INJECTION DRUGS & HARM REDUCTION

While stopping injection drug use altogether is the most efficient way to eliminate injection-related risks of HIV infection, this approach is not always feasible. Many drug users are neither willing nor able to stop their injection use. For this reason, interventions that include a focus on “harm reduction” are vital in responding to injection-related HIV transmission risks.

This issue of PERSPECTIVES explores the concept of harm reduction and describes specific harm-reduction interventions related to injection drug use. The Implications for Counseling section presents ways that counselors can employ harm reduction strategies in working with clients who have injection drug-related risks.

Research Update

For many years, health care providers and people who inject drugs have sought to make drug-using practices as free of harm as possible. In addition, providers have tried to present drug-using clients with realistic options to help them reduce harm to themselves, their families, and the communities in which they live. However, as a theory applied in research and as a defined model of service delivery, harm reduction is relatively new: service providers in England developed the pioneering Mersey Harm Reduction Model in the 1980s.1 This model and a harm reduction “movement” have emerged largely in response to the AIDS epidemic and the need for HIV prevention strategies.2

Beyond the risk of HIV infection, harm related to injection drug use can include other blood-borne infections. In addition, drug use in general—by injection or other means—can involve harm resulting from numerous factors such as taking a drug overdose, neglecting nutritional needs, or being involved in criminal activity in order to have money to buy drugs.

Harm reduction evolved as providers observed that abstinence-based HIV prevention excluded many drug users. Models of harm reduction aim to meet drug users “where they’re at,” in contrast to harm elimination models, which call for eliminating use as an immediate and necessary goal.

Harm reduction proponents acknowledge that nonmedical drug use will inevitably produce social and individual harm,3 but they do not assume that abstinence is the first or ultimate goal. Believing that complete prevention of drug use across society is not realistic, proponents of harm reduction try to help people live with their drug use, integrate into society, protect their health, and seek drug treatment when ready.3

Studies of various harm reduction efforts have found that employing these efforts does not lead to an increase in drug use.4, 5 Reviews on the subject report on studies that find injection drug users can and do change their injection practices to reduce the risk of HIV transmission.4 There are also reports that harm reduction approaches can be beneficial in improving health and developing

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important relationships between people who inject drugs and their health care providers. This may lessen drug injectors’ fears that providers will offer them care only if they first stop their drug use. In addition, by helping a person avoid HIV or other diseases that can result from drug use, harm reduction strategies can reduce future medical costs.

Interventions for Drug Injectors

While traditional approaches focusing on abstinence are useful for many people, they may not be effective for clients who are not at a place in their lives to stop using drugs. In some cases, these approaches may actually alienate clients and close them off to other, more achievable options. An agency that has pioneered harm-reduction interventions has developed “12 Suggested Steps of Harm Reduction for Drug Users.” These are modeled after the 12 Steps of Alcoholics Anonymous (AA), but are not endorsed by AA.

Harm reduction is designed so that specific interventions reflect individual interests and abilities. People may be open to changing their method of drug administration, for instance from injection to snorting. Or, it is possible, if unlikely, that they will be able to reduce the frequency of drug use. A person may make other changes such as not injecting drugs at shooting galleries or not exchanging sex for drugs. After successfully taking harm-reducing steps, a drug user may feel empowered to take further steps, perhaps eventually attaining abstinence or remaining committed over long periods to a harm reduction strategy.

Some common harm reduction interventions include injecting only with needles not used by others, cleaning needles, exchanging needles through needle exchange programs, and, for heroin users, enrolling in a methadone maintenance treatment program. Needle Cleaning

Cell culture studies have found bleach to be effective in deactivating HIV. As a result, bleach distribution—along with instructions on how to use bleach to disinfect used needles—is an important component of outreach education for injection drug users. But, because disinfecting the inside of a needle and syringe is not a foolproof process, bleach disinfection is not as safe as injecting with a needle and syringe that have not been used by someone else.

