

Harm Reduction Protocol

As practiced by the Chicago Recovery Alliance

June 1996

Dedicated to George Williams and John Szylar

George and John were founding members of the Chicago Recovery Alliance and were instrumental in developing and putting into practice CRA's motto of "Any Positive Change".

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About This Document

The Chicago Recovery Alliance

The motivation for the formation and work of the Chicago Recovery Alliance (CRA) has always been the pandemic of HIV disease and the parallel problems with drug use.

The CRA is committed to respect for every woman, child or man using alcohol or other drugs and reduction in drug-related harm for all people. Our goal is to encourage the integration of addiction, recovery, and HIV disease as one interwoven concern and assist "Any Positive Change" as people define it for themselves. Our work is divided into four general areas: Direct Service, Education, Advocacy, and Networking.

The CRA met for the first time in January of 1991. A diverse group of women and men wanted to address the interwoven issues of addiction, recovery and HIV disease. We first formed the ideological foundation of the organization which is best described by our touchstone phrase, "Individuals Working On Recovery Any Positive Change." This belief grew from our stark recognition that even a very small change in our behavior could protect us from exposure to HIV or re-infection with HIV. The first activity we choose to act on was one we felt few in Chicago would attempt due to political and/or philosophical objection: Harm Reduction Outreach with syringe-exchange. We began studying other programs in the U.S. and around the world. We started our first site of Harm Reduction Outreach in Englewood on January 18, 1992 and we've been there every week since. To date, we have opened 15 sites of outreach which operate every week in Englewood, Uptown (2), West Town, Humboldt Park, Woodlawn, North Lawndale, Grand Boulevard, Cicero, Harvey and East Garfield Park.

CRA is a participant in national and international efforts to define and refine the practice of Harm Reduction. CRA also holds a monthly Harm Reduction educational session, conducts training on Harm Reduction to interested organizations and provides testimony and other information to lawmakers. CRA is also an active participant in Harm Reduction practice as it develops across the world: participating in international and national Harm Reduction conferences since 1993, connected directly and through list servers on the internet to global discussion of Harm Reduction philosophy and practice, and involvement in development of Harm Reduction practice in Eastern Europe through the Open Society Institute.

About the Information Contained Herein

This protocol is being developed by CRA under a grant from the Chicago Department of Public Health. Its purpose is to generate a system for practicing assistance in helping others reduce drug-related harm in their lives.

This protocol is informed by the practice of Harm Reduction Outreach, as operated by the Chicago Recovery Alliance since January 1992. The refinement of this protocol will facilitate any person interested in practicing Harm Reduction in applying it to their population in a manner most consistent with the principles of Harm Reduction. As with all Harm Reduction efforts, this Manual is a work in progress, always looking to make additional positive changes.

Harm Reduction: History and Definitions

Harm Reduction: History and Definitions

Harm Reduction is anything that reduces the risk of injury whether or not the individual is able to abstain from the risky behavior. Inherently, it is a staged form of behavioral change, which is consistent with all the prevalent models of sexual and drug use behavior change and all the models of behavior change in these areas that have been shown to have some benefit.

--- David Ostrow, M.D., Ph.D.

Harm Reduction differs from current models in that it does not require individuals to remove their primary coping mechanism until new coping mechanism are in place. Thus, creating a easier more obtainable avenue for desired behavioral change.

--- Michael Scavuzzo, Harm Reduction Advocate

Harm Reduction is a relatively new social policy which has gained popularity in Britain the Netherlands and currently the United States. Although Harm Reduction can be used as a framework for all drugs, including alcohol, it has primarily been applied to injection drug use (IDU) as a way of slowing the spread of AIDS.

The first priority of Harm Reduction is to decrease the negative consequences of drug use. By contrast, drug policy in North America has traditionally focused on reducing the prevalence of drug use. Harm Reduction establishes a hierarchy of goals, with the more immediate and realistic ones to be achieved as first steps toward risk-free use or, if appropriate, abstinence.

Drug taking behaviors result in effects that are either beneficial (as in the case of life saving medication), neutral or harmful. Assigning a positive or negative value - a benefit or a harm - to such effects is subjective and open to controversy, but a Harm Reduction framework at least offers a pragmatic means by which consequences can be objectively evaluated.

In the UK, Harm Reduction can be traced back to the old "British System", which emerged as a result of recommendations of the Rolleston Committee of the 1920s. This group of leading British physicians concluded that in certain cases maintenance on drugs may be necessary to help drug abusers lead useful lives. To this day, injectable opiates are prescribed on a take home basis in Merseyside, a center for Harm Reduction policy serving the area around the port city of Liverpool.

The Merseyside model developed in response to an epidemic spread of drug use, particularly heroin, in the early 1980s. The Merseyside clinics, pharmacists and police force worked together to establish a unique model of Harm Reduction, a comprehensive approach involving prescription of drugs, syringe exchange and helping rather than punishing drug users.

In the early 1980s Amsterdam recognized that drug use is a disorder and that medical and social care must be provided to clear the path toward natural recovery. The city's first needle exchange program in 1984 was operated by the "Junky Union", a recognized organization of injection drug users. Taking a pragmatic and non-moralistic attitude toward drug use, the city developed a variety of Harm Reduction programs.

While Harm Reduction is a relatively novel idea in North America, one of its earliest forms of methadone maintenance programs has operated here since the 1960s. Methadone maintenance for injection drug users was seen as Harm Reduction for society, usually in terms of reducing crime or restoring drug users to the work force. Today, the spread of AIDS in opiate users has led to an urgent re-examination of existing methadone programs.

A number of countries and organizations have now adopted Harm Reduction as both policy and practice. The British Advisory Council on the Misuse of Drugs (AMCD) concluded that the spread of HIV is a greater danger to individual and public health than drug misuse. The World Health Organization has expressed a similar opinion, stating that attempts to reduce drug use must not compromise measures against the spread of AIDS. In 1987, the Canadian government adopted Harm Reduction as the framework for Canada's National Drug Strategy (CDS). It defined harm as "sickness, death, social misery, crime, violence and economic costs to all levels of government".

Injection Drug Use

In the United States, more than 30 per cent of reported AIDS cases are directly associated with a history of IDU, and in some areas of Europe, IDU accounts for as many as 60 per cent of cases. IDU is now associated with the most rapid transmission of the AIDS virus in many countries of the world.

