

A large, stylized red ribbon symbol is centered on the page. It is composed of two overlapping loops at the top, with two long tails extending downwards. The ribbon has a slight gradient and a drop shadow effect.

Prevention of HIV

transmission

among drug users

A training module for

field-level activities

Introduction

The development of this training module was commissioned by the UNAIDS Asia-Pacific Intercountry Team, Bangkok. The purpose of the module is to assist trainers to provide persons who are working in the field of drug use and HIV vulnerability with the necessary knowledge and skills to effectively develop and implement prevention programmes.

The module addresses a number of issues related to field-level activities for the prevention of HIV transmission among drug users as follows:

- Characteristics of drug users
- Drug related harm
- HIV transmission prevention among drug users
- Establishment and management of drop-in centres
- Staffing
- Information, education and Communication
- Counselling
- Outreach
- Medical treatment
- Referrals
- Substitution programmes
- Needle and syringe exchange and distribution
- Needle cleaning
- Working with police
- Other issues to consider

The module available as a hard copy and in Word 97 format. It is accompanied by and PowerPoint presentation consisting of 63 slides. The presentation material should be used in training courses in an interactive way. The various items and subjects should be discussed with the participants rather than simply presented. The use of all four parts of the module covers a period of a three to five days training course.

It is strongly recommended to plan for a training course additional activities such as field visits, discussions with drug users and people living with HIV/AIDS, discussion with field staff and medical officers. In addition, it is recommend to provide trainees with manuals for further reading, e.g., the WHO manual on rapid assessment and responses, and the manual of the Asian Harm Reduction Network.

This module was developed by Palani Narayanan. Many people contributed to the development of the module, including field workers, drug users, ex-drug users and professionals from all parts of the world. Special thanks are going to the Asian Harm Reduction Network and its members, particularly to the colleagues from India and Malaysia, who provided valuable comments and contributions. Last but not least, thanks are going to staff members and consultants of the Asia-Pacific Intercountry Team for their collaboration and their constructive review.



Purpose and objectives of the module

The purpose of this module is to assist trainers in creating an understanding among the participants of a training course on field-level activities for the prevention of HIV transmission among drug users on how to initiate such programmes and projects. The objective of the module is that at the end of the training course the participants should be able to plan, initiate and maintain programmes in the specific cultural and political context of their country, which would be feasible and effective to reduce the risk of HIV transmission among drug users. Emphasis is given in the module to practical rather than theoretical or political considerations.

How to use this module?

The module provides the trainer with a sequence of presentation materials on field-level activities for a three- to five-day training course. The material should not be used in “one piece”, but the trainer should allow for discussions, and should initiate for certain subjects small group work.

The module is neither country- nor culture-specific. The main task of the training course participants is to adapt the material the specific political and cultural context of the country or area, where they work. This adaptation process requires time for reflection and discussion; when planning for a training course, this time requirement has to be taken into consideration.

For many issues, such as the development of information, education and communication materials, counselling, outreach, medical treatment, etc. this module provides only a brief overview. Such subjects would require separate training modules and cannot be dealt with in a three- to five-day training course on field-level activities. However, the participants should be encouraged to tap the various information sources available and consult the handouts which are provided as course materials.

The trainer

This module is provided to trainers who are familiar with the subjects of drug control, public health approaches to HIV/AIDS prevention and harm reduction



methodologies for drug users. It is also assumed that the trainer is familiar with training techniques, and that he or she is able to work in a cross-cultural context.

In preparation of the training course, the trainer should carefully review the material presented in the module. If there are issues with which he or she is not familiar, the various background materials should be consulted. In addition, resource persons for particular issues could be invited. Very helpful is the participation of ex-drug users and people living with HIV/AIDS. For the section on medical treatment and substitution programmes, a nurse or a medical doctor could make valuable contributions. And for the subject on working with the police, a senior police officer would be appropriate to be invited.

The trainees

In order to successfully complete this module, the trainee must have a basic knowledge in drug control and HIV/AIDS prevention. Trainees could be government officials or personnel from non-governmental organisations. Experience shows that cross-cultural environments stimulate the discussion and enhance the understanding of various issues and concepts.

The trainees should be constantly encouraged to contribute to the course. He or she should understand that the course is not pure technology transfer, but that an important objective of the course is the adaptation of the material to the specific cultural, political and legal circumstances of the country or area of origin of the trainee. The trainee must be aware that it is dangerous and doomed with failure to simply apply certain techniques in an area without having it tailored to the needs of the target population and the specific situation of the target area.

Time frame of a training course

This module is designed for a three- to five-day training course. The presentation material should be used to provide background information and to initiate discussion. Lecturing should be kept to a minimum and as short as possible. To create a deeper understanding of field-level activities, and to enable the trainees to initiate such activities, it is important to include into the schedule field visits to suitable institutions and areas



where drugs are being used. It is also important to reserve ample time for discussions, exchange of experience, and task-oriented small group work.

To come to action, experience has shown that it is helpful for the trainees to include a module on project planning into the course. Such a module could run parallel to this course starting on day two, or it could be added at the end of the course. If planning activities are included, the course duration, naturally, would need to be extended.

Sample schedule

	Day1	Day2	Day3	Day 4	Day5
Morning	The drug user Drug related harm HIV transmission prevention among drug users hierarchy of goals	staffing information, education and communication	substitution programmes	field visits	working with police
Afternoon	establishment of an drop-in centre	counselling outreach	needle and syringe exchange and distribution programmes needle cleaning HIV testing	field visits	other issues to consider

Handouts

The trainees should be provided with handouts to enable them to deepen their knowledge and understanding in self-study. However, experience from past course indicated that the trainees should not be “flooded” with materials. The principle should be “less is more”. The participants should be provided with some key materials and should be acquainted with working with clearing houses, resource centres, libraries and using the Internet.



It is recommended to hand out to the participants a copy of the WHO draft manual on rapid assessment and response¹ and the manual of the Asian Harm Reduction Network on reducing drug related harm in Asia.² At the end of the course, a printed copy of the PowerPoint presentation material should be made available. In addition, some addresses of Web sites, which contain useful material should be provided. For example the home page of the International Harm Reduction Association on contains an annotated list of web site addresses relevant to issues of drug use and the transmission of HIV. Other material is referenced in the section on the description of and background information for the presentation.

Reference material for this module has been selected with the view of easy availability in the Asia-Pacific region. It is recommended to consult the Clearing House at the secretariat of the Asian Harm Reduction Network or the information officer of the UNAIDS Asia-Pacific Intercountry Team in order to obtain copies of the material.

Description of and background information for the presentation

The drug user

2,3 Intravenous drug users risk contracting HIV by sharing needles and syringes with infected persons and through unprotected sexual intercourse. Because of the illegal nature of their behaviour, it is difficult to target them with risk reduction interventions. To reach out to them with HIV education and risk reduction interventions, it is necessary to identify population characteristics, including their location, specific risk behaviour, key leaders and gate keepers.

