidence has been amassed that demonstrates that NSPs are effective in preventing HIV transmission and do not have a negative impact on communities they are located in. NSPs are cost effective (Commonwealth of Australia, 2002), do not encourage drug use (Wodak & Cooney, 2004) and can create links between drug users and drug treatment services (Hagan, McGough, Thiede, *et al.*, 2000). For further information about NSPs, see Appendix 2.

1.3 Abstinence-based approaches to drug dependence

Permanent ceasing of drug use is the outcome aimed for by traditional abstinence-based approaches to drug dependence. More recently, many abstinence-based services have acknowledged that few clients achieve abstinence, at least in the short term, and that it is 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 hold regular meetings of former and current drug users who are trying to maintain or achieve abstinence. Group members provide each other with support to achieve this goal. The most common self-help groups are Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). In 2005, there were over 21,500 registered NA groups in 116 countries (www.na.org). The AA/NA approach views drug and alcohol 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. Sponsors are former drug users who act as mentors and provide personal support to 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 term "therapeutic community" (TC) refers to a treatment approach where clients live within a small, structured community. TCs were originally developed for the treatment of psychiatric patients. The first TC for drug users, Synanon, was established in 1958 in the United States. Synanon based its treatment approach on the principles of AA and employed recovered problem drinkers and drug users. The goals of Synanon were to encourage psychological and lifestyle changes that would help clients to maintain their new-found abstinence (Gowing, Cooke, Biven, *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 TCs have a mix of professionals and ex-drug users as staff. The treatment approach is generally one of peer support. Clients are expected to contribute to both the general running of the community, for example, by completing household chores, and their recovery, by actively participating in group and individual therapy (Gowing *et al.*, 2002). 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 (Marlatt, Blume & Parks, 2001).

The effectiveness of TCs is difficult to measure as services provided vary widely from one TC to another. It is known that longer stays in treatment produce better outcomes (Simpson, Joe & Brown, 1997). The Australian Treatment Outcome Study (ATOS), an ongoing study of different drug treatment approaches, found that former clients of therapeutic communities with two years of continuous heroin abstinence had stayed in treatment for a mean of 58 days, compared to 28 days among those who had relapsed (Darke, Williamson, Ross & Teesson, in press).

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 carried out than could be expected and encouraged all TC practitioners to undertake high quality research into their programs, including program evaluations (Lees, Mannings & Rawlings, 2004).

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 (Broekhaert & Vanderplasschen, 2003). These TCs have begun to integrate harm reduction services into their abstinence-based treatment programs (Broekhaert & Vanderplasschen, 2003; Kellogg, 2003; Marlatt, Blume & Parks, 2001). Under this treatment model, harm reduction and abstinence-based approaches to drug use are regarded as complementing each other. Abstinence is still valued, but harm reduction is also considered a valid goal. European TCs in particular have recently adopted this integrated model (Broekhaert & Vanderplasschen, 2003). This shift has been described as moving from a goal of "abstinence only" to one of "abstinence eventually" (Kellogg, 2003).

Pre-dating this recent shift by almost twenty 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 program 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 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.

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 – 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), 1987-1988.

Relevant reports, WHOS Board of Directors meeting minutes, conference abstracts and presentations were examined for further information. The information gathered is presented as an historical account of how WHOS changed its service model from an abstinence focus to a harm reduction focus.

2.1 1985-86: Preparing the organisation

HIV infection first appeared among IDUs in Sydney and Melbourne in 1985 (Arachne & Ball, 1986; Blacker, Tindall, Wodak, *et al.*, 1986). Of 2,624 new HIV diagnoses in Australia in 1986, 131 (5%) were related to injecting drug use (National Centre in HIV Epidemiology and Clinical Research, 1996). Also in 1986, the Director of WHOS, Garth Popple, noticed an increase in the number of HIV positive clients presenting to WHOS. In particular, he observed clients known to be HIV negative leaving the service only to return at a later date as HIV positive.