The extremely rapid spread of HIV (Human Immunodeficiency Virus, thought to be necessary for AIDS) is a concern for IDUs and their sexual partners. Studies in the US and the UK have shown that 60-100 per cent of heterosexually acquired HIV is related to IDU, and that at least 40 per cent of IDUs are in relationships with non-users. In addition, more than 50 per cent of all pediatric AIDS cases in the US are associated with injection drug use by one or both parents.

Needle Exchange

Needle exchanges are a form of Harm Reduction applied to the enormous risks associated with IDU, arising primarily from the sharing of needles.

Injectors frequently report sharing syringes because of difficulties in obtaining them. This is especially true where laws prohibit syringe possession, or where syringes are unavailable when needed (late at night, when buying drugs, or in prison).

Needle exchanges recognize that many IDUs are unable or unwilling to stop injecting, and that intervention must occur to reduce the risk of HIV infection. This type of strategy is based on a knowledge and means approach to behavioral change: people are provided with information about the changes that are needed and also with the means to make these changes - in this case, sterile needles, syringes and other "works" for administering drugs, and condoms.

In the US exchanges began to appear in 1988 and today there are more than 75 syringe exchange programs. In Canada, exchanges were opened unofficially in Toronto in 1987, and officially in Vancouver in 1989. There are now more than 30 exchanges operating across Canada.

There is reasonable evidence that injectors who attend syringe exchanges reduce their risk behavior. In Montreal, the Cactus exchange reported a decrease in use of dirty needles from 37 per cent to 26 per cent over six months, and an increase in cleaning (with bleach) from 83 per cent to 93 per cent of occasions. The Edmonton exchange reported that the longer users attended the service, the less likely they were to practice risky behaviors such as sharing of dirty needles.

Because of the time lag between behavior and detection of infection there is as yet only limited direct evidence that increasing the availability of clean injection equipment reduces the spread of HIV. However, there is ample evidence of what happens when clean needles are in short supply. HIV rates in New York City, for example, where syringe exchange is still illegal, have reached 60 per cent among IDUs.

There is now also good evidence that syringe exchanges are successful at reaching large numbers of IDUs, many of whom are not in touch with other services and who have had little help in the past with drug problems. Increasingly cocaine and amphetamine users are coming to the services - a significant point since stimulant users are not often attracted to formal treatment services.

There are understandable concerns that Harm Reduction for IDUs will encourage existing use and help to recruit new drug users. As with methadone maintenance (see below), however, there is no evidence of increased drug use in any of the communities where syringe exchanges are operating. Estimates from around the world suggest that new recruits are not attracted into drug use and that the mean age of injection drug users has increased over time.

Methadone Treatment - A Drug Substitution Scheme

Methadone substitution therapy was pioneered in the United States in the early 1960s. A synthetic opiate generally taken orally in the form of a liquid, methadone has many of the same properties as heroin and morphine although it is much longer lasting (24-48 hours versus 8 or less).

The primary advantage of methadone is that it can reduce users contact with crime, the black market, and contaminated drugs. Because of its long lasting effects, methadone helps to keep users stabilized so that use becomes less frequent.

Methadone keeps clients in treatment, where as there is a high drop-out rate with other forms of treatment such as psychotherapy. Proponents of methadone argue that the routine imposed on the user's life in obtaining methadone helps to eliminate a lifestyle that makes other rehabilitation efforts fail.

Methadone maintenance is a good means of preventing health problems such as hepatitis and AIDS. Evidence now suggests that heroin users enrolled in methadone treatment programs may have lower HIV seroprevalence than users not enrolled in treatment. There are data which support the effectiveness of methadone in reducing high-risk injecting behavior as well as reducing the risk of acquisition of HIV.

It is clear that methadone has a significant role to play in slowing the spread of AIDS, in reducing drug-related crime and associated costs and in the treatment of opiate dependence. However, some informed observers have argued that if methadone programs are to be truly cost-effective, some changes are needed to attract and retain clients, and to keep them from using other drugs.

For example, since methadone does not provide a "buzz", some clients look for this experience elsewhere, using methadone to keep them stable.

One approach to this problem might be to supply sufficiently high levels of methadone to prevent injection. For those who still inject, supplying injectable methadone ampoules, with plenty of clean injection equipment, might be a solution. This approach is working successfully in Merseyside, England. However, neither of these approaches has met with much approval in places where progress in methadone treatment is equated with low doses of methadone instead of with the patient's overall adjustment regardless of dose level.

In a review of the role of drug treatment in AIDS prevention in the US, Edith Springer characterizes current methadone programs in North America as punitive applications of the "reward and punishment system" which sets up clients to lie to staff and prevents staff from counseling clients properly on their drug use and sexual behaviors. Oral methadone is the only route of

administration provided and staff are often poorly trained, especially in counseling. And yet, ". . . while the success rates for drug treatment are abysmally low, the staff and administrations continue to blame the clients rather than examine the treatment modalities and admit their crudeness and lack of relevance to their clients".

In Holland, methadone had been used in a Harm Reduction framework for several years before the peak of the AIDS epidemic, with the result that the rate of spread of HIV in drug users and their partners is now lower than it otherwise would have been. In Amsterdam, methadone is provided with a minimum of impediments in order to contact heroin users, to stabilize them, and to detoxify and treat them. A "methadone bus" program is used to distribute methadone throughout the drug-using community, but no take-home dosages are provided. Clients are also assisted with problems concerning housing, financial and legal matters. They are also provided with regular medical examination.

The primary disadvantages of some of the Dutch programs are reported to be that, like some of the US programs, they do not maintain all clients on levels of methadone high enough to prevent use of heroin, and they provide nothing other than oral methadone.

In all countries, one of the key factors underlying the success of methadone as a Harm Reduction measure is that it brings users back into the community rather than treating them like outsiders or criminals. This not only allows for rehabilitation of users, but it also breaks the drugs and crime cycle.

In Canada, several academics have suggested that methadone programs be expanded and made more accessible, flexible and liberal. This does not mean that treatment standards should be lowered. They cite research from around the world indicating that inflexible, low-level programs do not reduce injection drug use. The World Health Organization has recommended that wherever methadone maintenance is practiced additional programs be provided with less ambitious goals and objectives for injection drug users who may not be willing or able to enter other programs.