Drug related harm

4 The potential risks and harm caused by drug misuse are many. For an individual these include *inter alia* overdoses, accidental injuries, infections from non-sterile injections, abscesses, hepatitis, family break up, arrest, prosecution and long-term incarceration, loss of earnings, stigma and ostracism. For the community drug use can damage the entire fabric of society, causing public-order problems, unsafe neighbourhoods, drug-related crime, poverty, unemployment and loss of economic productivity as well as onerous health care and rehabilitation costs. However, the risk of contracting HIV is undoubtedly the most serious risk for drug users who inject.

¹ The rapid assessment and response guide on injecting drug use (IDU-RAR), prepared by Stimson, Fitch and Rhodes, WHO Department of Substance Abuse, Geneva, 1998 (available at the Clearing House of the Asian Harm Reduction Network)

² Manual for reducing drug related harm in Asia. The Asian Harm Reduction Network, Chiangmai, 1999



HIV prevention among drug users (5)

5 Once access has been gained to a hidden population of intravenous drug abusers, there are different ways of educating them to change their behaviour. The outreach workers could distribute information on HIV/AIDS, how it is transmitted, and how to inject safely. Clean needles and bleach kits may be supplied with instructions on how to clean needles. Information on the use of alternative non-injecting types of drug consumption could be discussed. Referrals to health clinics, rehabilitation centres, or social services could be made. Condoms may be supplied along with information on the risk of transmitting HIV to wives or girlfriends of intravenous drug users.

As an alternative to the outreach worker going out into the field, indigenous members of the drug using community may be trained to practice safe injecting and so provide these skills and information to their peers. A core group of drug abusers may be identified who possess the education, communication skills, willingness and respectability to become peer educators. Those who have regular contact with intravenous drug users such as bartenders, liquor store and drugstore owners, hotel managers, and convenience stores may be used as gatekeepers to provide literature, condoms, bleach kits, or referrals to health clinics or social services.

Such an approach to drug abuse needs to be accompanied by drug policies which will enable drug users to change their behaviour. It is not enough to inform drug users about the risks of their behaviour. They need to be provided with the resources to enable them to ameliorate and change their risky lifestyle.

Hierarchy of goals³

6 The principle that certain drug policy goals are more critical than others was clearly articulated by the British Government's Advisory Council on the Misuse of Drugs (ACMD) in 1988. It noted that HIV/AIDS was a greater threat to individual and public health than drug misuse. Thus the most urgent priority was to stop the spread of HIV/AIDS among drug injectors and from them to their sexual partners and the rest of the community. The ACMD recognised that as some drug users were unable or unwilling to stop using drugs in the short term, interim goals had to be considered. The Council thus developed the notion of a hierarchy of goals which was dictated by pragmatism. Thus, in order to prevent HIV transmission it is essential that drug users cease sharing injection equipment. However, if sharing is set to continue, drug users must be taught how to clean equipment before sharing and how to reduce the number of people with whom they share. A move from injecting to oral use is seen as an improvement as is a change from illegal use to prescribed oral methadone. In general, any reduction in the quantity and variety of drugs consumed is strongly encouraged. However, the ultimate aim of drug policy should remain complete detoxification and abstinence.

3 For a more comprehensive discussion of this issue, see ESCAP, Approaches to community-based HIV/AIDS prevention in the ESCAP region, New York, 1998



Drop-in centre (7-18)

- 7 In most of the Asian countries, drop-in centres will look rather simple, a fact which has some advantages as this lowers the threshold for drug users to frequent the place. (Discussion)
- 8 The course should discuss the purposes of a drop-in centre, some are provided in the slide;
- 9 the location of the drop-in centre is another subject for discussion: should it be close to the area, where drug users gather? The group should discuss pros and cons.
- 10 The group could work out the basic facilities which should be available in a drop-in centre.
- 11 The establishment and maintaining of a drop-in centre requires some funds; a provisional list is provided in this slide

Drop-in Centre: Acceptance of the community⁴

- 12 Acceptance by the community where the centre is located is an important issue. Experience has shown that, if the establishment of the centre is not prepared properly, the community could reject the centre, and some community groups could even stage violent protest.⁵
- 13 Very often, communities react with fear. Those who plan to establish a centre need to address such issues way in advance.
- 14 It is also important that the planners explain to the community what will happen when the drop-in centre is operational.
- 15 When the centre is operational, there are various means to increase community acceptance, some are listed in the slide. The group could explore how acceptance could be increased in the specific cultural context of the countries of the trainees.

Drop-in Centre: Other issues

- 16 Opening hours are a practical issue which requires advance planning. The centre should as much as possible serve the needs of the drug users; it is helpful to include drug users already in the planning stage.
- 17 What will be done in the drop-in centre? In addition to counselling, medical services and social work, the centre must serve the needs of the drug users; some ideas are provided with the slide.
- 18 The issue of rules could be controversial: the more rules, the higher the threshold. Some rules have been found in the past as essential. The group should be given enough time to discuss the issue.

Staffing⁶

- 19 A number of issues need to be discussed before recruiting staff for field-level activities. Some are listed in the slide. The group should have sufficient time to discuss the issue from the view of the specific cultural context of the trainees.

4 for a comprehensive discussion of issues concerning communities, see ESCAP, Community-based drug demand reduction and HIV/AIDS prevention, A manual for planner, practitioners and evaluator, New York, 1996; and ESCAP, Approaches to community-based HIV/AIDS prevention in the ESCAP region, New York, 1998

5 see Keyl et al., Community support for needle exchange programs and pharmacy sale of syringes: A household survey in Baltimore, Maryland. Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology, Volume 18, Supplement 1, 1998, ppS82-S87



20-24 In principle, three types of staff could be recruited: current users, ex-users and non-users. Slides 20 to 24 provide advantages and disadvantages of each category.⁷ The list may not be exhaustive. Team work is important. The group should work out the primary selection criteria for the members of the team which could include:

- Contacts within the target population;
- Some attributes that made them non-threatening;
- Good communication skills, stable lifestyle, and adequate education to do field work;

Information, education and communication

Information, education and communication strategies are a key part of behaviour change. Development of such materials could be subject of a separate training course. In this module, such strategies are discussed only briefly. For a comprehensive discussion of the issue, including content of messages, guidelines for training and overhead transparencies, see footnote.⁸

25 The group should discuss some very basic features in the production of information, education and communication materials.

26 The group should also discuss what to keep in mind when handing out materials.

27-30 When handing out materials, there are important points to consider, some of which are listed on this slide.

Counselling

31 Counselling could be the subject of a separate training course. If there is sufficient time, the module of *Medicine sans Frontières* is recommended.⁹ The group should at a minimum discuss which main issues have to be addressed during counselling (see slide).

Outreach (32-37)

For a detailed discussion see the module of Burrows et al.¹⁰

32 The group should discuss what it is meant by outreach; important to note is that outreach work is not only be done in the streets, but that there are many opportunity to outreach. The participants should discuss also how to discuss the various forms of outreach in the areas they are working.