The California Department of Health Services, Office of AIDS has issued recommendations for cleaning syringes [see box on page 5]. Correctly following these greatly reduces the risk of infection with HIV and other blood-borne infections. Beyond presenting methods for cleaning needles, the recommendations state that a person should never share cookers, cotton, water, bleach, or other injection equipment. A “cooker” is a device, such as a bottle cap or spoon, used to melt or dissolve heroin. A “cotton” is the material used to filter heroin and other drugs as they are drawn into a syringe. Beyond this, researchers recommend pulling syringes apart and cleaning individual components of the syringe, such as the interior of the barrel.

Needle cleaning protocols can present challenges: a person may not have access to or be willing to

Related Issue: Sex Partners of Injection Drug Users

HIV-related risks multiply when injection drug users have unprotected sex. Researchers attribute more than 25 percent of AIDS cases in the United States to HIV transmission resulting from the sharing of unclean needles. Among women, researchers link 46 percent of all AIDS cases to injection drug use and 18 percent to sex with partners who inject drugs.

Surveys find condom use among injection drug users to be very low, especially with regular sexual partners. Usage rates may be low partly because people may not know or want to know that a sex partner injects drugs. As a result, they may not see a need to use a condom during sex.

Studies of sex partners of injection drug users have primarily focused on female sex partners of men. While the population of women who have sex with male injection drug users is diverse, researchers have uncovered some common characteristics. Generally, these women do not inject drugs themselves but do show patterns of alcohol and other drug use, have low self-esteem, perceive their HIV risks as being low, and experience a sense of powerlessness about their partner’s drug use.
use bleach or may fail to keep bleach in the syringe for 30 seconds. Reports suggest that many who clean their needles with bleach keep bleach in the syringe for periods significantly less than 30 seconds.10 It is important to note that if bleach is kept in a syringe for periods of several minutes or more, it can disintegrate the elasticity of the rubber tip of the syringe that is attached to the plunger.

**Needle Exchange**

Needle exchange programs, also known as NEPs, seek to lower the rate of needle sharing among injection drug users by providing sterile needles in exchange for used ones.11 Needle exchanges typically offer a new needle to someone who presents an old needle for exchange. In addition, outreach workers at most exchange programs generally distribute educational materials on proper injection techniques and the risks of injecting drugs; they provide information about HIV infection; and, they distribute packets that may contain bleach, cotton, clean water, cookers, and condoms. Needle exchange proponents state that interactions between staff and needle exchange participants may instill a trust that facilitates adherence to safe injection techniques.4 This relationship may be the first in which an injection drug user sees a provider as someone who can be trusted.

Studies evaluating needle exchange programs have found that people who use exchange programs report a decrease in the HIV risks of drug-using behaviors.9, 10 Large-scale studies have reported that exchange programs did not “stimulate increased drug abuse in terms of frequency of injection or recruitment of new or younger users.”5, 11

**Methadone Maintenance**

Methadone is a medical intervention to stop heroin use for people with heroin addiction. When administered orally and in appropriate doses, methadone, which is itself a highly addictive drug, wards off heroin withdrawal symptoms and reduces chronic craving for heroin. This can enable someone addicted to heroin to function without adverse effects on motor skills or mental capability. Methadone is usually prescribed for those who have unsuccessfully tried to stop heroin use.

Studies support methadone treatment as an effective way to decrease or eliminate heroin use.13, 14, 15 Also, since methadone is monitored and administered in a medical environment, treatment programs provide a link between injection drug users and health care providers.