Of great concern at this time was the potential for HIV to spread rapidly among IDUs as it had in countries with more advanced epidemics than Australia (Arachne & Ball, 1986; Blacker *et al.*, 1986). For example in New York in 1984, 58% of IDUs presenting to a detoxification unit were HIV positive (Spira, Des Jarlais, Marmor, *et al.*, 1984) and a survey of residents in an Italian TC in 1984/85 found HIV prevalence to be 53% (Ferroni, Geroldi, Garric, *et al.*, 1985). 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 (Blacker, *et al.*, 1985). The diagram below, taken from Blacker *et al.* (1985) shows the relationships between the index case (marked with an "x" in the diagram) and his injecting and sexual partners.

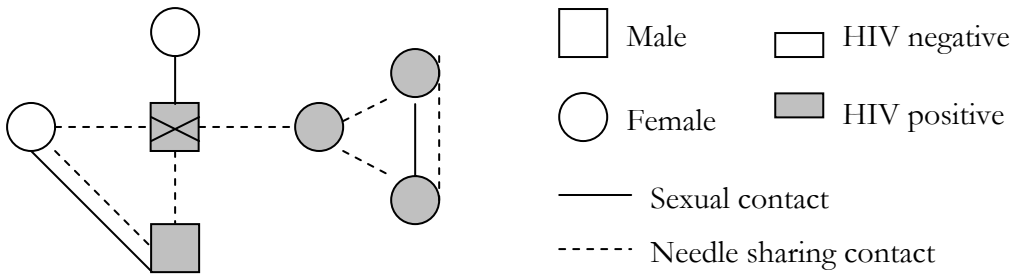

Figure 1: Pattern of HIV seroprevalence among the injecting and sexual partners of an index case. Adapted from Blacker *et al.* (1985).

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. Testing the contents of syringes returned to an NSP in December 1986 returned an HIV prevalence of 1% (Wodak, Dolan, Imrie, *et al.*, 1987). A second, similar study in August 1987 found the prevalence had increased to 3% (Wolk, Wodak, Morlet *et al.*, 1988). Sampling of IDUs in December 1987 revealed another increase, to 9% (Wolk, Wodak, Morlet, *et al.*, 1990). 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, as few as 5-10% of clients attending WHOS completed the program, meaning the majority of clients at WHOS were unable or unwilling to achieve or maintain abstinence. These clients left the program and returned to injecting drug use, thus risking contracting HIV. The Executive Director believed that treatment services seeing 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

In addition, there was a debate at the time that services operating with an exclusive abstinence focus would contribute to the spread of HIV among IDUs. It was argued that because abstinence-based services were not providing HIV education and preventive tools such as condoms and syringes, clients using these services would remain unaware of the risks of HIV and how to protect themselves from it. Some believed that all drug treatment services had a responsibility to provide IDUs with education, condoms and syringes in order to prevent the spread of HIV. The Executive Director of WHOS believed that this approach was commonsense and referred to it as "risk prevention". He began to consider the possibility of integrating HIV prevention services such as education, condoms and needle and syringe provision into the abstinence-based WHOS therapeutic communities.

In exploring the possibility of integrating harm reduction into the WHOS service model, the Executive Director was aware that the long-held aims and priorities of the service would need to be reassessed. The aim of WHOS in 1986 was that all clients be drug-free – the "abstinence only" aim. This approach to service provision was not meeting the needs of the significant number of clients who relapsed to drug use and had not received any assistance to ensure that they did not contract HIV or other infections. By focusing solely on abstinence, WHOS was failing to respond to the needs of many of their clients.

For the Executive Director, the process of reassessing the priorities of WHOS was about acknowledging the threat posed by HIV:

"Do we continue following our existing approach or do we deal with reality?"

Director, WHOS, 2005

The reality was that not all clients were willing or able to be abstinent. Some clients were leaving WHOS and engaging in HIV risk behaviours. Furthermore, despite the rules, clients within WHOS were using drugs and having sex and were thus at risk of HIV even while in the TC. Finally, even clients who completed the program and achieved abstinence could relapse at some later stage, also risking HIV infection. 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 organisation should shift towards an "abstinence eventually" goal. As the Executive Director noted,

"You might take 3 or 4 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 a process of consultation and consensus building. This took time but was essential. Senior WHOS staff, the WHOS Board of Directors and clients were informed about the HIV situation internationally, in Australia and within WHOS. These key stakeholders were encouraged to consider this evidence and apply a decision-making process known as a SWOT analysis.