Policy makers and programmers are increasingly exploring the need for methadone programs in prisons and the advantages of offering methadone treatment as an alternative to imprisonment. Closer links between methadone clinics, general hospitals and AIDS clinics are viewed as a means of ensuring a more efficient response to the needs of the HIV-infected population.

Comprehensive Programs: The Mersey Model

At present, the only truly comprehensive Harm Reduction programs are in Merseyside, England. These include not only syringe exchange and outreach education, but also prescription of drugs other than methadone, and police involvement at several levels. In Merseyside, Harm Reduction services comprise needle exchange, counseling, prescription of drugs, including heroin, and

employment and housing services. Many levels of service and a wide variety of agencies are involved and services are integrated to provide drug users with help when they need it.

Pharmacists play a vital role in the workings of the Merseyside system. Some pharmacists now fill prescriptions for smokable drugs in the form of "reefers" which provide an alternative to injection and produce the "buzz" that some IDUs crave. To prepare reefers, drugs such as heroin and methadone are injected into either herbal or regular cigarettes. Clients who have received injectable prescriptions for more than 10 years are now voluntarily switching to reefers in an attempt to stop injecting. In addition to reefers, the pharmacists dispense drugs in the form of ampoules, liquid, and aerosols.

At the end of June 1991, Mersey Region had the second lowest rate of HIV-positive IDUs of all 14 English regions: eight per million population compared with an English national rate of 34, and a top rate of 136 per million in North-West Thames; the rate for the UK as a whole was 51, with Scotland registering a rate of 183 HIV-positive IDUs per million population. The Merseyside programs have also been successful in reducing crime. In 1990 and 1991, the Merseyside police were the only force in the UK to register a decrease in crime rates.

Health Promotion and Education

Harm Reduction acknowledges that policy makers, educators and health promoters can tell drug users how and why they should prevent harm, and provide them with the means to do it, but only the users themselves can actually prevent the harm. Research has clearly shown that users will change their behavior in response to information about safer use, and that this change is greater if skills training as well as the means to ensure safety are provided.

Until the 1980s (and even currently in the US), the main response to drug use among young people in many countries has been school and media drug education programs based on a primary prevention ("Say No to Drugs") approach. These approaches usually present information intended to demonstrate the adverse consequences of drug use. Criticism has been leveled at this process because of its tendency to exaggerate the dangers and to perpetuate certain convenient stereotypes. In addition, the "just say no" approach assumes, against evidence to the contrary, that a child's decision not to use drugs becomes much easier once he or she is acquainted with the consequences. In fact, evaluations of primary prevention have shown that it has little or no impact on whether young people use drugs. Indeed, some studies suggest that excessive use of primary prevention may actually encourage drug use by creating a sense of mystique around the subject which appeals to children's natural curiosity.

Primary prevention assumes that drug use is abnormal and that drug users are deficient in knowledge, self esteem or skills. Yet some studies show that it is those with high self-esteem who are more likely to experiment with drugs. Moreover, research indicates that experimentation is an extremely poor

predictor of long-term use or abuse. Primary prevention approaches also ignore the pleasure and other benefits of drug use and fail to acknowledge that decisions to try drugs are often expressions of independence. This "deviancy amplification" divides users and non-users, and works against meaningful dialogue with adults. It does nothing to decrease harm and increase safety.

The Harm Reduction approach to education focuses on non-judgmental information about different drugs, their properties and effects, about the law and legal rights, about how to reduce risks, and where to get help if needed. It helps youth to develop a wide range of skills in assessment, judgment, communication, assertiveness, conflict resolution, decision-making and safer use.

A number of countries have begun to apply the principles of Harm Reduction education to all drugs. For example, a wide-reaching Harm Reduction model of drug education and prevention is being developed in the UK. It is grounded in the realities of young people's drug use, and has realistic and practical aims. It recognizes that Harm Reduction education is about drugs rather than against drugs. Teaching begins in early years around familiar substances other than drugs, and emphasizes that most of the things we consume have the potential for both harm and benefit depending on the way we use them.

Harm Reduction education is based on humanitarianism, pragmatism and a scientific public health approach. The principles of Harm Reduction drug education are that drug use is normal; it is associated with benefits as well as risks; it cannot be eliminated altogether, but the harms can be reduced; many young people grow out of drug use; education should be non-judgmental; it requires an open dialogue with the young and respect for people's right to make their own decisions; and it emphasizes positive peer support, not divisiveness.

Law Enforcement Options

Problem-Solving Policing in Montreal

An innovative pilot project mounted by police to help a Montreal neighborhood troubled by drug-related crime appears to have struck a good balance between suppression of the drug supply and reduction of demand. The Montreal Urban Community (MUC) police program in the city's Parc Extension district uses a get-tough approach with people caught selling drugs while offering treatment instead of jail to those found in simple possession.

"Parc Ex", as the area is known, was overrun with petty crime, drug trafficking and delinquency when the MUC police launched the program in April, 1992. A random survey conducted in the neighborhood indicated that residents were immobilized by fear and that an escalation in crime rates was inevitable. A special team of officers trained in "problem-solving policing" was put in place full time to attempt to reverse the neighborhood's downward spiral into crime, and to give residents a greater sense of personal safety.

The police visited drug treatment centers in the area to develop a better understanding of how they work and to meet addicts in treatment - the district has a high proportion of heroin users. On the street, police offered drug users support and assistance as an alternative to arrest for possession. Agreements were struck with detox and treatment centers in the area to allow people needing help to be referred there by police.

Evaluations carried out during the year-long pilot project indicated such a high level of success that the Parc Ex program has been renewed and is being extended to other neighborhoods.

Cautioning in Merseyside

The Merseyside police in the UK have become national leaders in developing a cooperative Harm Reduction strategy with the regional health authority to improve the prevention and treatment of drug problems, particularly with respect to the spread of HIV infection among IDUs. The police sit on health authority drug advisory committees and employ health authority officers on police training courses involving the drugs/HIV issue. They have also agreed not to conduct surveillance on treatment centers, to refer arrested drug offenders to services, to not charge for possession of syringes to be exchanged, and to publicly support syringe exchange.

A key feature of the Merseyside police strategy has been to use resources to deal with drug traffickers while operating a cautioning policy toward drug users. Cautioning involves taking an offender to a police station, confiscating the drug, recording the incident, and formally warning the offender that any further unlawful possession of drugs will result in prosecution in court. The offender must also meet certain conditions, such as not having a previous drug conviction and not having an extensive criminal record. The offender is also given information about treatment services in the area, including syringe exchanges.