Usually, a person will begin methadone treatment with a regimen that requires a daily trip to a methadone clinic and a daily urinalysis test to demonstrate the individual is not using heroin or other drugs. Dose and duration of treatment vary for each individual. If they remain free of heroin and other illegal drugs, methadone clients may receive enough of the drug to take on their own for several days and be subjected to urine testing only once or twice a week.14 Providers generally intend methadone to be a relatively short-term, transitional treatment lasting no longer than two to three years. Less than five percent of people

**Related Issue: Heroin, Cocaine, and Amphetamines**

Heroin, cocaine, and amphetamines are commonly injected drugs. While these drugs may be taken by other means, such as snorting, injection provides the most powerful and immediate effect. People sometimes mix heroin and cocaine in one injection, a combination called a speedball.

Heroin is an opiate, a class of drugs that suppresses pain and creates feelings of euphoria and sedation. Heroin, with effects lasting 3-4 hours, also causes feelings of warmth, a drop in blood pressure, and constipation. Daily heroin users develop drug tolerance,12, 17 and someone who is addicted experiences withdrawal symptoms when stopping use. These symptoms can be severe and include running nose, sweats, chills, cramps, and intense craving for more heroin.13, 19, 20

Cocaine and amphetamines are stimulants, drugs that increase blood pressure and heart and respiratory rates. Short-term effects also include increased alertness and mood elevation. High doses may cause a paranoid state of psychosis and an overdose can be fatal. Effects of cocaine and amphetamines are similar, except that cocaine’s effects are shorter-lasting, continuing 20-80 minutes, compared to 4-12 hours for amphetamines. Initial stages of abstinence from stimulants are marked by depression and drug craving.20

For people addicted to any of these drugs, stopping use is far more complex than simply dealing with symptoms of withdrawal. Drug service providers generally urge that interventions to help people stop drug use include behavior-based programs that provide support, inpatient hospitalization, or residential rehabilitation.
Implications for Counseling

Harm reduction is consistent with client-centered test counseling because it considers risk behaviors in the context of a client’s willingness or ability to consider or make changes.

Harm-reduction counseling provides clients with options. Counselors in client-centered sessions can present a variety of suggestions and learn which ones clients have interest in and see as feasible. Counselors and clients can then work together to decide ways to implement change and develop and fine-tune a plan to reduce harm.

In applying concepts of harm reduction, counselors must recognize that appropriate harm reduction approaches may differ among clients. Counselors must, therefore, view each client separately, including the risks of a client’s drug use, the context of his or her drug-using behaviors, and how drug use affects the client’s life. Keep in mind that patterns of addiction can affect a person’s ability to protect himself or herself, and recognize the reasons people use drugs and stop drug use. People generally enter drug treatment and recovery programs only after drug use has progressed to an unmanageable stage in which the harmful consequences of using drugs far outweigh the perceived benefits.

Be careful not to apply assumptions of what life is like for someone who injects drugs. Do not assume, for instance, that someone who injects drugs is sharing needles. Also, be careful not to assume that an injection drug-using client who appears impoverished, indigent, and emotionally unstable is any more or less ready to quit drug use than someone who appears financially stable and physically healthy. In addition, do not assume that drug use is the source of all problems a person may face. If, for example, a client says he or she is having interpersonal problems with a partner, ask the client what he or she sees as the problem, rather than assuming that it is related to drug use. This approach recognizes that some aspects of a client’s life may be manageable, even if other parts are unmanageable, and it gives the client an opportunity to make connections without judgment. At the same time, be aware that denial is a hallmark of drug addiction and be alert that a drug user will often minimize or deny that his or her drug use has any negative consequences.

In the context of an HIV counseling session, avoid directly challenging a client’s drug use. Remember that people who use drugs may see their use as important and perhaps necessary to survival. Even if a person says that drug use is becoming unpleasant, recognize that drugs may have once had a positive meaning for him or her. Counselors who do not understand the language, culture, or behaviors of injection drug use can learn more through workshops and from colleagues, or by asking clients for help in understanding. Be genuinely open to the education that clients can provide.

