REACHING THE HARD TO REACH

A major international review of outreach strategies with lessons for Britain

Outreach strategies in the USA, Netherlands and UK tend either to be treatment oriented or to aim for safer injecting. These should be seen as complementary objectives both capable of reducing HIV transmission. Providing services 'on the street' rather than back at the agency and employing ex-users both reduce the physical and ideological gap between the user and the service, and as such are likely to improve service uptake.

Tim Rhodes, Janet Holland, Richard Hartnoll, Anne Johnson, Sara Jones

The first three authors are from the Drug Indicators Project at Birkbeck College; Anne Johnson is a lecturer in epidemiology at Middlesex Hospital; Sara Jones is a researcher with the Centre for Research on Drugs and Health Behaviour.

MANY OF BRITAIN'S drug injectors are not in contact with helping services, and those who do not seek help are also more likely to be engaging in HIV transmission behaviour.[1,2] In response, there has been an increasing commitment to developing lower threshold interventions for hard-to-reach drug injectors.

Syringe exchanges are one of the most established of these, developed as an accessible and 'user friendly' agency-based service. But even exchanges have had only partial success in reaching injectors, and little success in maintaining contact with those most vulnerable to HIV infection.[3]

As a result, HIV education has begun to move out of the agency and on to the streets; outreach health education has fast become an expanding field. But, despite the sense of urgency, surprisingly little is known about the effectiveness of the approach in relation to HIV prevention.

In this paper we draw on examples of outreach in the United States and the Netherlands as well as the UK, and outline HIV outreach interventions in terms of two basic paradigms:

- programmes aimed at encouraging **safer injecting** behaviour;
- programmes aimed at engaging drug users in **treatment** to overcome their drug problems.

Many programmes are still in a developmental stage, and evaluation is often inadequate, but we hope this review will provide useful pointers for the development of outreach in the UK.

The shared objective of all HIV outreach interventions is the minimisation of HIV transmission behaviour. Detached interventions which aim to facilitate change *directly* 'on the street' tend to focus on safer injecting strategies; those aiming to attract users into existing services tend to focus on treatment-oriented strategies (see figure).

Peripatetic interventions, where the outreach worker visits clients in institutions such as prisons, depend on the organisations within which they operate, but are generally treatment-oriented.

Projects undertaking HIV outreach work may employ combined strategies related to client needs, which recognise a range of options in the process of behaviour change. For example, the hierarchy of objectives can run from cleaning used injecting equipment, to not sharing, to less frequent injecting, to stopping injecting. Treatment-oriented approaches range from methadone prescription to detoxification and abstinence.

From this perspective, strategies employed by safer injecting outreach interventions can be seen as complementary rather than contradictory to treatment-oriented approaches.

Safer injection

There are few syringe exchanges in the USA and in many states the availability of injecting equipment is severely restricted, so most US outreach programmes have incorporated bleach and teach campaigns.

The first was introduced in 1986 by the San Francisco Midcity Consortium to Combat AIDS.[4,5] Community health outreach workers, often ex-drug users, distributed one-ounce bottles of bleach to drug injectors plus condoms and HIV education materials. Each bottle carried clear written (Spanish and English) and pictorial instructions. The campaign was publicised by Bleachman, a 'superhero' who also made street contacts (see illustration on page 14).

The proportion of drug injectors using bleach increased from 3 per cent in 1986 to 86 per cent in 1987, indicating that the campaign had had considerable success in introducing bleach into injecting patterns. HIV infection among injectors in the city almost doubled over the same period, but as bleach use increased, the rate of new infections abated.[6]

Although directed at street populations, the San Francisco campaign also reached drug injectors on methadone programmes and brought more referrals to drug treatment centres than any other source.

In New York, however, bleach use was uneven and the campaign was relatively

ineffective[7]. One possible explanation is that the New York message was not as clear as that in San Francisco, since ethanol (which users mistook to mean beverage alcohol) was recommended in addition to bleach. Presenting a hierarchy of 'next-best' alternatives provides attainable objectives for clients, but providing a range of options also increases the risk of confusion. To minimise this risk, the preferred option should be clearly prioritised.

The first bleach intervention in the UK began in late 1988 in rural Berkshire.[8] Following the successful use of dealer networks to distribute anti-HIV 'wrap-pads' in Brighton, the project distributed 'bleach kits' through local dealers in areas with no syringe exchange. Dealers were the lowest threshold point of intervention, but kits were also distributed through pharmacies, and contained a coupon which could be returned for clean equipment at syringe exchanges.