33 A number of points are important to consider before outreach activities can be started. A controversial issue in practice is usually staff supervision. Time should be given to the participants to discuss this issue. The participants should be asked to put together their specific outreach kits.

6 For more information, see: Wiebel, W., The indigenous leader outreach model. Intervention manual. National Institute on Drug Abuse, DHHS, Public Health Service, NIH, NIH Publication No. 93-3581, Rockville, MD, 1993

7 For background information see also the following articles: Cottler and al., Peer-delivered interventions reduce HIV risk behaviours among out-of-treatment drug abusers, *Public Health Reports*, volume 113, Supplement1, June 1998, p.31; Broadhead and al., Harnessing peer networks as an instrument for Aids prevention: Results from a peer-driven intervention, *Public Health Reports*, volume 113, Supplement1, June 1998, p 42; Kumar et al., Community-based outreach HIV interventions for street-recruited drug users in Madras, India, *Public Health Reports*, volume 113, Supplement1, June 1998, p 58

8 Burrows D, Trautmann F, Bijl M, Sarankov Y, Chernenko O, Pogosyan L and Sarang A, Training on HIV/AIDS prevention strategies among injecting drug users in the Russian Federation by Médecins Sans Frontières - Holland: Training Guidelines. Médecins Sans Frontières - Holland. Moscow. 1999 (contact AHRN for a copy)

9 Burrows et al; see above

10 Burrows et al., see above



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- 34 Outreach activities in practice should follow the sequence “briefing, outreach, debriefing”. What is meant by briefing? Why is it important? Why is it important to work as a team?
- 35 When discussing with outreach workers their work, at least the four issues presented in the slide are coming up usually. Why are they important? Are there any other issues to be taken into consideration?
- 36 What is debriefing? After having their work done, outreach worker should not simply go home, but inform the team and the next shift on what has happened. The problem of documenting observations should be introduced to the participants.
- 37 This slides presents some basic rules of outreach work. Participants might want to add additional rules based on the experience of their country.

Medical treatment (38-40)

Over the past years medical treatment for drug users during outreach or at a drop-in centre became a growing necessity because many substances injected are contaminated and injection equipment is unsterile and outdated. Participants might want to reflect a while about why this is the case, and what role law enforcement is playing in the regard. Participants should be encouraged to share their experience with admitting drug users to hospitals for emergency care, or the treatment of ailments. Why is it sometimes difficult to find a medical practitioner to treat a drug user? Participants should discuss cultural and legal barriers. Ex-drug users could make valuable contributions to this discussion.

- 38 On a very practical level certain things need to be done to serve the needs of the clients. The slide should be used as a rough guide for the moderation of a discussion among participants and the sharing of experience. A medical professional (doctor, nurse) could provide valuable contributions. At the end of the discussion, the participants should have a clear idea on how to organise medical treatment in their specific situation (use black, white board or flip chart).

Referrals (41)

- 41 The identification of support services is an important step in providing services to drug users. Participants should be given enough time to “discover” existing support services. How to maintain good relations to support services?

Substitution programmes (42-48)

Substitution programmes are often discussed very controversial. Moralistic views are usually presented, and oftentimes participants of training courses become even rather emotional. The trainer should be aware of the fact that it is not the purpose of the course to review the pros and cons of substitution therapy, nor is it the purpose to discuss the pros and cons of the various substances. The trainer should take a pragmatic position, exploring which substances are available in the countries of the trainees, and which substances would be acceptable for the governments of the countries of the trainees. The trainer should have some experience with substitution therapy. If possible the participants should visit real life substitution programmes and discuss with staff members of such programmes the details. Substitution therapy is best learned on the job. Important is also that the participants not only hear the views of staff members of substitution programmes but tat they



have the opportunity to explore the views of the clients. A summary of salient points on substitution therapy is presented as [annex 1](#) to this module. The trainer might wish to consider to make a hard copy of annex 1 available to the participants at the end of the course or at the end of the discussion of this section. In addition, a lot of information is available on the world wide web. For details on buprenorphine, consult the NIDA web site.

- 43 Nevertheless, participants should be aware of the aims of substitution programmes. The various issues could be developed in a discussion; the slide serves for the moderation of such a discussion.
- 44 There a number of “down-to-earth” considerations, which are described on this slide. Again, a tip for the trainer: Avoid the discussion of the pros and cons of methadone versus buprenorphine, if not both substances are available in a country.
- 45 A substitution programme cannot be implemented with the consent of the government. In some cases, government gives a “silent” consent, meaning that it does not allow officially the implementation of a substitution programme, but tolerates it on an experimental basis. These issues have to be explored by the participants of the course. Intake criteria should also be discussed by the participants. Much could be learned from an on-going programme. Important to note for the participants: The main goal of the programme is to prevent HIV transmission.
- 46 The substitution programmes requires rules and procedures. They depend of the cultural and legal context of the project area and could be developed during the training course. Use black board and make the results of the discussion available to the participants as a hard copy.
- 47 It is not too difficult to determine the adequate dosage. Discussion with staff members of an on-going substitution programme are of great help for the participants. However, important to learn is that usually not too much but too less of the substance is given. Also important is that during substitution additional services are provided to the clients.
- 48 To pre-empt criticisms from the public, public relation exercises are important. Participants should discuss who to address in their country and how to do it. Programmes should only be expanded if sufficient resources are available to run it for a reasonable time.

Needle and syringe distribution and exchange (49-58)

Similarly to substitution programmes, needle and syringe exchange and distribution might trigger a heated, controversial and emotional discussion. The trainer should not entirely suppress such a discussion, but should moderate it with the view to come to very practical issues. There is overwhelming evidence that needle and syringe exchange programmes are effective in reducing the risk of HIV transmission among drug users.¹¹ A discussion with staff members of programmes is usually very helpful and brings the participants back to practical issues. Also important is the issue of buying syringes in a country where syringes are available in pharmacies should be discussed. The views of a drug users could be very helpful for the participants to understand sharing behaviour. A brief summary on such programmes is provided in [annex 2](#) to this module.



The trainer might wish to consider to make a hard copy of annex 2 available to the participants at the end of the course or at the end of the discussion of this section.

- 49 The effects of a needle and syringe exchange or distribution programmes are listed in this slide. The slides should be used as a tool for the moderator to guide the discussion.
- 50 This slide is a small reminder to pre-empt certain fallacies about such programmes.
- 51 Very practical considerations, which could, however, jeopardise the effectiveness of a programme. Usually, not enough syringes are distributed, making it necessary for the drug user to share equipment. For the issue on the consent of the government refer to the similar discussion under substitution programmes.
- 52 What is the difference between exchange and distribution programmes? The participants should discuss the pros and cons. The participants should learn that there are different target groups for such programmes.
- 53 Staff training is, of course important. Needle and syringe exchange and distribution programmes should not be run as an isolated intervention, but embedded in outreach techniques.
- 54 The various modes of such a programme are listed in this slide. Discuss the issue with the view of low-threshold interventions.
- 55 Finally, as a kind of summary of this section, this slides reviews the important considerations of such programmes.