Risk Assessment

In assessing a client’s drug-related risks, show genuine interest in his or her drug use; for instance, ask the client what using drugs is like for him or her and what he or she enjoys or does not enjoy about using drugs. Be aware that, perhaps because of negative experiences with institutional providers, someone who injects drugs may not volunteer details of drug use, but may be forthcoming when asked.

Ask clients to be specific in describing their injection and drug-using activities and the context for these. Does the client inject alone, with one or a few others, or in a shooting gallery? If he or she injects with others, what is the nature of these relationships? What drugs does the client use and how often does he or she inject them? Always ask where clients inject—for instance, in a bathroom, a car, a park, or a shooting gallery. Answers to this question can help determine such things as a client’s access to running water in order to clean needles. When asking such specific questions, assure clients about the confidentiality of the discussion. And, explain that counselors may ask the locale of a person’s drug use to assess risk-related issues, not to pinpoint the location for legal reasons.

Proceed with a discussion of risks, and assess the extent to which the client is willing to consider changes. Following the client’s lead, help develop a plan about specific behavior changes and help the client...
A Counselor’s Perspective

“People’s reasons for using and injecting drugs are complex. Harm reduction makes sense for many clients because it presents options that particularly recognize this complexity.”

make this plan as realistic as possible. In addition, always consider any potential challenges that may arise when a client attempts to make changes in behaviors and help the client develop ways to respond to potential challenges.

Specific Strategies: Stopping Use

For a client looking to stop using or injecting drugs, explore ways in which he or she hopes to achieve this goal. For instance, is the client planning to stop “cold turkey” or is he or she planning to slowly decrease the frequency or quantity of his or her use? What is the client’s history of trying to stop use? Is the client interested in pursuing medical detoxification, entering a recovery program, or receiving methadone maintenance? Are the client’s peers supportive of him or her stopping use?

Be aware that some people who want to stop using drugs continue to use because they fear the withdrawal experience. Help them see that there are ways to deal with this and become familiar with treatment programs. Keep in mind that economic, social, and personal factors may prevent a person from qualifying for or being in a methadone program. Methadone programs may, for instance, insist that clients abstain from all other drugs. While methadone can be a replacement for heroin, it is not a replacement for other drugs, such as cocaine.

Learn about treatment programs targeted to people with HIV, and learn whether programs give priority to people with HIV.

Not Sharing

Recognize that people share injection equipment for a variety of reasons, including convenience, peer influence, availability, the desire not to offend others, and a sense of intimacy. With clients who share equipment, ask if they are aware of the risks of sharing, explain what they are not aware of, and ask if they are willing to consider not sharing. If clients want to stop sharing, help them develop a realistic plan to do this.

Because clients’ reasons for sharing needles are often related to their relationships with those they share, explore these relationships. People may not consider it unsafe to share unclean needles with primary partners. A person may consider sharing with a primary partner as a gesture of love and trust. When this is the case, counselors can reframe this to state that love can also mean not sharing, and ask clients how they might experience intimacy without sharing. Explore any barriers that might prevent a client from implementing such a plan. Acknowledge the challenges a person might experience and validate feelings such as loss about ways of experiencing intimacy.

For clients unaware of the risks of sharing needles, explore negative consequences from sharing that they may have experienced or be at risk for experiencing. These consequences may include being infected with hepatitis types B or C or contracting endocarditis, an inflammation of the lining of the heart.

Cleaning

For clients who share injection drug-using equipment and plan to continue to do so, emphasize the importance of cleaning needles with water and bleach. Learn whether they clean their injection equipment, and whether they consider it possible to do so. Find reasons clients might want to clean their equipment. Support clients for what they have done in the past to do so, and validate that it can be challenging to have a clean needle. Understand the reasons clients may resist cleaning now, and respond to these reasons. Consider factors that might limit proper needle cleaning, for instance, a need to get a drug fix as quickly as possible, or a lack of access to clean water.

