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FOCUS

A Guide to AIDS Research and Counseling

Harm Reduction in the Era of HIV

Edith Springer, ACSW

It's 9:00 A.M. on a blistering hot Saturday in Harlem. As you walk east on 126th Street toward Second Avenue, you see three big blue and white tents on the sidewalk next to a vacant lot. In the first tent, people drop off used syringes and receive new syringes, other injection paraphernalia, and safer sex materials. In the next tent, a support group of 12 people sit in a circle on folding chairs. In the last tent, while new age music wafts from a boom box, practitioners insert acupuncture needles in two individuals, while other individuals sit relaxed in their chairs, beatific expressions on their faces, and needles sticking out of their ears. On the sidewalk a few yards away, a counselor conducts a "sidewalk psychotherapy" session.

Men and women wearing ID badges greet each person who approaches the tents, smiling and chatting with them, escorting them to the appropriate service. A case manager sitting behind a card table gives a client a food pantry referral while another looks in a file to find a detox unit that does not require insurance.

A red van, parked across the street, performs HIV counseling and testing. At 2:00 P.M., after the last participant leaves, the workers close up and start to drive away. The last truck has driven half a block when a woman runs up shouting and wheeling a shopping cart with 10 full "sharps" containers. The driver, who knows her and that she had come from afar, stops the truck and workers unload the sharps containers, giving her replacements and 3,000 new syringes.

This was a typical Saturday at New York Harm Reduction Educators, one of the largest harm reduction programs in New York, unique in its streetside service delivery model, which complements services reaching 15,000 people a year at three

offices in the Bronx and Harlem. Why do 15,000 marginalized people—drug users, parolees, sex workers, transgendered people, homeless people, mentally ill people—come to this program?

They come because the tents and offices are in their neighborhoods. They come because compassionate staff from the same communities and with similar histories treat them with dignity and respect. They come because all services are free and require no identification documents to access. They come because services are "user-friendly," culturally appropriate, informal, and geared toward users' comfort. They come because no one tells them what to do or to be any one other than who they are.

Where Did Harm Reduction Come From?

Harm reduction theory—the guiding premise of these services—was born in the early 1980s in Rotterdam. While syringes could be legally purchased in pharmacies in the Netherlands at the time, a large chain of pharmacies banned syringe sales to injectors of illegal drugs. This created a shortage that resulted in syringe sharing. Within months of the ban, rates of hepatitis B rose. In response, Dutch drug injectors formed unions ("junkiebonden"), which petitioned the health authority for syringes. The health authority, using a public health model rather than a moral or criminal model, agreed with the junkie unions: why should people get preventable diseases that harm the populace and cost the national health service money? Syringe exchange, whereby people traded sterile syringes and injection equipment for used equipment, became the first harm reduction measure.

Soon after, HIV exploded, and most European countries adopted syringe exchange. Meanwhile, the United States government sustained laws making syringe exchange illegal and stymying early harm reduction activities. Organizations, nonetheless, established illegal exchange to prevent HIV transmission in vulnerable populations.

Editorial: Society's Addiction

Robert Marks, Editor

Harm reduction is not new, but its tenets are more relevant than ever. In this issue of *FOCUS*, Edith Springer reviews those tenets, making it clear that many of the principles of harm reduction are native to the client-centered approach that many mental health practitioners already employ. Susan Kingston and Miles Conrad apply these tenets to the growing epidemic of methamphetamine use. The result is a primer that can inform a range of HIV programs.

Ironically, the most effective HIV-related harm reduction approach—needle exchange—remains illegal or underfunded throughout most of the United States, even though dozens of studies not only have proved it effective in reducing HIV transmission and increasing drug treatment referral, but also have demonstrated its broad acceptability to injection drug users. Few studies have shown otherwise.

The consequence of banning needle exchange is that the economic and social harm to society

is immeasurably increased. (Still, in 1997, researchers did try to quantify this harm. They found that had needle exchange been instituted between 1987 and 1997, it would have prevented more than 10,000 cases of HIV and saved more than \$500 million in treatment costs.)

I started to wonder what does society get out of outlawing needle exchange? For that matter, what does it achieve by outlawing drugs? I don't know enough about the issues involved to advocate complete legalization. But Californians have found an alternative to punitive and ineffective measures. Proposition 36, approved by the voters in 2000, offers drug treatment rather than jail to first- and second-time, non-violent, "simple drug possession offenders." In this way, the law injects harm reduction—both for society and for individuals—into an area normally dominated by efforts to punish users and failed attempts to "absolutely" protect society.

