

[Research Forum]

**The Integration of Harm Reduction into
Abstinence-based Therapeutic Communities:
A Case Study of We Help Ourselves**

Kate Dolan, Sarah Larney

National Drug and Alcohol Research Centre

Alex Wodak

St. Vincent's Hospital

Traditionally, therapeutic communities (TCs) have focused on providing abstinence-based treatment. However, with the emergence of HIV among injecting drug users, some TCs have evolved to include risk management or harm reduction strategies into their previously abstinence-based programs. We Help Ourselves (WHOS), a group of TCs in Australia, integrated harm reduction into their services in the 1980s. WHOS passed through a series of stages as it moved from a goal of “abstinence only” to one of “abstinence eventually.” Following these changes, client retention and length of stay increased and HIV risk behaviors decreased. The process by which WHOS integrated harm reduction into their services while maintaining a commitment to abstinence is outlined and a guide for TCs interested in adopting harm reduction is provided.

Correspondence concerning this article should be addressed to Sarah Larney, Program of International Research and Training, National Drug and Alcohol Research Centre, University of New South Wales, Sydney NSW 2052, Australia. E-mail: s.larney@med.unsw.edu.au

The therapeutic community (TC) is an approach to drug dependence treatment where clients live within a small, structured community with a mix of professional counselors and ex-drug users as staff. The primary goal of most TCs is to assist their clients to achieve and maintain abstinence from all drug and alcohol use (Marlatt, Blume, & Parks, 2001). Treatment activities vary between TCs, but generally include individual and group counseling, education, and the development of living skills. As well as actively contributing to their recovery, clients are expected to perform routine domestic duties to assist in developing general living skills (Gowing, Cooke, Biven, & Watts, 2002). Many TCs also encourage attendance at 12-step meetings of Alcoholics Anonymous or Narcotics Anonymous to introduce clients to support networks outside the TC (G. Popple, personal communication, March 2006).

The limited research evidence on TCs suggests that this approach may assist some drug-dependent individuals to cease drug use (Lees, Manning, & Rawlings, 2004). Other positive outcomes associated with TC treatment include reductions in criminal behavior and improvements in mental and physical health (Darke, Williamson, Ross, & Teesson, 2006). Longer stays in TCs produce better outcomes for clients (Darke, Ross, et al., 2005; Simpson, Joe, & Brown, 1997). One study found that former residents of TCs 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, et al., 2006).

As noted above, the primary goal of most TCs is complete abstinence from drug use. This worthy goal was formulated prior to the emergence of the HIV epidemic among injecting drug users (IDUs). Of the estimated 40 million people worldwide infected with HIV (UNAIDS, 2005), 10% are IDUs (Aceijas, Stimson, Hickman, & Rhodes, 2004). IDUs who share needles and syringes risk HIV infection. In parts of

China, up to 80% of IDUs are HIV-positive. In Jakarta, Indonesia, up to 40% of IDUs are HIV-positive and prevalence is estimated at 34% in Bangkok, Thailand (Aceijas et al., 2004). High HIV prevalence among IDUs can lead to a widespread, generalized epidemic if HIV is transmitted to non-injecting sexual partners (UNAIDS, 2005). Preventing HIV among IDUs is thus essential not only for IDUs but for the protection of the wider community.

The HIV epidemic has forced a re-evaluation of approaches to drug use and treatment. Interventions aimed primarily at reducing HIV and other drug-related harms, rather than drug use in itself, have been developed. These are broadly termed “harm reduction” strategies (Wodak, 1999). These strategies acknowledge that while abstinence is the most effective way of preventing drug-related harm, it is also very difficult to achieve and maintain. Thus, other measures are needed to protect IDUs from HIV and other harms until they are able to achieve abstinence. Harm reduction is part of a continuum of harm minimization that also includes supply reduction (e.g., policing) and demand reduction (e.g., education and treatment) (Ministerial Council on Drug Strategy, 2004).

Harm reduction strategies include outreach programs, HIV education for drug users, and needle and syringe programs (NSPs). There is a great deal of overlap in the provision of these services, with NSPs often providing outreach and education services and vice versa.