SWOT stands for strengths, weaknesses, opportunities and threats. Using a SWOT analysis enables decision makers to determine an appropriate course of action at a given time. The steps involved 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 to reach an informed and rational decision. A short example of a SWOT analysis for therapeutic communities considering incorporating harm reduction measures into their programs is presented below:

Sample SWOT Analysis

1. The *strengths* of such as proposal could include increasing client retention and minimising the spread of infectious diseases such as 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

Following this process, the Board of Directors and other key stakeholders came to agree 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. Supporters of the plan to introduce harm reduction included the NSW Department of Health and the Centre for Education and Information on Drugs and Alcohol (CEIDA). CEIDA was an organisation providing workforce development activities to workers in the drug and alcohol field. Support also came from ex-clients of WHOS. WHOS had 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 ex-clients were now working in the harm reduction field, providing HIV education to drug users and working in needle and syringe programs (NSPs). The ex-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 of WHOS, some WHOS clinical staff 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 organisational changes, staff training for harm reduction was rare. As an alternative to training, staff were encouraged to join the

management committee of a drug user organisation or organisations that focused on infectious diseases. Drug user organisations are staffed by current and former drug users who educate other drug users and provide services such as drop-in centres and NSPs. These organisations are based on the idea that the best people to educate and inform drug users are other drug users – a process called peer education. An example of a drug user organisation is the New South Wales Users and AIDS Association (NUAA). NUAA was established to provide peer education on HIV prevention to IDUs. Funding for the organisation is provided by the NSW Department of Health. Other services provided by NUAA include NSP, a drop-in centre, a magazine entitled "User's News" and education around hepatitis C and drug overdose prevention. NUAA also makes representations to the Government on issues of concern to drug users (NUAA, 2004). Spending time at NUAA exposed staff to different ways of thinking about drug use and harm reduction.

2.2 1987-90: Implementing harm reduction

Beginning in 1987 and 1988, the Centre for Education and Information on Drugs and Alcohol (CEIDA) provided much of the HIV information and education materials to be used at WHOS. CEIDA produced guidelines for WHOS around 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 to take as needed. There was some concern at the time that providing condoms would increase sexual activity in the TC, however, these concerns were not experienced in reality.

Will providing condoms increase sex in the TC?

A common concern when the issue of providing condoms in TCs is raised is that the number of residents engaging in sexual activity will increase. We now have evidence that shows that the provision of condoms in prisons (Dolan, Lowe & Shearer, 2004) and schools (Kirby, 2002) does not lead to an increase in sex by members of these institutions. WHOS did not experience an increase in the number of clients having sex in their TCs. It is safe to assume that providing condoms in TCs will not lead to an increase in sexual activity.

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, not monitored and that they would not be punished for having them.

It soon became clear that there was a great deal of work involved in implementing harm reduction into WHOS. A staff member to co-ordinate all harm reduction activities was needed. In 1990, WHOS received funding from the NSW Department of Health to employ someone to work on the harm reduction project full-time. Clearly, the introduction of harm reduction into the service had not reduced the ability of WHOS to attract funding; in fact, funding bodies appreciated that the service was brave enough to face criticism and make changes in response to the threat of HIV.

The new employee was titled 'HIV/Infectious Disease Coordinator'. In recognition of the importance of the role, this Coordinator was made equal in authority to the Treatment Coordinator. This sent an important message to both staff and clients that harm reduction was firmly integrated into WHOS and was of equal importance to the abstinence-based treatment program.

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

HIV Counselling and Testing

Receiving a positive diagnosis of HIV can be devastating. It is essential that people being tested for HIV receive counselling before and after the test (UNAIDS, 2004). Otherwise, clients 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 clients of WHOS requesting an HIV test. He would also provide counselling between the test and results if requested, and would even accompany clients to the testing clinic if requested. The identities of HIV positive clients were kept confidential. In order to further ensure confidentiality, WHOS now makes use of external sexual health services to provide HIV counselling and testing.

Individual and group education sessions

Education groups for WHOS clients initially focused on HIV prevention. They included information about how HIV is transmitted, safer injecting practices and using condoms. Two separate HIV education programs were developed; one for women clients and one for men. This was because women and men face different risks in relation to sexually transmitted HIV. In particular, more women than men engage in sex work, a high HIV risk activity. Topics discussed in groups included strategies to increase the regularity of condom use, the risks of sharing injecting equipment and how to use bleach to clean syringes.