Some clients may be willing to clean needles, but may not follow cleaning guidelines completely. Find out what might be keeping clients from fully adopting guide-
lines. Recognize, for example, that for some people 30 seconds is too long to spend on each step of cleaning. If clients are unwilling or unable to fully adhere to guidelines, suggest a modification, while emphasizing the value of using a water rinse prior to bleach cleaning, leaving water or bleach in the syringe for as near to 30 seconds as possible during each stage, and shaking and tapping the syringe throughout the process.

When it appears that clients are not going to fully adhere to cleaning guidelines, make sure these clients are aware of their risks. Ultimately, support these clients for what they are willing to do to reduce the harm of their use.

Be sure that suggestions about cleaning are sound. For instance, boiling syringes in water is a way to sterilize a syringe, but it will ruin the rubber on the syringe plunger, and prolonged exposure to bleach can also harm parts of the syringe.

Beyond needle-cleaning, some counselors instruct clients in specifics of safer needle-using behaviors so that clients can avoid health risks such as open sores, which can result from poor injection techniques.

**Needle Exchange**

Because needle exchange programs are illegal in California, a counselor may run a theoretical risk of being implicated in an illegal act by advocating exchange use to a client. Because of this, and also because of potential legal risks that clients in some locations may face in accessing needle exchange services, counselors should speak with their program supervisors about a test site’s protocol regarding discussions of or referrals to a needle exchange service. Depending on the direction of this discussion, learn about the availability of exchange programs in the area. In some areas, there are no local needle exchange resources. If there is a locally sanctioned needle exchange, be aware of information, including telephone numbers, addresses, hours of operation, and how the exchange works. Counselors may learn about locally sanctioned exchanges by calling drug treatment centers, social workers at AIDS service organizations, or chapters of the activist organization ACT-UP.

Recognize that some injection drug users are reluctant to visit needle exchange programs. Programs often operate in inner-city areas, which are inconvenient in many cases and may make people feel unsafe. Also, exchange users may not want to face public exposure. If it is in keeping with the counseling protocol of the test site, help clients identify these concerns. Also, explain that most exchange programs provide services anonymously. State that while people exchanging needles may be asked informational questions by those operating the exchange, they will not be asked for their names.

**Other Strategies**

Consider health risks beyond HIV infection that relate to a person’s injection behavior.

For instance, learn in what part

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**References**


of the body clients inject drugs. As use progresses, people may no longer be able to inject into the veins in their arms and legs and may inject veins in their groin area or neck. Injection into these veins can be dangerous and life-threatening. Explain this danger.

Explain also that improper injection techniques—for instance using needles that have become blunt—can cause abscesses of the skin and numerous infections. Consider a person’s willingness to make changes, and provide referrals to drug treatment providers or HIV service agencies that provide harm-reduction strategies to those who currently inject drugs.

**Personal Conflict**

Aspects of harm reduction may be challenging to some counselors. As such, it is important for counselors to explore feelings that arise when they consider harm reduction. A counselor’s experiences with injection drug use, drug use by a family member, or a counselor’s recovery process can lead a person to be defensive about his or her favored approach for healing that may not be consistent with harm reduction.

Explore issues of transference and counter-transference, such as anxiety in talking about drug use, and secure support for before and after challenging sessions.

**Case Study**

Beth, a 26-year-old, uses heroin and shares injection “works,” or needles, with her boyfriend. She always cleans the needles she uses and she injects drugs only with her boyfriend, but she is uncertain whether he injects and shares with others. Throughout their three-year relationship, Beth has struggled to convince her boyfriend that cleaning needles is important. She says that prior to their meeting, he cleaned needles some of the time, and she speculates that if he is currently injecting with others, he is likely to be cleaning needles only some of the time.

During sex, Beth and her boyfriend do not use condoms. She says they do not need to use condoms because she sees their relationship as monogamous. She says she has not had sex outside the relationship but she and her boyfriend have not specifically discussed monogamy. Her boyfriend tested HIV negative about six months after the couple met.