Outreach programs focus on making contact with difficult-to-reach or hidden populations of drug users for the purpose of providing HIV prevention education and tools (e.g., condoms and sterile injecting equipment) (Needle et al., 2005). It is a useful intervention in areas where drug users are unlikely to access office-based treatment services for fear of discrimination or arrest. Outreach programs can be highly

successful in reducing HIV risk behaviors among IDUs and linking IDUs to drug treatment agencies (Needle et al., 2005).

NSPs provide sterile needles and syringes, other injecting equipment, condoms and education about safer injecting to IDUs. A common concern is that providing needles and syringes to IDUs encourages drug use. However, there is evidence that this is not the case (Vlahov & Junge, 1998; World Health Organization, 2004) and NSPs can actually help reduce drug use by referring IDUs to drug treatment programs (Hagan et al., 2000). NSPs are highly cost-effective (Commonwealth Department of Health and Ageing, 2002) and prevent HIV and hepatitis C transmission (Vlahov & Junge, 1998). The effectiveness of NSPs in reducing HIV prevalence was demonstrated by an ecological study comparing HIV prevalence in 36 cities with NSPs to 63 cities without NSPs. In cities with NSPs, HIV prevalence was reduced by an estimated 18.6% per year; in cities without NSPs, prevalence increased by an estimated 8.1% per year (Commonwealth Department of Health and Ageing, 2002). In Australia, where NSPs were introduced in 1986, HIV prevalence among IDUs has remained below 2% for over two decades (National Centre in HIV Epidemiology and Clinical Research, 2005). If legislation prohibits the free distribution of needles and syringes, providing bleach so that IDUs may clean injecting equipment is an alternative (although less effective) strategy that can be adopted (World Health Organization, 2004).

The effectiveness of harm reduction strategies in curbing the spread of HIV has led some TCs to reconsider their abstinence-only focus (Broekaert & Vanderplasschen, 2003; Kellogg, 2003; Marlatt et al., 2001). These TCs have found that rather than harm reduction being in conflict with abstinence-focused approaches to drug use, abstinence fits within the hierarchy of harm reduction goals. Abstinence remains the

most effective way of reducing the negative consequences of drug use, but harm reduction provides IDUs with the knowledge and tools to remain healthy and alive until they are able or willing to achieve abstinence. The two approaches thus complement each other. TCs that have integrated harm reduction into their abstinence-based programs are described as shifting from an aim of “abstinence only” to one of “abstinence eventually” (Kellogg, 2003).

One such TC is We Help Ourselves (WHOS), a TC in Australia that began operation in 1972 with a focus on abstinence. As HIV began to spread among Australia’s IDUs, WHOS responded by modifying their approach to include harm reduction strategies. This article examines how harm reduction was successfully incorporated into the abstinence-based service offered by WHOS.

Aims and Methods

The aim of this study was to provide a guide to integrating harm reduction into abstinence-based TCs, particularly those in the Asian region. The study employed a qualitative approach to examine how WHOS integrated harm reduction into an abstinence-based service. Between October and December 2005, semi-structured interviews were held with individuals who had been involved in the WHOS policy shift in the 1980s. These included the then-Executive Director of WHOS (who retains this position as of April 2007) and the first harm reduction worker employed by WHOS. Interviewees were encouraged to provide a chronological account of organizational change at WHOS. Transcripts of these interviews were subjected to narrative analysis. Relevant reports, WHOS’s Board of Directors meeting minutes, conference abstracts and presentations were also examined. These primary historical sources, written between 1986 and 1992, provided an objective source of data to substantiate the information obtained through interviews.

Data were organized into stages corresponding to those in the well-known “Stages of Change” model, which holds that drug-dependent people pass through five stages in their efforts to cease drug use: pre-contemplation, contemplation, preparation, action, and maintenance (Prochaska, DiClemente, & Norcross, 1992). It was not intended at the outset to utilize the Stages of Change. However, during data analysis it became clear that the information collected corresponded to a remarkable extent to this model. As many counselors working in the drug treatment field are familiar with this model, it provided an ideal framework within which to present the findings.

Results

The process by which WHOS integrated harm reduction into their service model corresponds to the Stages of Change as proposed by Prochaska et al. (1992).