Anecdotal evidence suggests that the distribution of kits was more effective than cleaning advice alone, that the kits were well received by users, and that they facilitated referrals to pharmacies and syringe exchanges.[9]

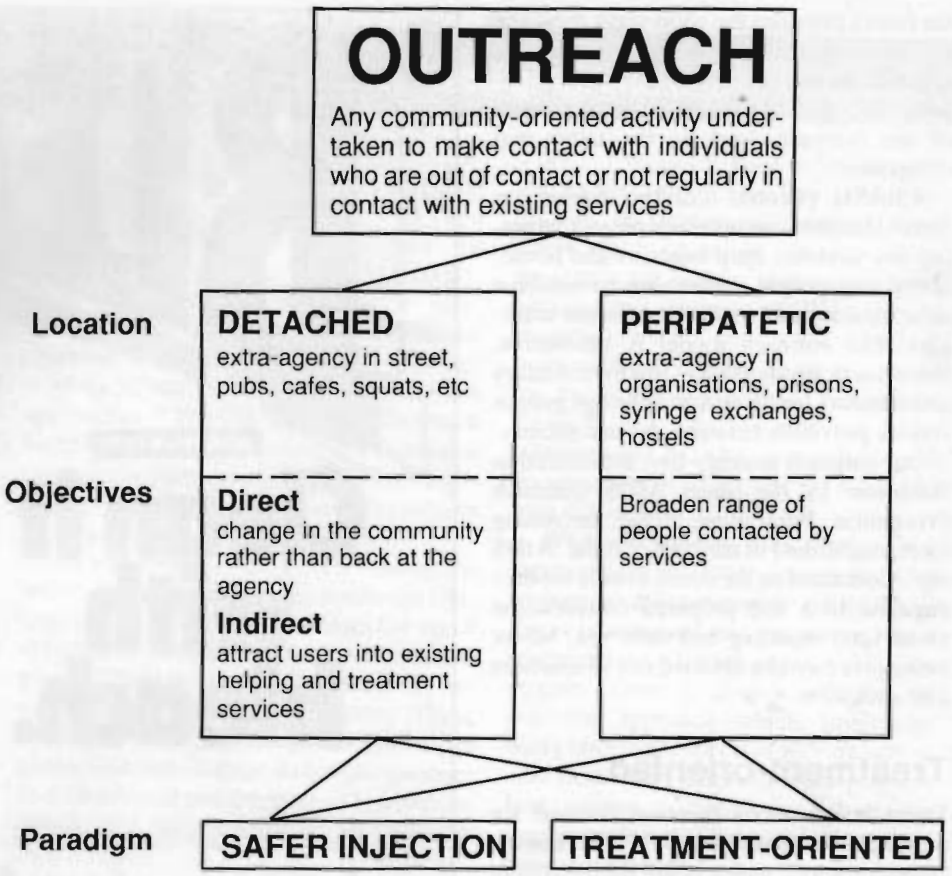
In some situations bleach and syringe exchange strategies have developed together. This combination can be advantageous for two reasons. First, whatever the availability of injecting equipment, sharing will inevitably occur – for example, with first-time injectors, when users are intoxicated, or in situations where sharing is both socially acceptable and desired.

Second, bleach use can readily be incorporated into normal injecting behaviour and is therefore a more achievable outreach objective than attendance at a syringe exchange: only a third of UK syringe exchange attenders make over five visits;[10] using a combined strategy, the Tacoma exchange in Washington managed to keep 90 per cent of its attenders injecting safely.[11]

Beyond syringe exchange

Other strategies have been developed, notably in Germany, Denmark, Norway and the Netherlands, in an attempt to complement syringe exchange programmes. Slot machines providing an assortment of needles and syringes have proved effective in offering anonymous and accessible 24-hour availability of injecting equipment in areas close to the drug scene, overcoming some of the major problems with strategies which rely exclusively on syringe exchanges.[12]

One of the oldest drug user self-help groups are the Junkiebonden in the Netherlands.[13] The group campaigns for modification of regional and national drug and policing policies. They helped set up the first syringe exchange in 1984 in Amsterdam as a hepatitis B preventive measure. Junkiebonden have more recently undertaken HIV education work with drug injectors, including outreach work, distributing condoms and syringes.