**Intervention**

Support Beth for cleaning needles and communicating the importance of this issue to her boyfriend, and learn her reasons for being vigilant in cleaning her works. Explain to her that while her cleaning practices reduce her risk of infection, she is still at risk for HIV and other infections through unprotected sex with her boyfriend if at any time since they met he has injected with others without cleaning his works or engaged in unprotected sex outside the relationship. Make sure she understands her risks from sex and the fact that these exist regardless of his having tested HIV negative two years ago.

Directly address the contradiction of the fact that Beth has gotten beyond the challenges of needle cleaning and discussing this subject, but she has not done so in the area of condom use. Learn more about why this contradiction exists. Ask how she feels about the fact that her boyfriend is putting her at risk. And, ask what options she believes she has.

Look more closely at communication in the relationship in general, and, specifically, related to risk behaviors that Beth and her boyfriend do not discuss. The lack of clarity about these subjects—for instance, whether he shares needles with others or has sex with others—affects Beth’s risks. Assess whether Beth sees her lack of knowledge on this subject as a limitation. Explain reasons it would be useful to have this knowledge and explore whether she sees it as possible to discuss this subject with him. Also explore any fears she may have of doing so. Recognize that she may believe that current communication in the relationship is good.

Determine Beth’s short-term and long-term goals, assess—using the Stages of Behavior Change model—where she is in regard to changing behaviors, and respond to this. For instance, if she is interested in changing risk behaviors, learn what changes she considers realistic, and what plan she might have to reduce risks. Keep in mind that she may not be able to envision change. Help Beth envision change by looking to simpler steps she can achieve.

Explore strategies she can use to make or further consider changes. As appropriate, explain that there are programs where stopping drug use is not a requirement for receiving services. If there are support services in her area for people who are uninfected and currently use drugs, present these to her. Learn the extent to which Beth sees that it is worth it for her to protect herself from infection. Make suggestions and ask her what she needs from her counselor and others who provide information or support. Have referrals available.
Test Yourself

1. Harm reduction strategies aim to: a) meet drug users “where they’re at” to help them reduce any harms associated with their drug use; b) improve the overall well-being of the drug user; c) reflect specific individual and community needs; d) all of the above.

2. True or False: Harm reduction focuses on abstinence as an immediate goal in any recovery program.

3. The following are considered at risk for HIV: a) sexual partners of injection drug users; b) people who share injection drug needles; c) none of the above; d) both a and b.

4. To be inactivated, HIV must be exposed to full-strength household bleach for at least a) 5 seconds; b) 15 seconds; c) 30 seconds; d) 1 minute.

5. True or False: Data show that needle exchange programs do not stimulate increased drug abuse in terms of frequency of injection or recruitment of new and/or younger users.

6. When administered in appropriate doses, methadone a) wards off heroin withdrawal symptoms; b) reduces chronic narcotic craving; c) enables a heroin addict to function without adverse effects on motor skills or mental capability; d) all of the above.

7. True or False: Methadone is used to help people stop heroin use, but it is not used to help people stop cocaine or amphetamine use.

8. Heroin withdrawal symptoms include a) heat flashes; b) sweats and chills; c) increased appetite; d) none of the above.

Discussion Questions
1. Effective harm reduction interventions require that counselors take into account the specific needs of each client and the community in which he or she lives. How can counselors do this?
2. Given that harm reduction presents a variety of options, how can counselors assess the most appropriate option for a specific client?
3. How can counselors assess and respond to their own biases that might lead them to focus solely on an abstinence approach and not consider non-abstinence harm-reduction approaches?
4. How can counselors reconcile difficult feelings they may have about the fact that a client employing a harm-reduction approach may still be at high risk for HIV infection?

Answers to Test Yourself
1. d.
2. False. Harm elimination focuses on abstinence as an immediate goal in any recovery program.
3. d.
4. c.
5. True.
6. d.
7. True.
8. b.
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