Pre-contemplation/Contemplation

In 1986, WHOS had a strong focus on abstinence. However, as few as 5–10% of clients completed the WHOS program. The majority of clients left WHOS and returned to injecting drug use, thus risking contracting HIV. The Executive Director of WHOS was personally aware of an increase in the number of HIV-positive clients admitted to the service and also of several cases of clients contracting HIV between admissions (G. Popple, personal communication, March 2006). These observations were supported by research findings. Syringes returned to a Sydney NSP were tested for HIV. In 1986, 1% of syringes tested contained HIV (Wodak et al., 1987). This rose to 3% in mid-1987 and reached 9% by December of that year (Wolk, Wodak, Morlet, Guinan, & Gold, 1990). HIV was clearly spreading among the IDU community.

The Executive Director of WHOS was concerned by these findings and began to consider the role of his organization in preventing the spread of HIV:

Do we continue following our existing approach or do we deal with reality? (Executive Director, WHOS, 2005)

A debate was developed among drug treatment counselors as to whether abstinence-based services were contributing to the spread of HIV among IDUs by not providing HIV education, condoms or syringes. The Executive Director believed that WHOS, and other drug treatment services, had a responsibility to assist those who relapsed to drug use to remain HIV-negative and healthy until they were able to maintain abstinence. He referred to this approach as “risk management.” Risk management involved acknowledging the realities of drug use, dependence and treatment. Many WHOS clients were unable or unwilling to abstain from drug use. Despite rules against such behaviors, clients were injecting drugs, having sex, and risking HIV infection while residing at WHOS. Furthermore, it was always possible that clients who completed the program and achieved abstinence could relapse at some later stage, again risking HIV infection. The Executive Director believed that preventing HIV among current and former clients should be as high a priority as being drug-free:

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)

Preparation

To explore the possibility of integrating risk management, or harm reduction, into WHOS’s abstinence-based TCs, the Executive Director

consulted with key stakeholders including the WHOS's Board of Directors. The Board was informed about the HIV situation internationally, in Australia and within WHOS, and encouraged to consider the strengths and weaknesses of harm reduction. According to the Executive Director, when presented with the facts, the Board quickly agreed that the strengths of the proposed changes outweighed the weaknesses and concluded that the integration of harm reduction into WHOS's TCs was likely to benefit clients.

It was also important to ensure that counselors employed by WHOS understood the reasons for promoting harm reduction and HIV prevention. Counselors were encouraged to join the management committees of drug user organizations to gain exposure to harm reduction in action. Drug user organizations are staffed by current and former drug users who educate other users and provide services such as drop-in centers and NSPs (see <http://www.nuaa.org.au/> for more information on drug user organizations). Other organizations that could be useful in this context are advocacy groups for people living with HIV/AIDS. According to the Executive Director, counseling staff quickly adapted to the policy of risk management.

Action

In 1987, WHOS adopted guidelines on HIV prevention, testing, and support. Condoms were placed in all toilets, free of charge, for WHOS residents to take as needed. No key informants believed that providing condoms resulted in an increase in sexual activity. This is in line with evidence from schools (Kirby, 2002) and prisons (Dolan, Lowe, & Shearer, 2004).

As the risk management/harm reduction program grew, an HIV Coordinator was employed. This position was equal in authority to

the Treatment Coordinator, indicating that harm reduction was firmly integrated into WHOS. By the 1990s, the WHOS's harm reduction program consisted of HIV counseling and testing, individual and group education sessions and outreach. Safer injecting kits, consisting of sterile needles and syringes, swabs, cotton, water, a spoon and information leaflets, were available free of charge in all toilets alongside condoms:

All we know is that we get, say 500 [needles and syringes] a year, and we've got 450 now, so 50 have gone out ... whoever took them needed them. (Executive Director, WHOS, 2005)

Maintenance

The majority of clients responded positively to the integration of harm reduction into WHOS. The harm reduction approach demonstrated to the clients that WHOS was a non-judgmental service committed to ensuring the health and safety of clients. A number of benefits flowed from this.

In the period after harm reduction was introduced, WHOS experienced an increase in program completion and client retention (Swift, Darke, Hall, & Popple, 1993). This increase in client retention is important, as a longer length of stay is associated with improved treatment outcomes (Simpson et al., 1997). There was also a large decrease in the number of clients leaving against staff advice. In 1985, 92% of clients who discharged from the service did so against the advice of staff. By 1988–1991, this had decreased to 40% (Swift et al., 1993), suggesting improved therapeutic relationships between clients and staff. In addition, after the implementation of the harm reduction program, self-reported client engagement in HIV risk behaviors decreased (see Table 1).