Red Thread is a similar self-help organisation for women working as prostitutes.[14] Other drug users' self-help groups are emerging as HIV prevention measures in other countries, such as the JES (Junkies, Ex-Users and Substies) in Germany.[15]

The smaller the gap between outreach strategies and helping services, the more likely those services will be used

But the network of syringe exchanges in the Netherlands is merely one component of a wider harm-minimisation programme. The 'methadone buses' are Amsterdam's lowest-threshold intervention and have been in operation since 1979. Staffed by medical personnel and outreach workers, they provide a comprehensive primary care service, including medical check-ups, methadone prescriptions and advice, in addition to HIV and drug specific assistance.

In contrast, in the UK and USA outreach forms a bridge between hard-to-reach populations and existing services, rather than providing a community-based primary health care service as in the Netherlands. This may in part explain why a greater proportion of Amsterdam's estimated drug users are in contact with helping services than in the UK or USA.[16]

The first mobile outreach unit in Britain was established in 1987 by Plymouth Health Authority.[17] Until recently withdrawn for lack of funding, the bus provided condoms, a syringe exchange, risk-reduction advice and medical referrals to women working as street prostitutes and to drug injectors. No general primary care services were provided. The outreach bus contacted around 50 of Plymouth's estimated 60-90 street prostitutes working the area, and many were regular contacts. The syringe exchange component was less successful in contacting drug injectors.

There are similar outreach units elsewhere in the UK, for example in Mersey,[18] and 'condom runs' by car into areas known for prostitution and drug use are also employed in Manchester and Edinburgh.

The Junkiebonden emerged from within the drug using community itself, a 'bottom-up' innovation. ADAPT (Association of Drug Abuse Prevention and Treatment), part of New York's AIDS Outreach Programme, also campaigns for drug users on policy issues, but developed as a 'top-down' intervention by health professionals and ex-drug users.[19,20,21]

ADAPT has considerable support from the public health sector, and is funded by the New York Department of Health. It combines safer injecting and treatment-oriented outreach objectives, but – unlike the Dutch intervention – aims to encourage individuals into treatment and helping services rather than to provide these services directly in the community.

There are four elements to ADAPT's intervention. Two programmes aim to encourage drug injectors into drug treatment services and HIV testing facilities. The third provides a long-term presence of outreach workers in established areas, and

the fourth provides the short-term presence of large numbers of outreach workers in specific locations; both these offer risk-reduction advice. ADAPT undertake much of the outreach work in the latter two components.

CLASH (Central London Action on Street Health) – an outreach project targeting sex workers, drug injectors and homeless young people – also aims to combine safer injecting and treatment-oriented strategies. The outreach model is innovative, since it was jointly established by voluntary and statutory health sectors to bridge gaps in service provision between the two sectors.

An outreach strategy first introduced in Baltimore by the Street AIDS Outreach Prevention Programme,[22] but becoming more established in the USA,[23] is the 'AIDS rap'. Contacted on the street, clients are then engaged in a set, prepared conversation about safer injecting and safer sex, before being given a more detailed risk assessment and advice.

Treatment-oriented

Street interventions increase demand for treatment-based services.[24,25,26] This knowledge, combined with a belief that treatment as such is an effective way of achieving risk-reduction, underlies treatment-oriented outreach strategies.

The best known example is the New Jersey Community AIDS Programme (NJCAP),[27] the first HIV outreach programme in the USA. Set up in 1985, NJCAP first focused on communicating safer injecting techniques through detached street work by former users. Demand from clients soon led to a change in strategy to facilitate their access into drug treatment agencies.

Charges for detoxification had been introduced in New Jersey as HIV had become prevalent. In response, NJCAP's outreach workers began to distribute coupons which could be exchanged for free detoxification at 25 treatment facilities. The 'coupon programme' met with considerable success: of 3000 coupons distributed initially, 68 per cent were redeemed (45 per cent of drug injectors using their coupons had no previous experience of treatment) and almost 30 per cent of the clients completed the free 21-day detoxification period.[28]

Since 1987, the New Jersey project has also operated a mobile outreach unit. Three vans provide primary care with particular emphasis on HIV, including on-site HIV antibody testing, though they do not offer prescription drugs. Preliminary data suggests the vans are effective in reaching drug injectors not previously contacted by the coupon programme.[29]

Following New Jersey's example, outreach buses were established in Tacoma, in addition to the syringe exchange. Coupons which allow low-cost enrolment on methadone maintenance or special 40-day detoxification programmes are distributed from the bus and by outreach workers. Tacoma's preliminary results are similar to those in New Jersey: nearly 75 per cent of the 218 coupons distributed have led to treatment admissions, 48 per cent enrolling on methadone programmes, and 44 per cent completing detoxification.[30]

San Francisco's anti-HIV superhero helped popularise bleach as a syringe hygiene method

One major problem for both the New Jersey and Tacoma treatment-oriented strategies has been the inability to expand the capacity of treatment programmes to meet client demand; long waiting lists remain a significant deterrent to treatment entry.