Needle cleaning (56-58)

Research has shown that needle cleaning programmes are not particularly effective, because the procedures are rather cumbersome, and drug users do not adhere to such procedures. This is also the case for public injectors.

- 56 Still, needle cleaning has still some benefits s a tool for outreach. Some benefits are listed on this slide.
- 57 Often participants overestimate the benefits of such programmes. This slide might guide a discussion on the constraints. The views of a drug users could facilitate the discussion in the course.
- 58 If a needle cleaning programme is being established, there a minimum of requirements, summarised in this slide.

HIV testing (59)

HIV testing can become a necessity in various intervention programmes. Usually drug users are also targeted by various survey programmes.

- 59 Confidentiality has to be stressed to avoid response refusal. Saliva tests for HIV could be given anonymously to establish the prevalence of HIV infection. Although this method may not be

¹¹ See for example: Heimer et al., Syringe exchange programs: Lowering the transmission of syringe-borne diseases and beyond, Public Health Reports, volume 113, Supplement1, June 1998, p 67; Vlahov et al., The role of needle exchange programs in HIV prevention, Public Health Reports, volume 113, Supplement1, June 1998, p 75



popular, it is an easier method than blood or urine tests in a non-professional setting. Partner notification is another important issue to be discussed in this connection.¹²

Working with the police (60-62)

Under the topic “Drop-in Centre: Acceptance of the community” issues on working with the police could come up, and slides 60-62 could be used already at that point in time. Particularly in countries where drug use is an offence in itself, the establishment of working relations with the police becomes essential. Police interventions could easily jeopardise any preventive intervention.

- 60 It is important that before working with the police, a situation assessment is carried out. The participants of the course could share with each other, what the attitudes of the police are in their project area. If that material has been collected, the slide could be used as a guide, next steps on how to get support could be developed by the group.
- 61 Strategies in working with the police are of course very country and area specific. This slide could serve as a guide for the discussion. Participants need to develop, however, their own strategies, based on their observations in the project areas.
- 62 Important to remember is that contact with the police needs to be maintained over time. It is therefore necessary to involve the community. The ultimate goal should be that police officers not only tolerate but support the programme.

Other issues to consider (63)

This is a catch-all topic of issues, which could come up during the training course. The trainer should be prepared to address the issues listed in this slide. If there is time enough participants could discuss these issues in small groups and come up with their own ideas, to be shared with the entire course.

12 Levy et al., The outreach assisted model of partner notification with IDUs, Public Health Reports, volume 113, Supplement 1, June 1998, p 160



Annex 1: Substitution programmes¹³

Introduction

Methadone maintenance treatment is mainstream public health approach that has been used in an ever-expanding number of countries around the world, since Dole and Nyswander first introduced it in New York in 1963. Over 300,000 persons are now receiving methadone maintenance treatment world wide including 115,000 in the USA, 10,000 in Hong Kong and 25,000 in Australia. There are wide variations in models of service delivery varying from very simple and low resource requiring programmes to those that are more complex and expensive. Some administer treatment from an office building or hospital while others are delivered from a community health centre, pharmacy or small bungalow. Some are staffed by multi-disciplinary teams of doctors, nurses, social workers and psychologists while others are managed by a nurse or minimally trained non-professional care giver, with part-time assistance from a pharmacist and doctor.

Methadone is one of a number of "opioid replacement therapies", otherwise known as agonist substitution pharmacotherapy, that are used internationally. Others include buprenorphine, opium tincture, LAAM, naltrexone (actually an opioid relapse prevention treatment) and morphine. Methadone is effective in substantially reducing unsanctioned opioid use, reducing drug injection and HIV transmission, reducing criminality, improving social re-integration and improving health. It has been found to be cost-effective (more than repays the costs of implementation) in western research studies (e.g. Scanlon, 1976).

In the early 1990s the National Academy of Sciences' Institute of Medicine in the U.S. stated:

Of all the modalities available for the treatment of opioid dependence, methadone maintenance has been the most rigorously studied modality and has yielded the most incontrovertibly positive results . . . Consumption of all illicit drugs, especially heroin, declines. Crime is reduced, fewer individuals become HIV positive, and individual functioning is improved.

However, the Institute went on to declare:

Current policy . . . puts too much emphasis on protecting society from methadone, and not enough on protecting society from the epidemics of addiction, violence, and infectious diseases that methadone can help reduce.

Principle 1: Opioid substitution treatment is effective in the treatment for opioid dependence. Although it is not a treatment for other kinds of drug dependence, such other

13 This paper was prepared by Dr Adrian Reynolds for presentation at a UNAIDS Intercountry Technical Workshop for the prevention of drug use and HIV/AIDS, Bangkok, 1999



drug use often declines or even ceases when a client is stabilised on methadone maintenance therapy;

Principle 2: Methadone is a synthetic opioid, which, through its cross-tolerance with other opioids, prevents opioid withdrawal and makes other opioid use relatively ineffective (acting as disincentive to further use)

Principle 3: Methadone causes no euphoria or “high” providing the dose is increased gradually, until withdrawal symptoms are eliminated and there is no craving to use additional opioids. If the dose is increased too quickly and beyond the prevailing level of tolerance, such drug effects may arise;

Principle 4: Methadone has no known toxic effects on the human body if taken at dose that is within prevailing level of tolerance, even if taken indefinitely;

Principle 5: Methadone allows people to live normal lives – to work, to drive a motor vehicle (providing not under influence of alcohol or other psychoactive drugs) – once dose is stabilised;

Principle 6: Methadone is safe in pregnancy and methadone maintenance therapy is preferable to haphazard use of heroin or other opioids, which increase the risk of miscarriage as well as other toxic effects:

Observation 1: Tincture of opium or phenobarbitone may be necessary to manage neonatal abstinence syndrome but there is no evidence of adverse psychomotor or developmental effects on baby as they grow older, nor any evidence of increased risk of drug use themselves from exposure in utero;

Observation 2: Methadone maintenance treatment attracts and retains a substantially larger proportion of opioid dependent persons than drug free treatments, yielding a greater net benefit to public health providing methadone maintenance therapy services are scaled up to meet the prevailing demand.

Process of Admission to Treatment

Various inclusion and exclusion criteria often used:

- i. Opioid use for more than 1/ 2/ 5 years (varies across countries, but presence of dependence and ongoing risk might be considered the main factors in assessment rather than duration of illicit drug use. The aim might be seen as one of preventing HIV infection and other harm, rather than satisfy certain arbitrary requirements. It is desirable to act early where indicated)
- ii. Opioid dependent
- iii. Tried and failed drug free treatment one or more times (not always appropriate)
- iv. Aged 16/ 18/ 21 years and over (varies across countries, but age might be considered secondary to preventing HIV infection).
- v. No active psychosis (schizophrenia is not an absolute contra-indication) - able to make an informed decision and respond to day to day requirements and safeguards of the programme)



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- vi. Able to attend for treatment daily;

The client comes to clinic requesting treatment (voluntary in most cases);

An assessment is undertaken to determine whether the person is opioid dependent and suitable for methadone maintenance therapy and whether methadone maintenance therapy might be helpful, appropriate and the best treatment option for them at this time. If so, the clinician also wishes to determine an appropriate and safe dose.