Table 1. Risk Behaviors of WHOS Clients on Admission and at Follow-up

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

Note: Data taken from WHOS (1998). Raw data unavailable.

Colleagues in other drug rehabilitation services had expressed concern about the steps WHOS had taken. By attending and presenting their research at conferences and widely disseminating the WHOS service model, the Executive Director was able to address these concerns and demonstrate that WHOS remained committed to abstinence, but also believed in providing assistance to clients who found abstinence difficult to maintain.

Currently, WHOS operates five TCs for people with drug and alcohol dependencies. Some of these TCs are located in urban areas, while others are in rural settings. The mission statement of these TCs is:

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

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

The current WHOS's harm reduction program is the HIV/AIDS Infectious Disease Service. Its aim is to minimize the spread of HIV and other communicable diseases among alcohol and other drug users, particularly IDUs. 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 education in HIV/AIDS and other infectious diseases, using groups and one-on-one strategies for clients in residence, and on an outreach basis for IDUs who may not be in contact with health services.
2. To conduct relapse and overdose prevention activities, using groups and one-on-one strategies targeting clients in residence and on an outreach basis.
3. To provide options to promote access to a drug-free lifestyle and HIV/infectious diseases treatment and support.
4. To integrate an approach of harm minimization into drug treatment services.
5. To oversee and maintain standard infection-control guidelines within all WHOS facilities.
6. To provide harm minimization activities to increase knowledge of safer practices and thus decrease risky practices.

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

1. HIV/AIDS Education groups for clients — Women-only and men-only groups meet weekly in all WHOS facilities.
2. Relapse prevention and drug overdose education groups — These groups meet regularly in WHOS facilities and on an outreach basis.
3. Staff training in harm reduction — All staff are expected to be familiar with harm reduction principles.
4. Condoms and needle and syringe provision — Condoms and “safe kits” are available in all bathrooms in WHOS facilities and are

offered to residents leaving the service. Safe kits contain needles and syringes, swabs, spoons, cotton, sterile water, a syringe disposal container, condoms, lubricant and information. Syringe disposal units are available in all bathrooms in all WHOS facilities.

5. Outreach service to former clients — This service promotes safer sex and safer injecting to former clients. The outreach service ensures ongoing links between IDUs and treatment services.
6. Amnesty management — Group or one-on-one meetings provide opportunities to violations of TC rules. No punitive action is taken as a result of information shared at these groups. Amnesty management provides WHOS with valuable information for planning and implementing the harm reduction program.

Discussion

WHOS's journey from an abstinence-based TC to a harm reduction-based TC promoting abstinence is a case study of an organization transforming itself in response to the challenges of the HIV/AIDS epidemic. This case study demonstrates that harm reduction and abstinence are not mutually exclusive; counselors can provide harm reduction education and services while still promoting abstinence as a treatment goal.

The subjectivity of much of the data collected for this study must be acknowledged. Interviewees had been integral to promoting harm reduction in Australia in the 1980s and remain employed within the drug and alcohol field. Furthermore, interviewees were asked to recall events that occurred twenty years previously. Incorporating primary sources such as annual reports and research papers somewhat addressed this problem.

The experience of WHOS shows that investigation of risk management or harm reduction strategies may be beneficial for abstinence-based TCs wanting to prevent HIV transmission among their clients. The process of change occurs through a series of stages. Table 2 presents a guide to identifying the stage of change an organization is at, and activities that can be undertaken to move the organization into the next stage. This guide is based on the experience of WHOS and information provided by interviewees.

In the age of the HIV epidemic, TCs should accept a responsibility to provide IDUs with the knowledge and tools to protect against HIV infection. Providing these services at WHOS resulted in improved outcomes for clients, including increased client retention and increased length of stay. Integrating harm reduction into abstinence-based TCs can produce many benefits for the organization, counselors, and above all, clients. While the process of change is rarely easy, it can be managed by identifying common ground between different viewpoints and progressing through the stages of change outlined above.