The first time offenders are cautioned, they are not given a criminal record. On the second and third occasions they are sent to court and fined for possession of small quantities or sentenced for possession of large amounts. If an addict becomes registered by getting in touch with service agencies, then he or she is legally entitled to carry drugs for personal use. The overall effect of this policy is to steer users away from crime and possible imprisonment.

The Future

Interest in Harm Reduction world-wide has increased greatly in recent years, in part because of the advent of the International Conference on the Reduction of Drug-Related Harm in Liverpool, England, in 1990. At the Fourth International Conference in Rotterdam in March, 1993, Dr. Marcus Grant of the World Health Organization (WHO) acknowledged the progress that Harm Reduction approaches have made toward "acceptability, even respectability". A mark of that new-found respectability is the fact that the Conference is coming to North America for the first time in March, 1994.

Harm reduction is a humane, cost-effective and ultimately sensible way to deal with drug-related problems. However, much work remains to be done to bring it to all who need it. Many barriers stand in the way of this effort. In his address to the Fifth International Conference, Dr. Grant emphasized that Harm Reduction is "for the whole world, not just the rich". One of the challenges for the future is to bring Harm Reduction to the developing world. Dr. Grant also expressed concern that society is too "battle-fatigued" by drug issues to look beyond the extremes of prohibition and blanket legalization. Both options are

too drastic, whereas Harm Reduction can provide a balance which does not now exist.

Among barriers to acceptance of Harm Reduction in many countries is a widespread devotion to a limited definition of idealism. Harm Reduction accepts that some harm is inevitable, whereas the "ideal" of zero-tolerance excludes all compromise and sets impossible goals. In North America, total abstinence has long been seen as the only acceptable goal of treatment for abuse of legal drugs and the only acceptable "normal" state with respect to illicit drugs. Harm Reduction expands those options, but in no way precludes the possibility of abstinence.

Society's reluctance to view drug use as a legitimate form of risk taking poses another significant barrier to acceptance of Harm Reduction. While societies tolerate and even encourage some far more dangerous forms of risk-taking (such as car racing, mountain climbing, boxing and bungee jumping), drug-taking is singled out as something inherently and primordial evil. Harm reduction, because it accepts the possibility of drug-taking under certain circumstances, is often viewed as promoting intolerable behavior.

Religious opposition, public apathy and confusion around drug policy, and a growing inability of nations to intervene in domestic social issues because of international trade and other agreements all present obstacles to the adoption of Harm Reduction principles. Because it operates in the gray areas between extremes, Harm Reduction is not easily defined and promoted. It raises many legitimate questions: Who decides what constitutes a "harm" and in what order should harms be reduced? The prescribing of injectable drugs, for example, can reduce the risk of HIV and the rate of acquisitive crime, but other evidence suggests it might also prolong the habit of injecting. Which course of action is more desirable and for whom?

Harm Reduction does not provide clear-cut answers and quick solutions, but it has the capacity, if properly applied, to address difficult problems while not compromising the quality and integrity of human life in all its rich and diverse complexity. As the motivating principle behind Canada's Drug Strategy, it charts a pragmatic and realistic course for this country with respect to drug policy. It also obligates us to more clearly define Harm Reduction approaches and to carefully evaluate their impact. In the end, these approaches will stand as both a product and a measure of our humanity.

Chicago has also been grappling with the novel approaches born in harm reduction practice for years. Like other places, the biggest challenge for assimilation of Harm Reduction practice is the critical examination of the current system which is often based on abstinence-only. Abstinence as the single and demanding focus of intervention with drug users has endured although it is not supported by research, common principles of human relating or effectiveness. Once subject to critical examination and comparison, many opt for the more compassionate and effective practice of harm reduction. In Chicago, service providers continue to seek out information on harm reduction practice as they

become open to another perspective. Hopefully, this tendency to critically evaluate our work will continue to be motivated by the HIV pandemic as well as the simple desire for effective options.

General Process Guides

for

a

Harm Reduction

Approach

General Process Guides for a Harm Reduction Approach

These guidelines are intended to assist us in becoming familiar with an approach which practices the essential elements of Harm Reduction.

The essence of Harm Reduction is providing education in a respectful non-judgmental way. By providing individuals factual information in a manner which is non judgmental and clearly understandable, the individual can make educated choices thus reducing harm.

Harm Reduction simply stated is any positive change.

Positive change is relative to the individual and therefor needs to be determined by the individual. Harm Reduction Advocates work with individuals to determine what changes are desired. Advocates can help determine goals for change that are realistic given the myriad of circumstances that create unique situations for all individuals. The interaction should include all possible avenues for change and to assist individuals in obtaining their goals, in a non judgmental, respectful interaction.

Advocates need to be well versed in a wide variety of Harm Reduction options and networked with Harm Reduction friendly community services such as clinics, healthcare professionals, housing, legal services, shelters, food centers, drop in centers, etc.

Harm Reduction advocacy is best approached on a one on one basis. Approaches need to be fluid and flexible as the life circumstances of each individual vary.

Harm Reduction advocacy needs to remain constantly open and vigilant to new forms of positive change as new avenues present themselves. Advocates must possess a readiness and willingness to incorporate lesson learned from clients into their ongoing work.

**Introducing
Harm Reduction
and
Refining Our Roles**

Introducing Harm Reduction and Refining Our Roles

The introduction of Harm Reduction is necessary because of the usual mainstream approaches to public services often require the client to meet a high threshold of criteria to access services. This is not true of Harm Reduction. In fact, an essential introduction to Harm Reduction includes a disclaimer to the ways we have usually offered assistance for drug-related difficulties.

For instance an individual interacting with a needle exchange program for the first time will often arrive ready to tell you what you want to hear to receive sterile equipment. "I want to stop shooting, I plan on quitting, I'm interested in a methadone program", when in reality they are seeking clean needles. Getting beyond the "What you want/need to hear" stage is critical.

Needle exchange is one example of how Harm Reduction activities introduce individuals to the wide range of Harm Reduction related services.

Harm Reduction philosophy can be incorporated into most forms of public service.

Defining Harm Reduction informs individuals that there are no requirements for participation in Harm Reduction related activities. They are informed that they can choose the avenues for change, when and if they want to. This form of self empowerment allows them to make the choice(s) in how they want to interact with the Harm Reduction effort. This often creates a trusting, respectful relationship which allows for a positive Harm Reduction interaction.