- i. Drug use history (drugs used/ quantity/ frequency/ patterning/ duration)
- ii. Opioid dependence history and assessment
- iii. Drug treatment history
- iv. Periods of abstinence and how attained, relapse episodes and triggers
- v. Medical / psychological/ social history – level of family support and social integration
- vi. Medical examination looking for medical problems plus signs of drug intoxication or withdrawal
- vii. Urine test looking for “drugs of abuse” to confirm history and physical assessment
- viii. Other pathology tests (FBC/ LFTs/ CXR/ TPHA and RPR/ HIV/ HCV/ HBV (if not vaccinated)
- ix. pre-test HIV counselling plus HIV prevention counselling on unsafe sex and unsafe drug use; if finances permit and client wishes to have tests done;

Treatment options are discussed with the client, as is their suitability for this treatment, their treatment preferences, and the potential benefits and personal costs of methadone maintenance therapy. They are given written materials on what to expect of methadone treatment (e.g. first several doses will not completely eliminate withdrawal symptoms because of long half life of methadone and need for 4-5 doses (4-5 days) before reaching steady state blood levels) and on risk reduction, so they may make an informed decision

If client decides to enter methadone maintenance therapy, treatment goals are negotiated and the timings and responsibilities of both clinician and client are discussed. Where resources allow, the client may choose between a high intervention programme with added counselling and other psycho-social services or a low intervention programme with little added intervention. That is, apart from crisis care when needed.

Principle 7: Treatment is begun on the day of presentation – there is no need to demonstrate motivation. Coming for treatment is motivation enough and it is the challenge of the clinician to build upon this. Delaying treatment may also prolong risk exposure and illegal activity.

Principle 8: In many countries, confidentiality is protected by legislation: only serious threats to public interest allow staff to breach this Act and inform relevant authorities under the protections of alternative legislation;

The client is formally registered by Health Inspectors responsible for administering the Poisons Regulations – requirement by law for medico-legal reasons and



to prevent double treatment at another clinic: photograph, identification features documented, demographics for case management and statistical reporting purposes. In some countries, everything goes onto sophisticated computer software including digitalised photograph, which is emailed to dosing point;

Principle 9: Usually, no rules or expectations on appearance are laid down for dress, body piercing or whatever. That is the client's choice and arbitrary rules of this nature can dissuade people in need from accessing services. However, there is an expectation that clients and staff will always treat each other politely and with respect;

The client is dosed at the clinic for the first 4-7 days until stabilised clinically, told not to use other drugs if at all possible, so they can be properly assessed next day to see if they need an increase in dose. They are also told not to drink alcohol or drive or operate machinery until stabilised.

The client is examined for signs and asked about symptoms of opioid withdrawal, and the dose is increased accordingly by 5-10 mg/ day, with a maximum increase of 30 mg in any seven-day period, until stabilised. In general, the starting dose does not exceed 40mg per day and caution is exercised for a starting dose above 30 mg a day. Dose increases are made with more caution if there is evidence of hepatic dysfunction (e.g. related to hepatitis C).

Observation 3: Some people settle on relatively small dose but empirical evidence gathered has informed us that 60 mg or above is invariably necessary to extinguish or largely extinguish continued illicit drug use. A small number of people require doses in excess of 100 mg/ day.

Observation 4: It is important to establish a trusting and client-centred approach from the outset as clients sometimes believe they must exaggerate their withdrawal discomfort out of fear that they will otherwise be under-medicated;

Observation 5: Methadone is administered once daily as a syrup (1, 5 or 10 mg/ ml) diluted in 50-100 ml of orange juice or cordial or in some countries, by 40 mg tablet which can be divided. The client must speak afterwards to demonstrate s/he has swallowed the medication (sometimes try to conceal in mouth, spit out and inject or sell later);

Observation 6: Some clients become nauseated and vomit after methadone dosing. They are re-dosed if actually observed to have vomited up their dose within 10 minutes of its administration and advised to sit down for 20 minutes after dosing then and in future until this problem settles;

Community pharmacy dosing point is arranged close to where client lives, works or prefers in some models while in others, client continues to attend clinic for daily dosing; Client often pays proportion of total cost of methadone each day, weekly or fortnightly;

Observation 7: Methadone is itself relatively inexpensive, ranging from US\$0.06 per 50 mg in Viet Nam, to US\$0.10 in Thailand to US\$0.16 in Australia. However, in



developing nation context, this is expensive. One might consider cost-effectiveness and ‘user pays’ arguments, must the latter will make it impossible for the very poor to access treatment. Additional operational costs will vary according to sophistication of the model adopted... staff salaries, rental or capital depreciation of owned facility, consumables, telephone/ fax/ computer etc. In Hong Kong, while the client pays only HK\$1.00 per day, the actual cost is HK\$9.84 (US\$1.23). In Australia, the average full cost per day is about US\$2.50. In a programme operating in a village, the add-on costs will be relatively small.

Client returns to clinic for re-evaluation 2 weeks after entry into methadone maintenance therapy (if pharmacy model is adopted). Treatment goals are revisited, pathology test results provided (where relevant) and discussed along with HIV post-test counselling. Risk reduction information is repeated and discussed and medical, social or other referrals arranged as appropriate;

Observation 8: in a small minority of cases, a behavioural agreement may need to be negotiated with the client - where there is a recent or current history of behavioural problems - in an effort to reduce or avoid such problems in future. It may be signed and witnessed but carries no legal status. The dosing pharmacist may also sometimes find this necessary and helpful. Such contracts are not always adhered to without some hiccups but they can help stabilise behaviour in a client who is “distressed with the world and the world with them”.

On-Going Clinical Management

Psycho-social interventions may be offered where resources allow. In some models, such interventions are seen as essential to accepting the premise of long term substitution treatment. It is hoped that such counselling will assist the client to move towards a drug-free status and sooner. Alternatively, clients may be referred to outside services of this nature. The experience in many countries has been that clients often come for the medication but are poorly compliant with add-on psycho-social interventions. There is only limited evidence in western settings demonstrating additional benefit from such interventions but they may improve outcomes by enhancing retention and coping in treatment. Some clinics make attendance for counselling compulsory while others do not. Some offer certain positive contingencies (rewards) to those who avail themselves of such add-on interventions, for example, additional take-home doses;

In some models, take home doses may be made available after 2-3 months in treatment, when the prescriber is confident that the client is stable and unlikely to take multiple doses all at once, in combination with other drugs or in a manner that places them at risk of overdose and death. A further concern is injection of take home doses but many clinicians do not worry overly about this providing they believe it is done only occasionally, safely (with sterile injection equipment) and without risk of toxicity. Others would not feel comfortable with or accept this.