After successfully running HIV education groups, the HIV/Infectious Disease Coordinator introduced a relapse prevention group. This group focused on teaching clients to avoid situations in which they might relapse and how to cope if they did relapse. Many drug users cut themselves off from treatment after a relapse, often out of embarrassment or shame. The relapse prevention group encouraged clients to see relapse as a setback, not a failure, and to remain in treatment even if they did relapse.

Group sessions were also held in WHOS' "halfway houses". Halfway houses accommodated clients who had completed the program but were not yet ready to live outside a supportive environment. These groups focused on providing skills to cope 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 program. 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 purpose of the outreach program was to keep clients alive and as healthy as possible until they were able to achieve abstinence from drugs.

The HIV/Infectious Disease Coordinator would maintain contact with high-risk clients after they left the WHOS program, whether they had completed it or not. Safer injecting and sexual practices were promoted to these clients. Clients were also made aware that they were welcome to return to WHOS at any stage if they wished to make another attempt at achieving abstinence. The outreach service was particularly important in letting clients know that the TC still respected and cared for them. It helped clients to remain in contact with a treatment service, making it easier for them to access treatment if they decided to make another attempt at achieving abstinence.

Condoms and Needle and Syringe Programs

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.

Figure 2: A WHOS safe kit, with information leaflets, three sets of injecting equipment, condoms, lubricant, and syringe disposal container ("fitpack").

These kits were placed in all toilets in WHOS. Kits were also offered to all residents choosing to leave the program. As previously with condoms, no formal records of the numbers 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

There was some concern among staff that providing condoms and injecting equipment might send conflicting messages to clients and indeed, some clients expressed confusion that sex and drug use were not allowed, but condoms and syringes were. It was important to work with clients to make sure they understood why condoms and syringes were available. The HIV/Infectious Disease Coordinator would explain to clients that the staff at WHOS wanted clients to be prepared for any event. While they hoped that all clients followed the rules all the time, they knew that some clients would break the rules. When that happened, it was important for the client to be able to avoid HIV and other infectious diseases. The Coordinator would also point out to clients that condoms and syringes don't have to be used just because they are there. Abstaining from sex and injecting drug use in the presence of condoms and syringes became a lesson for clients on coping with risky relapse situations.

After learning about why harm reduction strategies had been introduced, most clients responded positively. It was clear to them that WHOS was a non-judgmental environment committed to ensuring the health and safety of clients. WHOS did not experience a reduction in admissions in response to the introduction of harm reduction; rather, as word spread, the number of IDUs seeking treatment at WHOS increased.

Will providing syringes increase drug injecting in the TC?

It is commonly thought that providing needles and syringes will encourage drug use. Research shows that needle and syringe programs in the community do not encourage increased drug injecting (Hartgers, Buning, van Santen, *et al.*, 1989; Watters, Estilo, Clark, *et al.*, 1994). Nor do they encourage non-injecting drug users to begin injecting (Guydish, Bucardo, Young, *et al*, 1993). Finally, providing injecting equipment does not affect drug users' motivation to seek treatment or reduce drug use (Bluthenthal, Gogineni, Longshore, *et al.*, 2001). It is reasonable to assume that making sterile injecting equipment available will not encourage TC residents to inject drugs.

2.3 1991-2006: Evaluating and disseminating harm reduction at WHOS

Evaluating services provided is essential for ensuring that scarce resources are being used effectively. WHOS carried out both informal evaluation activities and commissioned a formal evaluation from an external research organisation. Some evaluation activities were

incorporated into standard organisational procedures. For example, data on the ethnic background, housing status, employment history and treatment history of all clients was gathered during a standardised admission interview. At discharge, length of stay and reason for discharge were recorded.

The simple evaluation activities carried out by WHOS showed a number of positive changes had occurred after harm reduction was integrated into the service. The data collected by WHOS shows that the TCs experienced an increase in program completion and client retention. Records indicate that in 1986 4.4% of clients completed the program. During the period 1988-1991, after harm reduction was introduced, the percentage of clients completing the program increased to 11.5%. The median length of stay in 1986 was just 4 days. Between 1987 and 1991, this increased to 17 days (Swift, Darke, Hall *et al.*, 1993).