U.S. society is like me. I don't

use substances in order to solve my problems, but I, like many of us, have used other psychological methods—to diminish pain. If only society recognized the ways in which its own "lifestyle"—consisting of untreated mental illness and underfunded mental health care, unmitigated poverty, institutionalized racism, and band-aid approaches to childhood sexual abuse—leads to dysfunction, it might begin to recognize how this lifestyle induces drug use. In response, it might address the source of drug use and not make half-hearted attempts to insulate itself from the effects of addiction.

What if we used harm reduction to treat society's denial? If we asked "society" to talk about what it truly wanted to achieve through its governmental policies, it might occur to our "client" that the approaches that might serve the goals of prosperity, quality of life, safety, and health would be those that focus on reaching people at the place they are most amenable to help. It might occur to society that approaches like Proposition 36 might eventually lead not only toward achieving an individual citizen's goals but also society's.

As harm reduction moved through different countries, each culture interpreted it a bit differently. The model is flexible, portable, and adaptable. Like the Twelve Step Fellowship, it is a "bottom-up" model created by people struggling to find a solution to a problem.

Although harm reduction is associated with drug use and HIV, it can be used with any issue, any service, and any population. Harm reduction can be applied to case management, to medical care, to psychotherapy. Most broadly, harm reduction seeks to reduce the harmful consequences of any behavior or condition as these range on a continuum from most to least harmful. It is the opposite of "all or nothing" intervention in that people can almost always find a way to reduce risk and harm, even when they cannot, or do not wish to, eliminate them.

Key Harm Reduction Tenets

There are eight key tenets of harm

reduction. While harm reduction agencies practice all of them, many traditional agencies are already practicing some of them as part of their philosophies of service delivery. Many agencies strive to make their services accessible to clients, providing transportation and child care; others have no fees for service; and still others try to follow social work's guideline of "meeting people where they are." Just as harm reduction envisions the process of reducing harm on a continuum, harm reduction practice itself can be viewed as a continuum with some agencies implementing more or fewer of the key tenets. As the Twelve Step Fellowship says, "Take what you can use, and leave the rest behind."

The first tenet is that harm reduction is client-centered and user-friendly, in order to maximize the convenience, comfort, and support of the participant, not of the provider. Service delivery is hampered by barriers such as identification require-

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Unlike traditional services, harm reduction focuses on process, leaving outcomes to clients, the only ones who can control them.

ments, appointment-only systems, intrusive intake questionnaires, drug-free requirements, and fees for service.

Second, participants are treated with kindness, respect, and dignity, like “normal” people. They are not pathologized or labeled. The people served by harm reduction programs are often trauma survivors or people stigmatized by society. Rude and uncaring treatment sustains this trauma and pain and leads people to avoid seeking help.

Third, unlike traditional service delivery, which focuses on outcomes, harm reduction focuses on process; leaving outcomes to clients, the only ones who can control them. Workers in many traditional agencies assess a client’s problems and respond with pre-delineated actions to achieve pre-determined outcomes. No matter how well-intentioned the effort, pushing people toward worker-defined outcomes is ineffective.

Harm reduction workers follow a process of identifying client-defined outcomes: creating contact with target populations through outreach, incentives, and appropriate services; building relationships; defining and prioritizing issues to be addressed; exploring choices for dealing with these issues; and supporting clients through the process of self-determined action plans and interventions. Harm reduction emphasizes the creation of a therapeutic alliance between the worker and the participant, a true partnership that is the foundation for the work that follows. Participants, themselves, decide when they have reached their goals.

Fourth, harm reduction conceives of change as slow and incremental—not rapid and linear—often punctuated with starts, stops, and backward movement. A person is most likely to be successful with change if he or she starts with the smallest “baby step.” Abstinence drug treatment may have low success rates because it seeks to achieve change all at once, an approach that is ultimately unrealistic, even absurd. The Stages of Change Transtheoretical Model informs harm reduction by delineating a five stage process that can be used to design interventions and to assess people’s readiness to take on an action toward behavior change.¹ Motivational interviewing, a directive counseling model geared to behavior change, is frequently used to help participants move through these stages of change.²

Fifth, harm reduction recognizes that each person is unique and that “cookie-cutter” and “one size fits all” approaches do not work to meet unique needs. In response, harm reduction seeks to provide the greatest number of choices to participants. For every issue that may affect a client, workers research a range of choices for problem solving, resource provision, or intervention, and explain these choices to participants.