Treatment progress and treatment goals are reviewed at intervals of 3-6 months, or earlier if requested by client or clinician;

Principle 10: clients may remain in methadone maintenance therapy in some countries for as long as they can continue to benefit from treatment and if they are not



motivated, do not feel ready or confident or cannot manage to withdraw. Seen as analogous to any other medical treatment for which there is no definitive cure but for which there is a good clinical management tool.

Principle 11: Some countries with substantial resources have established national, state and clinic policies, procedures and treatment guidelines to give clear direction to programme staff in their clinical activities. They are often reviewed regularly. However, this may be seen as a barrier to establishing a less complicated but effective methadone maintenance therapy programme in less well resourced developing nations. Some simple guidelines and safeguards should nevertheless be documented for staff as methadone can prove lethal in overdose if certain principles are not adhered to (e.g. withholding or reducing the dose on a particular day if a client presents in an intoxicated state). WHO/SAB can provide such policy and practice guidelines to Member States if requested to do so;

Principle 12: The dose is withheld and the patient reassessed if their methadone dose is not collected on three consecutive days. This is for clinical safety purposes.

Principle 13: The clinician needs to take care not to induce dependence on other drugs including benzodiazepines, which may sometimes be prescribed;

Principle 14: Urine testing is useful as a means of monitoring programme outcomes (degree of drug use) but is considered less important than was once the case in supporting clinical management. If there is trust between client and clinician, the client is just as likely to tell the clinician that s/he has used an unsanctioned drug. Trying to “catch” the client out can serve to reduce trust and impair the therapeutic relationship. There is no evidence that regular urine testing enhances treatment outcomes, although it may sometimes be useful for clinical management purposes if the client is unable to respond as a reliable self reporter of unsanctioned drug use. Urine testing adds substantially to the cost of methadone maintenance therapy and consumes a lot of staff and client time, time that might be better used in supportive counselling;

Principle 15: Many clinics establish a grievance process so that any problems that arise between clinician and client can be addressed in an objective, independent and fair way. They enhance a sense of natural justice and trust between client and clinic staff;

Principle 16: If staff always endeavour to relate to clients in a respectful, tolerant, ‘professional’ and compassionate way - even if they do not agree or feel comfortable with a client’s behaviour – they will invariably find they have more success in reaching out to and helping the client.

Principle 17: Limit setting may sometimes be necessary to safeguard clients who behave in a chaotic manner, at least for a period of time, but it is helpful if the reasons for any such limits are carefully explained and communicated to the client in an open, honest and clear manner.

Principle 18: Flexibility in policy and practice provides clinician and client with more room to move according to the circumstances and makes for a smoother, more effective and happier clinical setting. In some circumstances, firm decision-making may be necessary to safeguard the client and / or the clinic, however, the clinician should always try to remember what he or she would hope for when themselves seeking help



from the health care system. Would they hope for individualised, fair and caring treatment? How would they react if treated without dignity or respect?

Principle 19: Clear, regular and frequent communication between all staff involved in a methadone maintenance therapy programme is essential if dosing accidents are to be avoided and if treatment is to be optimised.

Observation 9: In many countries, clinics will provide up to 400 treatment slots per site, sometimes more. In others, as few as 20 patients may be registered with a prescriber and if a General practitioner model is adopted, as few as 1-10 clients. Counsellor case loads of 50 clients are considered manageable in a high intervention model as is a doctor: client ratio of 200:1. However, in Hong Kong 10,000 clients are supervised and treated by three full time doctors and 50 part time doctors. That is equivalent to a ratio of 1250:1. In northern Thailand, there is no doctor in the Akha Hilltribe clinics and clients must go to Mai Chan Hospital if they need medical attention;

Observation 10: The methadone dose does not escalate indefinitely, although a small number of clients may seek ever increasing doses from the prescriber because they are searching for something that methadone is not meant to provide – a drug ‘high’.

Observation 11: If a client indicates a wish to withdraw from methadone, it is usually undertaken at a rate of 5 mg/ week, slowing the rate when the dose goes under 20 mg/ day. If the client relapses into heroin / other opioid use during this withdrawal period, they may be encouraged to put their withdrawal effort on hold or to have their dose increased again. Alternatively, clients may choose to be admitted to an inpatient facility and be withdrawn more rapidly under symptomatic pharmacotherapy cover (e.g. clonidine, lofexidine, diazepam, other). More recently, ultra rapid opioid detoxification (UROD) has been introduced in some countries, using naltexone flooding under anaesthesia or under heavy sedation with lorazepam plus clonidine.

Observation 12: decisions should be made about the level of documentation that must be maintained for clinical, medico-legal and administrative purposes;

Observation 13: In some circumstances, highly regulated checks and balances must be established for the storage and dispensing of methadone. In other circumstances, such safeguards may be less important;

Observation 14: Consideration must be given to the nature and level of training and clinical supervision to be provided to all staff of a methadone maintenance programme. Where resources allow, competency based training may be considered, but this will often not be feasible;

Observation 15: Variability in methadone maintenance therapy program treatment outcome has been found to be most influenced by methadone dose, duration of treatment, and ancillary services. Of these, dose is the only independent variable for which there is substantial empirical evidence demonstrating its influence on treatment outcome. Nevertheless, counselling should be provided wherever possible to support clients and help them through their many life problems. The provision of counselling is also likely to make methadone maintenance therapy programmes more acceptable to decision-makers and to the community;



Observation 16: It is important that prescribers have a sound understanding of the pharmacology of methadone and more generally, an understanding of drug-drug interactions, if methadone maintenance therapy programmes are to be managed safely. Overdose events and death arising out of poor clinical management are tragedy enough. Such events can also lead to a questioning of the credibility of the programme and place it under substantial community and political pressure;

Observation 16: It is sometimes difficult to get agreement from members of the community for the establishment of methadone clinics. This is often labelled the NIMBY (“Not In My Back Yard”) syndrome. At some level, politicians and other decision-makers have found it necessary to stand firm in supporting the establishment of these clinics. Each country will have a different way of addressing this challenge;

Observation 17: methadone maintenance therapy is actually not difficult to implement. The principles of operating a good programme are straightforward and not difficult to apply;

Observation 18: Some people do not feel comfortable applying these principles and do not feel that people who make poor choices in their lives should not receive such treatment. It is important to remember that methadone maintenance therapy programmes can protect and benefit the whole community.

Observation 19: There is an over-representation of mental disorders and mental illness among opioid dependent populations. This needs to be taken into account when providing drug treatment of any type to this group of people. The provision of psychiatric assessment, treatment and care can serve as an important part of a methadone maintenance treatment programme. Some programmes are able to provide such services on a sessional basis each week. Others work closely with local Mental Health Services to ensure that these needs are met. Clinicians and support staff should always consider the possibility that some clients are unable to respond reliably if at all to programme rules and requirements, because they are suffering from a mental health disorder. Those who might be labeled as having an “anti-social personality disorder” also need greater support and carefully considered clinical management, so as to minimise their distress and hazardous behaviour. In such cases, clinical responses that are flexible, tailored to the individual circumstances and positive contingency in orientation are likely to achieve the best outcomes for the individual and community alike.