Energy or effort once used by the client to fit into a program or service can now be directed to focusing on the real needs of the client and positive change can begin to happen immediately.

Engaging Individuals

Once the client understands how Harm Reduction works they will usually want to know what other services are available to them.

For many individuals, using the syringe exchange is the only Harm Reduction option they want to access. However most times clients can be engaged by simple conversation concerning health, safer injection, vein care information, etc.

Volunteers and advocates can also engage individuals by simply pointing out obvious health or life threatening conditions such as abscess or infection problems. Most of the time it is just the fact that someone cared enough to talk to them, that leads into a positive Harm Reduction experience and future Harm Reduction related interaction.

Clarifying purpose to relationship

It is important to clarify the purpose of the relationship between the Harm Reduction Advocate and the client. The client must be made aware that the advocate will provide the client with the necessary information to help the client in achieving his/her goals and support them in their decision making process.

Giving range of examples of positive change

Harm Reduction advocates begin the process by informing the client of the wide range of options for positive change. In the example of needle exchange efforts it can be anything from other needle exchange locations to safer injection practices or complete abstinence. A Harm Reduction practitioner offers and respectfully accepts the selection of any option for positive change.

Describe client role of deciding on what they want to work on

Advocates inform the client that it is their decision to make what ever changes they want.

Describe your role to clarify, discuss, offer suggestions and expertise

Once goals are established by the client, advocates work with the client to clarify what the client seeking and begin to discuss the avenue(s) for change educating the client so the client can make informed decisions on how to proceed. The advocate then can offer suggestions based upon their experience and their knowledge of what services are available to reach their goals.

Describing limitations to the client/advocate relationship

Advocates in the course of establishing the relationship with the client must be clear about the limitations of the relationship. Limitations may be that of the organization providing the outreach, the law or that of the personal boundaries or limitations of the advocate.

Collaborative Assessment

Collaborative Assessment

Questions used to help identify areas of attention:

- What would you like to change regarding your drug use?
- How important are these things to you?
- Which change(s) would you like to work on first?
- How would you like to make the changes you desire?

CRA Advocates use their experience to help the clients assess areas of attention in the following general categories of Harm Reduction related activities. These categories listed below include but are not limited to:

- Safer Injection
- Safer Sex
- TB Issues
- D-I-Y Detox
- Ongoing Harm Reduction Contacts
- HCV Issues
- Acupuncture
- Overdose Issues
- Abscess Care
- Vein Care
- Nutrition/Precursors
- Exercise
- General Healthcare
- Drug Prep/Split Issues

CRA Advocates can then refer clients to Harm Reduction friendly options that include but are not limited to:

- Food
- Family Assistance
- CRA Activities
- Shelter
- Legal Help
- Harm Reduction Related Support Groups
- Healthcare
- Addiction Treatment

Collaborative Evaluation for Positive Change

Collaborative evaluation allow the client participation and ownership in his/her change process. Working collaboratively with a Harm Reduction Advocate, the client can establish realistic goals which when obtained instill a sense of accomplishment and empowerment. While it is important that the client has this privilege it is equally important that the advocate has the experience and knowledge to suggest all known avenues for any positive change within the realistic scope of the goals determined by the client.

Generating Options For Positive Change

While it is important to understand the basic premise of Harm Reduction and to document general options for change it is equally if not more important for Harm Reduction advocates to work directly one on one with clients to establish goals that are obtainable given individual circumstances.

Advocates need to be creative, fluid and realistic to work within the boundaries of the client.

Client Selecting Options for Their Positive Change

Once the client is made aware of all possible options concerning positive change, the client can decide on what options they would like to work on. The advocate should then support them in their decision and provide them with all possible avenues to obtain their goals.

Work on Client Selected Options

Clients can then begin to work on their selected option with the support of the Harm Reduction Advocate. Advocates should attempt to follow up on the clients progress to determine if the clients goals are being met, determining stumbling blocks for the client and suggesting possible alternative or changes to help the client obtain their goal.

Harm Reduction Options

Harm Reduction Options

This section include options that have been identified by CRA's outreach workers and Harm Reduction advocates as being the options most needed by the communities CRA provides outreach within. Community Advisory Groups, which are composed of people actively injecting from each area of the city, have been instrumental in identifying these areas.

This list is not meant to be exclusive and should be seen as only some of the options to reduce drug-related harm.

Options are published in the following manner:

- **Harm Reduction Option**

- ***Take Away Messages - (One Liners for Outreach Workers)***

- **Sub- Category**

- Additional text to support take away messages.

- **Safer Sex**

- ***Chances of catching a disease are reduced by always using a condom or latex barrier in all of your sexual encounters.***

- ***Knowing your condom is safer than knowing your partner.***

- ***You cannot tell if someone is infected by looking at them.***

- ***It's always safer to cum 'on'something than 'in'something.***

- **Safer Sex**

- Safer sex is not getting bodily fluids (cum, semen, vaginal juices, blood, including menstrual blood, breast milk) in your mouth or inside your vagina or ass by using a latex or plastic wrap barrier.

- When having different kinds of sex use a fresh condom or barrier in each orifice.

Vaginal or Anal Sex

Use condoms for your penis, latex gloves on your hands, dental dams, or household plastic wrap to keep fluids from entering your body.

Its also important to know feces can also transmit germs and STD's including Hepatitis B and non HIV related yeast infections in women.

Mouth, Lips, Tongue

Oral sex, licking, sucking, eating out, and going down on your partner's vagina, penis, or ass (rimming). Is much safer than penetrating sex.

Oral sex is safest when you keep bodily fluid out of your mouth by using a latex or plastic wrap barrier.

Kissing

Kissing, with or without the tongue, is considered safer sex.

Fingers, Hand, Fist

Using your fingers, hand or fist is safer than conventional or penetrating sex.

For safe penetration , use a slippery, lubed-up latex glove.

Try placing two gloves on the same hand, this way it is easy to , strip the top glove off before moving on to the next place

Lubrication

The Slipperier the Safer

Water based lubes are good to use because they are fun and reduce the chance of creating tears or sores inside the vagina or on the penis.

A small amount placed inside the condom, can help prevent condoms from breaking or ripping during sex.

Sex Toys

Treat Them Like They Are Part of Your Body

Sex toys should always be always be cleaned in between use with 1 part bleach to 10 parts soapy water.