Choices may be non-traditional, such as acupuncture detoxification supplemented with herbs, dietary changes, or counseling; or traditional, such as twelve-step self-help groups or in-hospital detoxification followed by “rehab.” They may seek to move clients from chaotic drug use to stable drug use (drug use management programs); enable them to gradually cut down drug use (slow reduction courses); or help them to get off drugs entirely (slow reduction to abstinence or traditional treatment options, including methadone maintenance). It is up to clients to choose what they think will work best for them. At the same time, it is up to harm reduction providers to help participants understand their choices and the factors that might influence decisions.

Sixth, harm reduction meets people where they are, in particular, lowering the threshold of service to reach the largest number of people. High threshold interventions requiring identification documents, complex intake processes, repeated follow-up, planned appointments, or fees for service or insurance coverage will work for some clients, but may discourage many others. Clients refer to these unwanted requirements as “jumping through hoops” to get services.

For example, New York Harm Reduction Educators provides a range of thresholds through four different models of case management. At the lowest threshold, 1-800-Get Connected enables clients to reach a case manager for help with crises, referrals, or three-way conference calls with other agencies. It requires little follow-up or even physical presence. There are three case management approaches with incrementally higher thresholds for participants who want and can manage appointments and can sustain follow-up. Clients can work incrementally toward higher levels of commitment and follow-up, but they have to begin with a model that is comfortable for them, and many would not seek services at all if the lowest threshold models were not available.

Seventh, harm reduction workers present themselves to clients as “consultants,” not authorities, controllers, or parents. The worker’s job is to help his or her clients

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determine what concerns they want to work on and what actions they want to take, and then to support clients through whatever process they select, advocating for them when necessary. Workers seek to avoid infantilizing or disempowering clients by telling them what they should do. Outcome-oriented alternatives to harm reduction may successfully “fix” one “problem,” but they may fail to help clients develop self-efficacy and skills. Process-oriented interventions seek to prepare clients to live in the real world and teach them how to resolve their own problems in the future.

Eighth, a key task for harm reduction is to fight the effects of stigma. Stigma internalizes negative feelings that make it difficult for people to take care of their health and the health of their communities. People who differ from the controlling class’s view of “normal” are marked as “deviant,” a label that encourages other people to mistreat them. Such negative labels make people feel undesirable, “spoil their identity,”³ and create self-fulfilling prophecies. For example, New York psychotherapist Michael Shernoff uses harm reduction approaches to help men who have sex with men recognize that internalized homophobia may, in part, be driving their desire to have unsafe sex.⁴

In this way, harm reduction fits nicely into the context of psychotherapeutic treatment: a safe environment free of judgment that leads clients to explore the meaning of sexual behaviors and encourages them to decide for themselves what level of risk is comfortable. By letting clients know they have choices and can make their own decisions, treatment empowers them and avoids engaging resistance.

Thinking “Out of the Box”

Harm reduction practitioners have discovered that much of the traditional wisdom about drug users and other marginalized people is untrue. For example, traditional standards of practice assert that active drug

users cannot benefit from psychological interventions, especially psychotherapy, and cannot hold jobs. For this reason, many programs require drug users to become drug-free before they can access therapy, participate in groups, or become employed. San Francisco therapists Patt Denning and Jeanie Little suggest the opposite: psychotherapy can provide an alternative to drug treatment in addressing drug-related problems, particularly when drug use is a way of coping with past trauma or mental illness.⁵

Denning explains that drug users are people with problems and that the problems need to be addressed as they would be with any client. She states: “People can and do make changes in their lives while still using drugs or alcohol, and they do participate in treatment if they are allowed to lead the way.”⁵ Denning believes that drug users are not in denial; they have difficulty admitting that they have problems because they are under constant criticism for using drugs. Further, she applies motivational interviewing techniques to stabilize motivation, and she refuses to stigmatize drug-using clients as uncooperative.

Most harm reduction programs run vocational training programs that prepare clients to work in the agency. Rather than being the last step in the process of recovery, as traditional models posit, employment is often the first step for drug users in developing new lives, and the 1997 National Household Survey on Drug Abuse found that 70 percent of people who had used drugs in the prior month said they had full-time jobs.⁶

Finally, harm reduction serves providers as well as clients. Harm reduction can be adapted to almost any service or intervention, and applied to almost any population. By dropping “all-or-nothing” outcome-oriented approaches, which hold workers responsible for client actions over which they have no control, harm reduction offers providers achievable goals that enable them to feel far more successful in their work.

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Clearinghouse: Harm Reduction

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Harm Reduction for Methamphetamine Users

Susan Kingston and Miles Conrad

Current literature provides ample information linking methamphetamine use with HIV transmission, particularly among men who have sex with men and injection drug users. Studies have documented alarming rates of unprotected sex, increased numbers of sexual partners, and high prevalence of HIV and other sexually transmitted diseases among methamphetamine users.¹⁻⁴ Harm reduction counseling can fill a critical gap to address the health needs of users who may not be reached by other responses such as drug treatment or substance use prevention.