	1986	1991
Program completion rate (%)	4.4	11.5
Median length of stay (days)	4	17

Table 2: Program completion and client retention in 1986 and 1991. Adapted from Swift *et al.* (1993).

This increase in client retention is especially important, as longer length of stay is associated with improved treatment outcomes (Simpson, Joe & Brown, 1997). There was also a large decrease in the number of clients leaving against staff advice. In 1985, 92% clients who discharged did so against the advice of staff. By 1988-91, this had decreased to 40% (Swift *et al.*, 1993).

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, this had reduced to 19% engaging in unsafe sex and just 5% sharing needles and syringes (WHOS, 1998).

	On admission	18 month follow-up
Practicing unsafe sex	26%	19%
Sharing needles and syringes	14%	5%

Table 3: Risk behaviours of WHOS clients on admission and at follow-up. Adapted from WHOS (1998).

These data show that after harm reduction was introduced to WHOS, client retention and program completion increased – the opposite of what had been feared by some. Furthermore, there were reductions in HIV risk taking behaviour by clients.

Despite their success, a number of other drug rehabilitation services were expressing concern about the steps WHOS had taken. There were suggestions that WHOS should not be permitted to maintain its membership of the Australasian Therapeutic Communities Association, the peak representative body for TCs in Australia. WHOS was able to use the data collected in their evaluation projects to address this opposition. Their evidence was clear and convincing; harm reduction had positively impacted on WHOS.

It is difficult to argue against this evidence. This is why evaluating harm reduction as it is introduced is essential if a service is going to effectively address opposition to their approach. 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 served as President of the Association for several years.

Convinced of the value of their new service model, the Executive Director of WHOS and his colleagues set about disseminating their knowledge. This involved attending and presenting at conferences nationally and internationally and becoming involved in drug and alcohol advisory committees. In this way, other professionals became exposed to the concept of integrating harm reduction into abstinence-based treatment services.

Following is an abstract of a paper presented at the 20th World Federation of Therapeutic Communities Conference, 2003, by the 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 numbers of drug overdose deaths. 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, and with HIV now 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. 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 all rehabilitation centres and TCs are not the same, to think so is a mistake that can lead to a polarisation that can damage the field(s); treatment services are like services in any field, part of an evolving 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 services into their abstinence-focused therapeutic community without negatively affecting 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. While staff were initially reluctant to move away from the "abstinence only" goal, with discussion and examination of the evidence for harm reduction, they too came to realise that abstinence would still be valued by the service 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.

There had been concerns that WHOS would be unable to attract funding for their services. This was not the case. In fact, after the implementation of harm reduction WHOS received extra funding from the NSW Department of Health. Another concern was that clients would not be happy with the changes WHOS had made. However, the clients appreciated that WHOS was helping them to remain healthy and safe, even if they were unable to achieve abstinence on this attempt. WHOS continued to attract clients and open new TCs incorporating harm reduction principles.

2.4 We Help Ourselves Today

As at 2006, We Help Ourselves operates five therapeutic communities for people with drug and alcohol dependencies. WHOS New Beginnings is for women only, while WHOS Metro is for men only. The other three TCs cater to women and men. One WHOS TC, Methadone to Abstinence Residential, is specifically for clients who wish to cease methadone maintenance treatment. All WHOS TCs operate with under the following mission statement:

"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*

This mission statement specifically acknowledges the importance of harm reduction to WHOS services.

The current WHOS harm reduction program is referred to as the We Help Ourselves HIV/AIDS Infectious Disease Service. The aim of this service is to minimise the spread of HIV and other communicable diseases among alcohol and other drug users, particularly injecting drug users. The HIV/AIDS Infectious Disease 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 HIV/AIDS and other infectious diseases education, using groups and one-on-one strategies for clients in residence and on an outreach basis, for those users who are injecting and may not be in contact with health services.
2. To conduct relapse and overdose prevention activities, utilising groups and one-on-one strategies targeting clients in residence and on an outreach basis.
3. To provide options to promote access to a drug free lifestyle, HIV/infectious diseases treatment and support.
4. To integrate a harm minimisation approach into drug treatment services.
5. To oversee and maintain standard infection control guidelines within all WHOS facilities.