When using a dildo or butt plug, always dress it in a new condom, when switching between partners, or from vagina to ass.

- **Safer Injection**

One Shot, One Sterile Syringe

Use Your Own - Needles, Cookers, Cotton, Water

The Cleaner Everything is the Better

New Paraphernalia - Clean Hands - Safer Shots

Cooking Don't Kill Nothing

For Best Healing - Alcohol Before - Pressure Not Alcohol After

Can't Get New - Shake Sixty

Safest injection is making sure everything is clean, freshly washed with soap and water or, ideally, new and sterile.

Use a new sterile syringe for each shot, when ever possible.

Use your own needles, cookers/spoons, cottons/filters and water.

Wipe before not after- Use the alcohol prep to thoroughly clean the injection site prior to injection not after.

Shake Sixty- When you cant get new needles, bleaching your needles first, flush with water several times before bleaching, this gets rid of most of the blood which can coagulate if it comes in contact with the bleach first, then fill the syringe completely with bleach and shake or tap it for a count of sixty, then get rid of bleach that's in the syringe and fill it with bleach again, repeat, when done bleaching flush the syringe several times with water. Never reuse or share water, always use fresh water.

Use water and bleach or alcohol to clean your cookers/spoons, too.

Injection Alternatives

Smoking, snorting, swallowing and alternative injection sites are all safer alternatives for individuals who are experiencing problems related to injection or injection sites.

The utility of switching drugs used

Switching drugs to reduce the harm of a particular drug such in the case of substituting marijuana for alcohol in the case of someone experiencing liver related problems.

Working with finances to afford drugs consumed.

Working within ones finances to afford drugs consumed individual can reduce harm to themselves and their families by being able to pay their bills, keep a roof over their head, keep food on the table and remain a productive member of their community.

Decrease frequency of use (increasing frequency of not using).

By decreasing the frequency of drug use individuals do not have to inject as often reducing the chance of infection, harm to veins, etc.

Decrease concentration of drugs consumed.

Share and discuss long- and short-term physical effects of drug use.

Share and discuss separating drug use and driving/working/other tasks.

Share and discuss creating safer drug use environment- where, with whom, when, etc.

Share and discuss risks and benefits of combining drugs.

Discuss the personal benefit/purpose of drug use and safer ways to meet needs.

Share and discuss benefits of sleeping on stomach after using.

Share and discuss utility of, and alternatives to, the disease model of addiction.

Share and discuss the utility of 12-Step meetings, Rational Recovery, Women for Sobriety, Moderation Management, etc.

Share and discuss all forms and types of abstinence.

- Vein Care

The Smaller the Needle - The Smaller the Hole

Different Spots - No Tracks

Shoot With the Flow

Shoot Where the Red Ain't

Release the Tie - Before You Get High

For Best Healing - Alcohol Before - Pressure Not Alcohol After

Use a new, small gauge syringe was each time you shoot.

Alternate injection sites.

Filter your drugs through new, clean dental cotton.

Allow your mix to cool before shooting

Use a wide, Stretchy, easy to release tie.

If your veins roll, hold them lightly to help guide the point in.

Release the tourniquet before pushing the plunger down.

After you shoot apply pressure to the site with a clean tissue, cotton or piece of toilet paper (not an alcohol pad) until bleeding stops.

- Abscess Prevention

Clean your injection site thoroughly before you shoot, Use a new syringe each time. Filter your drugs well.

***IV is safer than IM is safer than skin-popping -
better blood flow = less infections***

Abscesses are infections under the skin, caused by dirt and bacteria which get into your body.

To avoid abscesses, clean your injection site thoroughly, don't just wipe, use the alcohol prep in a scrubbing motion. Use new or bleached needles and fresh sterile water.

If an abscess appears try using antibiotic creams, bacitracin is the best because it doe's not contain sulfur drugs which some people may be allergic to.

Seek medical help, abscesses rarely go away on there own.

If the area around the abscess becomes swollen or if you see a red streak moving away from the abscess toward you heart,

SEEK MEDICAL ATTENTION IMMEDIATELY.

Without attention abscesses can lead to loss of a limb and death.

- Overdose Prevention

Respect What You Inject

Know and Trust Your Source

New Supply - Give It Only a Small Try

Shoot With A Friend - It Might Save You In The End

One of the biggest risks people encounter with drug injection is overdose. Injection delivers a high level of potentially lethal drug(s) to the brain at a high speed. When an overdose occurs the level of the drug(s) is too much for the brain to handle. The individual becomes unconscious, can not be woken up, or the toxic effects of the drug has harmed them.

Naloxone for opiate overdose

- Nutrition

The Better You Eat - The Better Your High

Drink enough water to piss clear - Clear Piss is Healthy Piss

Eat, especially protein, prior to drug use.

Increase intake of water to avoid dehydration.

Learn about and consider the utility of nutritional counseling (including vitamin supplements) for lessening or eliminating drug use or for other purposes.

- General Healthcare

***Come to the Van - They'll Have A Plan -
To Take Care of Your Health - The Same as the Next Man***

Share and discuss developing relationship with Harm Reduction-savvy physician(s) to monitor condition, especially organs or conditions effected by the drugs used.

- Exercise

The Better Shape Your In - The Higher You'll Get

Regular exercise can help your body stay in shape and process the drugs and chemicals you inject.

It can also produce healthier veins and blood flow.

- Acupuncture

Can Ease Withdrawal

Can Help You Get Better Highs

- Alternative Medicines
- Massage
- Ongoing Harm Reduction Contacts

Information is Power

Any Positive Change

By checking in with your harm reduction advocate, you can learn more about healthier ways to do what your doing or ways to change or stop.

Advocates can let you know what's available and provide you with information or referrals to help you make a plan for what ever it is you want to do.

We know the best way for us to help you is to let you make the choices that are right for you and to help you obtain your goals.

Your progress can help us stay in business, so if you can let us know how your doing.

General Information

Related to

Harm Reduction Options

General Information Related to Harm Reduction Options

What To Do When An Overdose Occurs

If you can not wake the person up or keep them awake, their life is in danger.

Lie them in the recovery position as described below and call an ambulance.

(Insert graphic here to replace the text below)

- 1) Lie them on their stomach,
- 2) place their right hand next to their face with the right arm next to their body,
- 3) extend their left arm in front of them in line with their body,
- 4) extend their left leg straight in line with their body and
- 5) extend their right hip 90 degrees from their body with the right leg in line with their body.