Observation 20: Some people feel uncomfortable replacing one drug of dependence, heroin, with another (methadone). In response to this concern, it is relevant to note that methadone treatment is not associated with any euphoria or drug reinforcement effects of the type that are sought when people begin using drugs. When methadone is administered in a dose that meets the individual’s level of opioid dependence, their opioid withdrawal symptoms are relieved and they feel ‘normal’ and able to get on with their daily tasks. In this sense, methadone maintenance is no different to many other mainstream medical treatments (for further comments on this concern, see excerpt from a book edited by Ward, Mattick and Hall (1998)).



Risks and problems associated with methadone maintenance therapy

Diversion/ theft of supplies from anywhere along the chain of transfer from manufacture to dosing - this is not a reason to not offer methadone maintenance therapy, rather, it is a reason for paying increased attention to ensuring a secure chain of transfer of all supplies and ensuring effectively enforced accountability mechanisms. Diversion is rarely a major problem;

Clinical side effects that may be experienced:

- ◆ Nausea and vomiting (usually settles)
- ◆ Constipation (usually settles with dietary adjustment and stool softeners)
- ◆ Lethargy (may respond to dose reduction)
- ◆ Reduced saliva associated with all opioids and added sugar contributing, along with often poor diet and poor dental care to tooth decay
- ◆ Sweating - this may occur as side effect of methadone or as a result of inadequate dose
- ◆ Amenorrhoea... but menstrual periods more often than not become regular when stabilised on methadone
- ◆ Reduced sexual libido (may respond to dose reduction)
- ◆ Continued unsanctioned drug use with risk of overdose and in some cases, death
- ◆ The latter points to need to monitor clients more closely and implement certain protective clinical actions when they display clinical evidence of instability and poor progress in treatment. It also points to the need for sound clinical knowledge and skills.

Ethical aspects of opioid replacement therapy

Ward, Mattick and Hall, 1998

The following is an excerpt from a book edited by Jeff Ward, Richard Mattick and Wayne Hall. It may be helpful to some who feel uncomfortable with the idea of replacing one drug or dependence with another, as a form of treatment.

Not all the controversies surrounding opioid replacement therapy can be empirically resolved. There are critics, for example, who have strong moral reservations about opioid maintenance programs. The underlying basis for these moral reservations, and the bearing of research evidence and clinical opinion on them, needs to be briefly discussed because there remain many people in the general community and in the drug treatment community who are opposed on moral grounds to opioid replacement therapy.

We accept Hume's (1739/1888) argument that statements about what one ought to do cannot be inferred from statements about what is the case. Nonetheless we believe that empirical evidence has a bearing upon the evaluation of moral principles, as do many modern ethicists (e.g., Rachels, 1986). This is clearest in the case of the utilitarian moral justification offered for opioid replacement therapy by its proponents that its benefits to both the patients and the community outweigh its costs. They accordingly have an obligation to demonstrate that it achieves its aims of reducing injecting heroin use and crime, while improving the health and well-being of a substantial proportion of its



patients, and without incurring greater social harms. Some opponents of opioid replacement therapy argue that it fails to achieve these goals in that substantial numbers of patients continue to inject illicit drugs and engage in criminal activity. Research evidence on the impact of opioid replacement therapy on illicit opioid use, crime and health status is clearly relevant to an evaluation of these competing claims.

A utilitarian appraisal of costs and benefits does not address all the moral objections to opioid replacement therapy. Some of its opponents, for example, argue that opioid replacement therapy is unacceptable because it simply "replaces one drug of dependence with another". These critics often insist that all opioid addicts should become abstinent from all opioid drugs, including methadone. Empirical evidence is relevant to the evaluation of this moral objection to opioid replacement therapy for the reason outlined by Kant in the late eighteenth century- namely, showing that a moral obligation is empirically impossible, or at least extremely difficult to meet, provides a good reason for modifying it. An appraisal of this moral objection to opioid replacement therapy is made difficult by the fact that the reasons why such critics find drug substitution so morally objectionable are rarely spelt out. Its appraisal requires a brief consideration of the possible underlying reasons for this moral objection.

The opposition to opioid replacement therapy is rarely based upon an objection in principle to the therapeutic use of opioid drugs (although one of the side-effects of the hostility to opioid drugs has been an aversion to their legitimate medical use on the part of both doctors and patients). If the objection to opioid replacement therapy was simply one consequence of a general opposition to the medical use of opioid drugs, then the use of opioid drugs to produce analgesia for childbirth and post-operative pain would also be morally objectionable.

If opioid replacement therapy is objectionable because long-term opioid use may maintain opioid dependence then similar objections would have to be made to the use of opioid drugs for analgesia in palliative care, and the management of chronic intractable pain of non-malignant origin. In cases of life-threatening illnesses and chronic painful conditions, patients may be maintained for months, sometimes years, on substantial daily doses of opioid drugs, with many of them developing the signs and symptoms of opioid dependence.

If the long-term medical use of opioid drugs is condoned, it is difficult to understand the basis for the moral objection to opioid replacement therapy. Is it because heroin addicts were not "ill" when they began to use opioid drugs for their intoxicating effects? Is it because they are in some sense "responsible" for becoming dependent upon non-medically prescribed opioid drugs? An exclusive focus on the original reasons why people become dependent, such as the pursuit of intoxication, ignores the real distress and adverse effects of opioid dependence on the user's health. It is also a moral appraisal that is rarely applied consistently. Our community, for example, provides expensive medical treatment to deal with the consequences of behaviour that was in some limited sense "voluntarily" entered into. These consequences include conditions as varied as: alcoholic liver disease, AIDS, lung cancer, heart disease, obesity, and sexually transmitted



diseases. If treatment for these conditions is regarded as morally acceptable while opioid replacement therapy is not, the suspicion is that the objection to this form of therapy is based upon the prejudice that opioid drug users are "undeserving" of treatment.

Whatever the underlying rationale for the objection to opioid replacement therapy, research evidence is relevant to an evaluation of the moral claim that abstinence is the only acceptable treatment goal for opioid-dependent people. An insistence on abstinence from all opioids presupposes that abstinence is relatively easily achieved and sustained by those who have become dependent upon opioids. This assumption is contradicted by evidence on the results of opioid detoxification and drug-free treatment, and by the findings of the small number of studies of the careers of opioid-dependent persons (Gerstein and Harwood, 1990, chapter 4; Goldstein and Herrera, 1995; Hser *et al.*, 1993; Stimson and Oppenheimer, 1982; Thorley, 1980; Vaillant, 1973, 1988), all of which show that opioid dependence can become a chronic, relapsing condition with a high rate of premature mortality.