6. To provide harm minimisation activities to increase knowledge on safer practices in order to decrease risky practices.

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

- HIV/AIDS Education groups for clients. These groups are held on a weekly basis for women and men in all WHOS facilities.
- Relapse prevention and drug overdose education groups. These groups are provided regularly both to clients in WHOS facilities and on an outreach basis.
- Staff training in harm reduction. All staff must be familiar with harm reduction principles.
- Condoms and needle and syringe provision. Condoms and "safe kits" are available in all bathrooms and for 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 available in all bathrooms in all WHOS facilities.
- Outreach service to former clients. This service promotes safer sex and safer injecting to former clients. The outreach service plays an important role in keeping clients who are currently injecting in contact with treatment services.
- Amnesty management: A group or one-on-one meeting that provides opportunities for residents to discuss incidents of rule-breaking in the TC. No punitive action is taken as a result of information shared at these groups. Amnesty management provides WHOS with valuable information to assist in planning and implementing the harm reduction program.

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 conceptualised in a manner familiar to many drug treatment professionals – as a "stages of change" model. In this section, the steps an organisation 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 organisation is at and plan the incorporation of harm reduction measures into their service.

3.1 Pre-contemplation

Organisations 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 working in pre-contemplative organisations. 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, organisations are aware of HIV among their clients and are concerned about preventing its further spread. Organisations 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 familiarise themselves with the concept of harm reduction and evidence supporting this approach. If possible, visit and observe harm reduction services such as needle and syringe programs in action. Develop connections with local harm reduction networks or drug user organisations. 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. Organisations that review the evidence and decide to incorporate harm reduction into their current services should then move into the preparation stage.

3.3 Preparation

Organisations that make a commitment to harm reduction have reached the preparation stage. Strong leadership from a harm reduction advocate within the organisation 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, present the arguments for harm reduction and discuss any concerns that are raised. Identify and build on common

ground; for example, all parties would agree that controlling the HIV epidemic is important. With this as a starting point, discuss different strategies to prevent HIV transmission, including both abstinence-based and harm reduction approaches. Promote rational decision-making by making use of tools such as SWOT analysis as described above. It may be helpful to talk about shifting the organisation from the aim of "abstinence only" to the aim of "abstinence eventually" (Kellogg, 2003). This stage may take some time, but efforts to prepare the organisation and others for change will benefit the future operation of the service.

In addition to consulting with relevant others, all organisation staff should undertake training so as to understand the philosophy of harm reduction, the effectiveness of different harm reduction measures and how to provide 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 before and after assessments will provide data on how much staff 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 organisations such as AIDS Councils, community-based harm reduction services or drug user groups.

Before moving into the action stage, 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 minimise any unexpected events. Draft an evaluation strategy also. This should define the kinds of questions you would like to answer (e.g. Has client retention improved?) and the types of data you will collect from clients.

3.4 Action

In the action stage, organisations act on decisions made in the earlier stages. The organisation implements the harm reduction measures deemed appropriate. Where multiple changes are being made, it may be easier to introduce one harm reduction strategy at a time. For example, start by beginning an HIV education program. After staff and clients have adjusted to this, 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

Organisations in the maintenance phase have implemented harm reduction and should now undertake evaluation projects. Both harm reduction and abstinence aspects of the organisation's treatment program should be evaluated. Evaluating the effectiveness of the program ensures that scarce resources are being used appropriately. Regular program evaluations also ensure that high standards are maintained and can provide feedback for further improving programs. 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 in order to provide guidance to other drug treatment organisations. Prepare research papers for publication in peer reviewed journals. Present your findings at drug or HIV-related conferences (it is often possible to apply for funding to help cover travel and conference registration costs). Other ways to disseminate information include giving presentations at other drug treatment services and inviting drug treatment professionals to visit and observe the harm reduction program in action.