Safer Injection

Vein Care & Safe Injection Suggestions

Find a place with good light and take the time to do it right.

Looking after veins when hitting up really does make for easier using.

1. Use a new, fine gauge syringe was each time.
2. Filter drug solution through dental cottons, or another clean cotton filter-avoid cotton wool and cigarette filters - they have sharp, brittle fibers which damage veins. Filtering reduces the risk of infections, vein obstructions and abscess.
3. Alternate injection sites - don't go back to the same site until the red is gone there.
4. Use an easy to release tourniquet. Any veins that roll should be held lightly with a finger to guide the fit in.
5. The tourniquet was let off before pushing the plunger down.
6. When a vein is missed, the tourniquet should be released and the fit removed. Missed sites should be held lightly with a finger until the bleeding stops.
7. After injection the fit should be pulled out and pressure should be applied to the site with a tissue, some cotton or piece of toilet paper (not an alcohol pad) until bleeding stops.
8. About fifteen minutes after injecting vitamin E cream can be rubbed over the veins including any misses. This clears up bruises and helps to soften scarring in the skin and veins. Regular use of this cream helps to keep veins in good condition.

Vitamin E cream can be gently massaged into the affected areas once or twice a day during and after a binge or regular using to help veins recover and soften any scarring. Pre-existing scarring can also be softened with regular use.

To avoid infections, fingers, mixing spoon (cooker) and injection sites can be carefully wiped each time with fresh alcohol pads or washed with soap and water.

Each person using together having their own cooker, cotton, and water and mixing and sharing your drug without using previously used equipment also helps with safer hits.

Selection of Safer Injection Sites

Two of the safest areas to inject into are the thigh muscle and veins in the arm.

Veins in the forearm, if in good condition, are also good injection sites.

Veins in the legs are also a good location, however the blood flows slowly so one must inject slowly and be wary of the artery that runs along side of the vein.

Skin popping in the stomach area is OK, however avoid veins and arteries in this area.

Avoid injection in the neck or groin- veins are deep and have arteries running along side of them.

Avoid injection in the hands and feet- these veins are fragile and injection will be painful- if you must inject here inject very slowly.

Preparing the Injection- Powders

Dissolve powders in water- water should be boiled for ten minutes and allowed to cool- this should kill almost all germs in the water.

If you have to add something to help the powder dissolve - use vitamin C, lemon juice may contain a fungus which may cause an eye infection.

Heat the liquid in a clean spoon or cooker with a match or a lighter, the heat will help dissolve the drug(s). Cooking does not sterilize anything...

Preparing Tablets

Tablets are manufactured to be swallowed, there is no completely safe way of injecting them. The chalk content in tablets and pills is a major cause of vein collapse. When ever possible avoid injecting drugs that come in the form of pills or tablets, swallow them instead.

To prepare tablets for injection crush them as fine as possible- using two spoons that have been rinsed in boiling water.

Avoid injecting drugs that don't dissolve well - many people have lost limbs after injecting poorly dissolved drugs and there is also an increased risk of abscess.

Street drugs are rarely pure and may contain additional substances. Smoking and snorting is a much safer alternative than injection.

- Hepatitis B - (HBV)

HBV Can Live For Months On A Surface

HBV is carried in blood, semen, vaginal fluids and discharges. It is easily passed on by sharing needles and having vaginal or anal sex without a condom.

You can catch it from: sharing needles, tooth brushes, razors and by equipment used in tattooing, acupuncture, electrolysis and ear/body piercing that has not been properly sterilized and from breast milk from an HBV infected individual.

You can't catch it from: shaking hands, coughing, sneezing, sharing knives and forks, or toilet seats.

Some people with HBV feel sick for months. Others never feel sick at all. Those who get sick may have the following symptoms: general weakness, headaches, fever, upset stomach, stiff or sore joints, yellow coloration of the skin, dark urine and a pain in the right side.

Many people with HBV think they have the flu. Most people recover from HBV, but those who do not may end up with lasting liver problems or cancer of the liver. If the liver stops working the person may die.

You can catch it easier than HIV, however unlike HIV or Hepatitis C, there is a vaccine you can have for Hepatitis B. It's three shots over a six month period that you can get at most any clinic.

- Hepatitis C - (HCV)

HCV Can Live For Months On A Surface

HCV prevention is making sure everything is clean, freshly washed with soap and water or, ideally, new and sterile.

HCV transmission is different from HIV and HBV because it is chiefly environmentally transmitted. What that means is that you can get HCV by contact with dried and old blood. If your finger, picks up some HCV from a used syringe or cooker and you touch a fresh injection site, you are at risk of HCV.

Syringes, cookers/spoons, cotton, old tissues, even the plastic bag you carry your works in, or anything that has been in contact with blood, can carry HCV.

The incubation period, from infection to the development of acute HCV, is about one to three months and is generally a mild illness, with nausea and abdominal pain, and fever.

Around the time these symptoms disappear jaundice may occur. (jaundice is a build up of bile, a digestive fluid, which discloses itself as a yellowing of the skin and eyes, and sometimes a discoloration or darkening of urine)

Tuberculosis- TB

TB is a airborne infection that come from contact with an individual with active TB. (coughing, sneezing can introduce large amounts of TB in the air)

TB can be detected in early stages by a skin test called PPD, which inserts sterilized, neutralized TB under the skin to check for reaction. The test is usually done on the underside of the forearm, and is checked for reaction in three days.

Symptoms of TB:

Fatigue, dry unproductive cough, cough increases during night time hours, low grade fever and night sweats. These symptoms are common to many illnesses therefore testing is necessary to determine TB infection.

If untreated TB is life threatening. Also failure to complete medication as prescribed can cause of development of a multi-drug resistant strain of TB which reduces the ability of current medications to treat this illness.

TB primarily effects the lungs, however it can be found in other organs.

A positive reaction to a test does not necessarily mean the individual is infected. It means the individual has been exposed to TB and their bodies have produced antibodies to TB. If a person has been found to be exposed to TB a chest x-ray can determine if the TB is active or if the individual has just been exposed.

If active TB is found, treatment begins with a short isolation period, daily medication. In some cases preventative measure will be taken for people who are not currently proven to have active TB.