Acknowledgments

The authors wish to thank the World Health Organization Western Pacific Regional Office for their support in funding this project; Ms. Kate Corcoran for conducting the interviews; and the following people for giving their time to be interviewed: Mr. Garth Popple, Mr. Bill Robertson, Mr. Peter Todaro, Mr. Michael MacAvoy, Mr. Stuart Riley, and Ms. Rigmor Berg.

Table 2. Suggested Activities for Abstinence-based TCs Interested in Risk Management/Harm Reduction Approaches to Drug Dependence

Stage of organizational change	Suggested activities
<p>Pre-contemplation: Organizations are yet to consider the possibility of integrating harm reduction into their TC.</p>	<ul style="list-style-type: none"> • Counselors with an interest in harm reduction may wish to raise HIV transmission and prevention issues with colleagues.
<p>Contemplation: Organizations are aware of HIV among their clients and are concerned about preventing transmission.</p>	<ul style="list-style-type: none"> • Become familiar with the concept of harm reduction and evidence supporting this approach (see http://www.ihra.net/ for information on harm reduction). • Visit and observe harm reduction services such as NSPs in action. • Develop connections with local harm reduction networks or drug user organizations. • Learn about the extent of HIV among clients and options for addressing HIV in the client group (e.g., HIV education, condom provision, and needle and syringe provision).
<p>Preparation: Organizations that make a commitment to harm reduction have reached the preparation stage.</p>	<ul style="list-style-type: none"> • Meet with key stakeholders: counselors, official bodies that oversee the treatment service, other drug treatment service providers, current and potential clients, and local law enforcement agencies. Outline your plans to introduce harm reduction and acknowledge people's concerns. To build support for harm reduction, 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.

Table 2 (Cont'd)

Stage of organizational change	Suggested activities
	<ul style="list-style-type: none"> • Prepare new mission statements, policies and other documents that incorporate harm reduction principles and methods. • Counselors should undertake training in harm reduction. A variety of training packages are available for this purpose (see http://www.wpro.who.int/health_topics/harm_reduction)
<p>Action: Organizations implement the harm reduction measures deemed appropriate.</p>	<ul style="list-style-type: none"> • Introduce one harm reduction strategy at a time. For example, introduce an HIV education program and after staff and clients have adjusted to this, consider condom or needle and syringe provision. • If possible, assign one person to oversee the implementation and everyday operation of harm reduction activities. This person can ensure that counselors and clients understand why harm reduction has been incorporated into the service and provide ongoing services and training.
<p>Maintenance: Organizations in the maintenance stage should build on positive change through dissemination of the new service model and ongoing staff development.</p>	<ul style="list-style-type: none"> • Evaluate both the harm reduction and abstinence aspects of the service. This ensures that high standards are maintained and provides feedback for improving programs. Outcomes to measure might include changes in risk behaviors, drug use, client retention, treatment completion, and physical and mental health of clients. • Disseminate research findings widely. Publish research findings in peer-reviewed journals (see Dolan, 2005) and present at drug or HIV-related conferences. Inform other drug treatment services in your area about your research. • 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.

References

- Aceijas, C., Stimson, G. V., Hickman, M., & Rhodes, T. (2004). Global overview of injecting drug use and HIV infection among injecting drug users. *AIDS, 18*(17), 2295–2303.
- Broekaert, E., & Vanderplasschen, W. (2003). Towards the integration of treatment systems for substance abusers: Report on the Second International Symposium on Substance Abuse Treatment and Special Target Groups. *Journal of Psychoactive Drugs, 35*(2), 237–245.
- Commonwealth Department of Health and Ageing. (2002). *Return on investment in needle and syringe programs in Australia*. Canberra, ACT, Australia: Author.
- Darke, S., Ross, J., Teesson, M., Ali, R., Cooke, R., Ritter, A., et al. (2005). Factors associated with 12 months continuous heroin abstinence: Findings from the Australian Treatment Outcome Study (ATOS). *Journal of Substance Abuse Treatment, 28*(3), 255–263.
- Darke, S., Williamson, A., Ross, J., & Teesson, M. (2006). Residential rehabilitation for the treatment of heroin dependence: Sustained heroin abstinence and drug-related problems 2 years after treatment entrance. *Addictive Disorders and Their Treatment, 5*(1), 9–18.
- Dolan, K. (2005). *Writing for publication: The basics* (NDARC Technical Report No. 231). Sydney, NSW, Australia: National Drug and Alcohol Research Centre.
- Dolan, K., Lowe, D., & Shearer, J. (2004). Evaluation of the condom distribution program in New South Wales prisons, Australia. *Journal of Law, Medicine and Ethics, 32*(1), 124–128.
- Gowing, L., Cooke, R., Biven, A., & Watts, D. (2002). *Towards Better Practice in Therapeutic Communities*. Bangalow, NSW, Australia: Australasian Therapeutic Communities Association.
- Hagan, H., McGough, J. P., Thiede, H., Hopkins, S., Duchin, J., & Alexander, E. R. (2000). Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation

- in Seattle drug injectors. *Journal of Substance Abuse Treatment*, 19(3), 247–252.
- Kellogg, S. H. (2003). On “Gradualism” and the building of the harm reduction-abstinence continuum. *Journal of Substance Abuse Treatment*, 25(4), 241–247.
- Kirby, D. (2002). The impact of schools and school programs upon adolescent sexual behavior. *Journal of Sex Research*, 39(1), 27–33.
- Lees, J., Manning, N., & Rawlings, B. (2004). A culture of enquiry: Research evidence and the therapeutic community. *Psychiatric Quarterly*, 75(3), 279–294.
- Marlatt, G. A., Blume, A. W., & Parks, G. A. (2001). Integrating harm reduction therapy and traditional substance abuse treatment. *Journal of Psychoactive Drugs*, 33(1), 13–21.
- Ministerial Council on Drug Strategy. (2004). *The national drug strategy: Australia’s integrated framework 2004–2009*. Canberra, ACT, Australia: Author.
- National Centre in HIV Epidemiology and Clinical Research. (2005). *Australian NSP survey national data report 2000–2004*. Sydney, NSW, Australia: Author.
- Needle, R. H., Burrows, D., Friedman, S., Dorabjee, J., Touzé, G., Badrieva, L., et al. (2005). Effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users. *International Journal of Drug Policy*, 16(Supplement 1), 45–57.
- Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, 47(9), 1102–1114.
- Simpson, D. D., Joe, G. W., & Brown, B. S. (1997). Treatment retention and follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors*, 11(4), 294–307.
- Swift, W., Darke, S., Hall, W., & Pople, G. (1993). *Who’s who? A report on the characteristics of clients seen at We Help Ourselves (WHOS)*

- 1985–1991 (NDARC Technical Report No. 14). Sydney, NSW, Australia: National Drug and Alcohol Research Centre.
- UNAIDS. (2005). *AIDS epidemic update*. Geneva: Author.
- Vlahov, D., & Junge, B. (1998). The role of needle exchange programs in HIV prevention. *Public Health Reports*, 113(Supplement 1), 75–80.
- We Help Ourselves. (1998). *Annual report*. Sydney, NSW, Australia: Author.
- Wodak, A. (1999). What is this thing called harm reduction? *International Journal of Drug Policy*, 10(3), 169–171.
- Wodak, A., Dolan, K., Imrie, A. A., Gold, J., Wolk, J., Whyte, B. M., et al. (1987). Antibodies to the human immunodeficiency virus in needles and syringes used by intravenous drug abusers. *Medical Journal of Australia*, 147(6), 275–276.
- Wolk, J., Wodak, A., Morlet, A., Guinan, J. J., & Gold, J. (1990). HIV-related risk-taking behaviour, knowledge and serostatus of intravenous drug users in Sydney. *Medical Journal of Australia*, 152(9), 453–458.
- World Health Organization. (2004). *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users*. Geneva: Author.

結合緩害計劃於禁制為本的治療社區：
「我們自助」的個案研究

過往，治療社區（therapeutic communities）的治療計劃都以禁制為本。然而，隨着注射毒品者感染愛滋病毒，有些治療社區已把危機管理或緩害策略結合於「禁制為本」的服務內。「我們自助」是澳洲的一組治療社區，於 20 世紀 80 年代已把緩害策略結合於其服務內。「我們自助」的目標由最初的「只有禁制」發展至「最終能自我克制」，當中經歷了多個階段。因應策略的轉變，受助人留在治療社區內的時間多了，而感染愛滋病毒的高危行為減少了。本文概述了「我們自助」在堅守禁制理念下結合緩害策略的過程，並向有意採取緩害策略的社區給予指引。