Finally, organisations in the maintenance stage should ensure that all staff engage in regular training and professional development activities. These may include formal training programs, 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 in how a drug treatment organisation 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. Organisations for IDUs need to 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 for not only drug injectors, but also their communities. Organisations 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. The reality of relapse: Balancing abstinence and HIV prevention
While the best way to avoid drug-related harms like HIV is to be abstinent from drug injecting, the reality is that many clients of drug treatment services relapse. Sometimes they relapse very soon after starting treatment; sometimes they 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 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 providing clients with education about HIV and how to protect themselves, through to outreach, to making condoms and sterile needles and syringes available to clients as they are needed. 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 organisations that implement harm reduction services find there is 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 such as HIV. It is possible to incorporate harm reduction into therapeutic communities while still promoting abstinence.

5. The process of change
Therapeutic communities wishing to incorporate harm reduction into their service model need a strong advocate for their cause within the organisation. 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 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 want to achieve out of treatment. Most clients, if asked, would say they wish to be abstinent from drug use. However, many clients will relapse during or after treatment, placing them at risk of HIV. It is vital that TCs 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 to their service in response to the threat of HIV has improved their ability to attract and retain drug users in treatment. More drug users in treatment leads to decreased HIV transmission and increased numbers of 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 organisation 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.

In order to best serve the clients of therapeutic communities, the needs of clients must be considered. 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 organisation, staff and above all, clients.

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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 emphasis 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 only needs one dose in 24 hours. Instead of spending their time seeking heroin, a patient on a stable dose of methadone is able to concentrate on everyday activities, such as working, studying and caring for their 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.

- **MMT reduces HIV seroconversions**: A study comparing HIV-negative IDUs in and out of MMT found that after 18 months, 22% of those not in treatment had acquired HIV, compared to only 3.5% of those in treatment (Metzger, Woody, McLellan, *et al.*, 1993).

	Baseline	18 month follow-up
HIV prevalence of non-MMT group	0%	22%
HIV prevalence of MMT group	0%	3.5%

Table 4: HIV seroconversions among IDUs in and out of MMT. Adapted from Metzger *et al.* (1993).

- **MMT reduces deaths:** The mortality rate of IDUs in MMT is one-third to one-quarter to that of IDUs not in treatment (WHO/UNODC/UNAIDS, 2004). In a study of a randomised controlled trial of a prison-based MMT program with 382 participants, there were no deaths of participants in MMT. However, there were 17 deaths among participants not in MMT (Dolan, Shearer, White, *et al.*, 2004)

- **MMT reduces criminal offending:** 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 (Lind, Chen, Weatherburn, *et al.*, 2005).

Offence	No. prevented
Robberies	12
Break-ins	57
Car thefts	56

Table 5: Crimes prevented per year per 100 heroin users in MMT. Adapted from Lind *et al.* (2005).

- **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 a period of 8 months or longer had a re-incarceration rate of only 23 per 100 person-years (Dolan *et al.*, 2005).

APPENDIX 2: NEEDLE AND SYRINGE PROGRAMS

Needles and syringe programs (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.

- **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 (Commonwealth of Australia, 2002).

- **NSPs do not encourage drug use:** A World Health Organization review of the evidence around NSPs concluded that NSPs do not cause an increase in injecting drug use (Wodak & Cooney, 2004); indeed, NSP attenders decrease the frequency of their injecting (Gibson, 2000).

- **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 (Hagan, McGough, Thiede, *et al.*, 2000).

- **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 located adjacent to a methadone maintenance clinic in inner Sydney, but an examination of urine samples of the clients of the methadone program found no increase in illicit drug use compared to clients of another methadone clinic (Wolk, Wodak, Guinan, *et al.*, 1990).

- **NSPs help prevent HIV transmission:** A large ecological study compared HIV prevalence over time in 29 cities with NSPs to 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 (Hurley & Jolley, 1997).

APPENDIX 3: THE TWELVE STEPS OF NARCOTICS ANONYMOUS

1. We admitted we were powerless over drugs – that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn over our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove all out shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or other.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. 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 the result of these steps, we tried to carry this message to those that still suffer and to practice these principles in all our affairs.

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/

Narcotics Anonymous: An international fellowship dedicated to helping drug users overcome their dependency. URL: http://www.na.org

NSW Users and AIDS Association (NUAA): A drug user organisation based in Sydney. URL: http://www.nuaa.org.au

Program 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 program service.
URL: http://www.harmreduction.org/pubs/news/spring99/hsimpson.html