Methadone

Methadone is an opioid drug which can be prescribed as a substitute for opiates such as heroin as part of a treatment program.

Methadone is itself addictive; however, it has a number of positive attributes.

- By receiving a controlled amount of methadone each day, clients can stabilize their drug intake.
- Methadone is usually given as an oral mixture, thus avoiding the risks associated with injection.
- It is a long acting drug and needs to be administered only once a day.
- Clients no longer need to find a substantial amount of money on a daily basis to support their drug habit and can thus avoid criminal behavior and imprisonment.
- Once stable on methadone it is much easier for clients to make positive changes in their lifestyle.

Do It Yourself Detox Information

Heroin and other opiates-

Things to try:

- Yoga or meditation
- Relaxation sessions, listening to relaxation tapes
- Warm baths, bubble baths, lavender oil helps
- Rescue Remedy, Bach Flower concoction available from health food shops
- Tincture of oats, available from food shops and said to help stop craving
- Valerian tablets, available from health food shops, help with mild and moderate hanging out but may not be enough for a full on detox.
- Multi-vitamin tablets, even vitamin B injections. B12 and B3 deficiencies are common in detox and you really notice the lack of energy and depression. B6, Vitamin C and zinc will also help.
- Don't make any life altering decisions because you are depressed.
- Avoid high anxiety, high energy situations.
- Benzodiazepines, if you can get a doctor to give you some use only as long as you are detoxing. The last thing you want is a benzodiazepine habit, withdrawal from this can be worse than withdrawal from heroin.

Methadone Detox

Methadone detox is about the worst. It takes more than twice as long as heroin and the effects can be harder. The general advice for methadone is to come off gradually. Don't try to detox off on anything more than 20 mls if you have been on it for over a month. Get your clinic to manage your dose to 20 or less before trying complete withdrawal.

Withdrawal from heroin and methadone is not without suffering it will not be pleasant. Following the above suggestions are certainly not a definite guide to detoxing, however it will certainly minimize the level of discomfort.

Infections and Abscess Care

Symptoms of Infection Are:

- Swelling or redness near an injection site-
- A hard lump located near an injection site, otherwise known as an abscess-
- Feeling warm or hot- all over, in one limb or one vein, or an injection site-
- Pain- in a vein, or a limb, or near an injection site-
- A general feeling of unwell for any length of time-

Left unattended infections nearly always get worse and can lead to loss of a limb and death. If symptoms exist, professional care should be sought as soon as possible. Seek out a sympathetic doctor or visit the hospital and GET IT TREATED.

Evaluating
&
Assessing
Behavior Change

Evaluating Harm Reduction

Evaluation of Harm Reduction programs is necessary to determine if Harm Reduction efforts do indeed reduce the amount of harm, as well as refining the service for maximum impact and to justify public investment. The following describes a variety of evaluation options for Harm Reduction.

Process Evaluation

A process evaluation would measure how and how well Harm Reduction programs conduct their service. It is the most common and perhaps the least costly way to evaluate most HIV intervention programs, including harm reduction. In the absence of significant funding, experts say this form of evaluation, coupled with assessments of clients' behavior change, can demonstrate program effectiveness and address common criticisms of Harm Reduction efforts. (29, p.14)

Outcome Evaluations

Outcome evaluations, like those described below, measure the effectiveness of Harm Reduction through behavioral or biological outcomes. Outcome evaluations can help identify whether Harm Reduction reduces behaviors that lead to high risk activities. However, these evaluations are time consuming and significantly more expensive.

Assessing Behavior Change

Documenting behavior change would provide useful information about the potential of Harm Reduction efforts to reduce HIV transmission and related harm. Positive changes in risk behavior would imply that clients are reducing their exposure to HIV and reducing the amount of harm to themselves and their respective communities. This kind of study can be conducted quickly and with less expense than a study which requires HIV testing. It also avoids the problem of individual who would avoid the study because of their reluctance to be tested.

There are misgivings about the validity of this evaluation method. Studies based on self-reported behavior rely on the honesty and accuracy of the participant who may feel pressured to give the "right," socially accepted answer versus an accurate one. Having educated the target population on the philosophy of Harm Reduction, i.e.- their need not having to meet specific criteria, the answers obtained from the target population would be more truthful and accurate than those obtained from similar studies conducted within programs not Harm Reduction specific. Allowing the study to be conducted by the actual individuals providing the service would also produce similar results because the target population would have already established a relationship with the service provider. Findings may be biased because the study would be conducted by

people who operate the programs and have a vested interest in a positive outcome. Still, results have not varied significantly, whether such studies were performed by program staff or by an outside evaluator. (4, p. 24)

Clinical Trial Model

According to chemical dependency researcher Des Jarlais, clinical trials are considered the optimum method of assessment. They are also the most difficult to conduct. High costs, complex logistics, ethical issues and a lack of a "deep pocket" funding source impede conducting a rigorous evaluation. It would require comparing numerous communities, submitting study participants to baseline HIV tests, and purposefully denying certain groups access to HIV interventions and Harm Reduction services. Such a study would cost tens of millions of dollars. (4, p.9) Charles Eaton, acting director of the New York Office for Drug Abuse Intervention, believes that a clinical trial is an inappropriate way to access any public health intervention, because it would require denying people access to services that may have important consequences to their health. (30)

Longitudinal Cohort Study

Such a study would track new HIV, HCV, and TB infections among a large group of drug users over time. It would help determine what if any intervention has an effect on behavior changes and HIV incidence. Drug users would be recruited from various cities throughout a community, including needle exchange programs. This kind of study would not withhold services and would be logistically more feasible than a clinical trial. But, it would require a large population sample, be highly labor intensive and expensive. (31)

Conclusion

Conclusion

Current data imply that Harm Reduction efforts are effective in reducing HIV transmission among drug users. Studies also show that such programs reduce high risk behavior and have residual benefits, such as helping addicts reduce the amount of harm to themselves and their communities as well as helping addicts to get treatment. Definite proof of whether harm reduction efforts control the spread of HIV among intravenous drug users does not exist and will be hard to obtain.

Harm Reduction programs merit further investigation and experimentation. Studies are necessary to determine the design of programs that are legal and have maximum effect. Programs must overcome obstacles which include reaching communities of women, adolescents, new and infrequent users, as well as obstacles related to laws, funding, and ridiculously expensive research and evaluation components which limit the potential effectiveness of programs which can make a difference.

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