The evidence indicates that the majority of opioid addicts relapse to heroin use shortly after detoxification. Drug-free treatments attract fewer patients than methadone maintenance, have lower rates of retention in treatment, and lower rates of successful graduation to a sustained drug-free lifestyle, although they do reduce the frequency of injecting drug use and benefit their patients in other ways (Gerstein and Harwood, 1990).

The evidence on the heroin using careers of opioid-dependent persons shows that the proportion of people who become and remain abstinent is of the order of 10% within the first year after treatment, and that about 2% per annum achieve abstinence thereafter (Goldstein and Herrera, 1995; Hser *et al.*, 1993; Joe and Simpson, 1990; Vaillant, 1973). The small literature on the longer-term outcomes of methadone maintenance treatment, also indicates that over 5 years and longer the proportion of opioid-dependent persons who achieve enduring abstinence from all opioids (including methadone) does not differ between those receiving drug-free treatment and methadone maintenance treatment (Maddux and Desmond, 1992).

While people remain opioid dependent, their annual chances of becoming abstinent are not much higher than their risk of dying prematurely. Dependent heroin users have a substantially increased risk of premature death from various causes. These include: drug overdoses, violence, infectious diseases spread by sharing contaminated injecting equipment, and alcohol-related causes in a substantial minority of heroin users with concurrent alcohol problems (Goldstein and Herrera, 1995; Hser *et al.*, 1993; Joe and Simpson, 1990; Vaillant, 1973). Mortality studies among cohorts of treated heroin users before the advent of HIV/AIDS indicated that they were 13 times more likely to die prematurely than their age peers (English *et al.*, 1995). More recently, HIV/AIDS has been added to the causes of premature deaths among heroin users in the USA (Des Jarlais *et al.*, 1989) and Europe; emerging evidence suggests that this will become a more important cause of premature death among heroin users in Australia in the future, as will liver disease caused by infection with the prevalent hepatitis C virus (Crofts *et al.*, 1993).



The difficulty that many dependent opioid users experience in achieving abstinence does not exclude abstinence as a treatment goal for opioid-dependent people. Drug-free treatments which aim to achieve abstinence clearly have a place in the treatment response for those opioid-dependent people who want to become abstinent. Some opioid-dependent people also choose to enter drug-free treatment programs after a trial of methadone maintenance treatment. But it is clear from the high failure rate of abstinence-oriented programs and the mortality risks of chronic opioid dependence that there is no compelling moral reason for insisting that abstinence is the only acceptable treatment goal for everyone who is opioid dependent.

For all these reasons we believe that there is a strong utilitarian ethical justification for communities to provide opioid replacement therapy to opioid-dependent people. In the light of some misunderstandings of our view, it is necessary to say that a utilitarian rationale for opioid replacement therapy should not ignore the rights and interests of patients who participate in opioid replacement therapy programs. Opioid replacement therapy and other forms of treatment for dependent heroin users ought to be provided first and foremost for the benefit of those who seek them. But they will also benefit the rest of the community, which provides the utilitarian justification that is an important part of the case for public provision of opioid replacement therapy in these self-interested times. Opioid dependence should not disqualify persons from citizenship, nor is it a reason for their enjoying less than full civil rights. Opioid replacement therapy patients accordingly should enjoy the same rights as any other patients, including an opportunity to comment on the way that treatment is provided, and access to the same procedures as other patients for resolving grievances or addressing complaints about the way that their treatment is provided. Anything less than this risks making opioid replacement therapy the coercive form of social control that some critics accuse it of being.

Reference: *Methadone Maintenance Treatment and other Opioid Replacement Therapies*, Edited by Jeff Ward, Richard P Mattick and Wayne Hall, ISBN No. 90-5702-239-7: 480 pages :1998.



Annex 2: Needle and syringe exchange and distribution

Methods of delivery

(a) Needle and syringe exchange programmes

- Some programmes only give out the same number of needle and syringes as are returned (“one for one”)
- Other programmes encourage one for one but do not require it.
- Others give out as many needle and syringes as the client requests, within limits (5-30)
- One for one policy has pros and cons associated with it

Advantages:

Takes needle and syringes out of circulation (majority of needle and syringes are disposed of safely in some but not other countries), encourages safe disposal, gets used injecting equipment out of circulation, thereby lessening the chances that it will be re-used.

Disadvantages

Very time consuming, may act as partial barrier to getting as many sterile NandS out into the community as possible, no published reports anywhere in the world of a non-health care setting needle stick injury leading to HIV, hepatitis B and C infection – so it is argued that it is not so important to place a lot of resources into disposal schemes

(b) Needle and syringe availability programmes

Needle and syringe availability programmes provide injecting equipment without expectation that they will be returned, on basis of need to get sterile equipment out into the community where it is needed, as quickly and easily as possible. They are less expensive than needle and syringe exchange programmes. Exchange may be an optional add-on, for example, some pharmacies may have a sharps bin where clients can place their used needles and syringes but they are not counted.

- Pharmacies (may monetary incentive for return of used needle and syringes schemes – free if used needles and syringes are returned, small charge if not)
- Primary health care services (need to educate and persuade health care workers of the importance of this strategy, which is often difficult)
- Hospital Emergency Departments
- Supermarkets
- Convenience stores
- Vending machines



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- Mobile services (buses)
 - “Foot soldiers” (outreach workers on the street)

Equipment offered

- Needles and syringes in varying barrel sizes and needle gauges according to needs of client (which drug they are injecting, its volume, its viscosity)
- Sterile water (but expensive)
- Alcohol swabs
- Filters
- Condoms
- Disposable tourniquets (rarely)
- Disposal containers (rigid walled, puncture resistant, sealable)
- Risk reduction educational brochures (unsafe sex, unsafe drug use)
- General health information brochures

Other services offered

- Supportive counselling or advice (only if requested, which is invariably the case after trust and credibility builds. If issues are forced, has been found that clients may not come);
- Treatment of abscesses and other infections
- Referral services for drug treatment, medical treatment, mental health care services, social services, legal; services, STD treatment (if not offered on site)
- HIV testing accompanied by pre- and post-test counseling
- STD testing
- Bleach cleaning

Other purposes served by needle and syringe exchange programmes

- Research
- Epidemiological monitoring
- Early tactical warning system (detecting newly emerging trends in drug use types, toxicity and practices that may present new or enhanced public health risk and that can be responded to by the health and other sectors rapidly and in a way that can avoid unnecessary deaths)
- Networking



Distribution

- Shelves – client chooses what he or she needs
- Equipment is placed in paper bags so no-one will know what is in there when they leave
- Pre-packed kits

Policies and protocols

Can be helpful to work out how workers should perform their tasks and how they should manage difficult situations e.g. if very young people request needles and syringes

Summary

Needle and syringe exchange and availability programmes can offer much more than sterile injecting equipment and can serve an important role in reaching people who use drugs and in protecting and promoting public health.