There are two established models of prison outreach in the USA, both in New York, where at least a fifth of inmates are HIV antibody positive and at least 30 per cent regularly injected drugs before imprisonment.[31] Both are based on a treatment-oriented approach.

Pre-KEEP was based on research showing that 80 per cent of prisoners arrested on drug use charges were not in treatment. The aims are to encourage prisoners into treatment and detoxification programmes, to prevent relapse on release, to reduce criminal recidivism while in treatment, and to initiate long-term planning for drug treatment initiatives.[32]

Pre-KEEP is unique in being long term and uninterrupted: a prisoner in treatment before incarceration can continue inside, and one who enters treatment in prison can continue after release. The programme also allows prisoners to be maintained on methadone.

ARRIVE is an HIV prevention training project for injecting drug users paroled from prison. It aims to prevent parolees from relapsing into injecting and other HIV transmission behaviours, and to encourage productive reintegration into the community.[33] Using social learning and community therapeutic techniques, the project trains parolees for outreach and peer education work in the HIV prevention field.

Lessons from abroad: innovate and evaluate

It is clear from this selective review that the need to reach hard-to-reach populations demands varied, flexible and responsive outreach programmes. Safer injecting and treatment-oriented strategies should be seen as complementary rather than contradictory, since both have been shown to reduce HIV transmission behaviour. Detached interventions have increased demand for treatment and helping services, for example in San Francisco[34] and New York.[35]

In this context, agencies may need to review their practice in relation to the development of rapid and informal service delivery and the location of services within easy reach of the targeted populations. From the perspective of the client, the smaller the physical and ideological gap between outreach strategies and helping services, the more likely it is that those services will be used. In the UK continued reliance on agency-based services rather than, for example, incorporation of primary health care into outreach, may limit the uptake of those services by hard-to-reach populations.

During its developmental stages, collaboration between outreach and research may be of particular value. The San Francisco bleach project was based on lengthy prior ethnographic research; Cal-PEP (Californian Prostitutes Education Project) was developed from a collaboration between the prostitutes' self-help group COYOTE (Call Off Your Old Tired Ethics) and AWARE (Association for Women's AIDS Research and Education).

Scot-PEP, the Scottish Prostitutes Education Project in Edinburgh, which began detached work with women and men sex workers in late 1989, is modelled on such approaches.[36] The Chicago AIDS Outreach Intervention Project[37] employs a combined community ethnography and epidemiological approach, originally designed to contain community outbreaks of heroin use.

As with other US projects favouring the 'outreach ethnographic' approach, the Chicago project effectively combines the use of indigenous outreach workers with ethnographic field workers who are both researchers and outreach educators. These combined strategies provide an immediate action research element which can produce both theoretical and practical insight into the design and implementation of outreach interventions.

Professionalisation can erect a barrier between the drug user and the service; outreach work is quintessentially about approaching users on home ground. Many US outreach teams employ indigenous workers (ex-drug users or users in treatment) instead of professional outreach workers.

Growing evidence from projects in New York,[38] Chicago,[39] Boston,[40] Denver,[41] and Baltimore[42] suggests that such workers are invaluable in communicating street health education messages. This strategy is not without problems,[43,44] but only a small minority of HIV outreach projects in the UK appear to use indigenous workers.[45] There is an argument, too, for resources to be made available to facilitate self help (as with the Junkiebonden and ADAPT) where particular communities of drug users are willing to take this route.

What we can learn from international experience is that interventions must be responsive to community needs, flexible, experimental and innovative when compared to existing service delivery models. There is also a need for an outreach approach which simultaneously targets all aspects of HIV transmission behaviour, since outreach projects face greater problems in influencing drug users' sexual behaviour than their injecting practices.

Rigorous monitoring and evaluation should be integrated into each programme from the outset. The increasing threat of HIV infection among hard-to-reach populations requires not only an innovative approach to health promotion but also re-evaluation of treatment strategies in the UK.

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The full report *Out of the agency and on to the streets: a review of HIV outreach intervention in the United Kingdom, United States and Netherlands* is available from the Drug Indicators Project, Birkbeck College, 16 Gower Street, London WC1E 6DP.