Characteristics of Methamphetamine

The pharmacology, behavioral norms, and neurological impact of methamphetamine use present unique challenges to harm reduction approaches. A typical methamphetamine high lasts eight to twelve hours (a cocaine high lasts only 15 to 30 minutes) and often stretches into a longer “run” during which a user maintains a high, usually without sleep, for days or even weeks. Several days of exhaustion, sleep, and acute depression, known as the “crash,” follow the high. During these extended ups and downs, methamphetamine users may be too distracted, exhausted, or secluded to engage in clinical interventions.

Additionally, the paranoia or psychosis that can result from chronic use or sleep deprivation often keeps users away from services such as needle exchange, drug treatment, and health clinics, all traditional engagement points for users of other drugs. Cognitive

impairment as a result of chronic drug use, concurrent mood or hyperactivity disorders, and compulsive sexual behavior are typical and add to the complexity of counseling methamphetamine users.

While the philosophy and objective of harm reduction—the support of positive, incremental change towards client-defined goals—do not differ depending on the drug of choice, the implementation of harm reduction does. Applying the harm reduction mantra “meeting users where they are at” can be difficult with methamphetamine users, whose exact “at” points are either hidden beneath layers of distrust or are constantly shifting in waves of drug-induced impulsivity. This article discusses how service delivery and counseling might be structured to further harm reduction goals for people who use methamphetamine.

Methamphetamine use impairs attention span, memory acuity, impulse control, learning function, and abstract thinking. This diminishes users’ abilities to process or recall information and to conduct abstract cognitive functions such as perceiving risk and consequences, making decisions, and prioritizing actions. To accommodate these deficits and enhance client engagement and retention, implementing service elements such as telephone reminders, flexible “no-show” policies, and access to multiple services in one visit or location can be useful.

Mornings, Mondays, and Fridays (when users are often high or crashing) tend to be poor times for service utilization. Evenings and mid-week days work better. Drop-in hours rather than strict appointment schedules, very brief (or no) intake forms, and shortened waiting times better serve these clients, who tend to react spontaneously to their own needs and have diminished tolerance for stress and frustration.

Addressing Harms of Methamphetamine

Given the nature of methamphetamine use, there are three key harms that might

The most basic harm reduction message for meth users is to eat, drink, and sleep.

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be minimized through counseling. To compensate for client impulsivity and impaired judgment, counselors should help clients develop personalized plans to avoid harm and maintain safety *before* getting high.

The most basic harm reduction message for users addresses essential human needs: eat, drink water and sleep. Meeting these needs will help the body withstand highs, ease crashes, and delay the onset of paranoia—all effective “selling points” for users.

Sexual activity is a second focal point. Methamphetamine can be a powerful sexual stimulant for both men and women, resulting in longer-lasting, more frequent, and more compulsive sex than that observed among other drug users. Sexual activity may also diverge from core sexual identity, for example, allowing straight-identified men to have sex with other men. Not all users, however, are conflicted by this behavior-identity discordance, claiming rather that “On meth, I’m just sexual.” Counselors should avoid interpreting this behavior as orientation confusion; instead, they should assist clients in reducing undesirable consequences such as the HIV and sexually transmitted disease transmission, pregnancy, or involvement with abusive partners. Again, counselors should encourage clients to think through sexual decisions and make sexual safety plans *before* getting high.

Lastly, commonly shared beliefs among users can contribute to risk taking and harm. Many methamphetamine users consider their drug to be more “functional” than heroin or cocaine. Methamphetamine users see themselves as “getting things done,” including purposeful activities such as sex, work, or home maintenance. They see heroin or cocaine users as spending their highs nodding off or looking for more drugs. This belief in methamphetamine’s “benefit” can nurture feelings of invulnerability to negative consequences. In addition, methamphetamine users see the drug as representing excitement, personal power, escape from restrictive norms, and a desirable risk.

These beliefs may interfere with perception and appreciation of harm. At the same time, however, they offer harm reduction providers effective “leverage points.” Counselors may encourage clients to make positive behavior changes in order to sustain their “high” activities. For example, a male client may cut down on escalating drug use if he is concerned that drug-induced impotence will interfere with desirable sexual activity. Sensation-seeking clients may be more open to discussing “harmful” behaviors if counseling affirms this aspect of their

personality and allows them to define “risk” or negative consequences for themselves.

Dealing with Paranoia

Perhaps the greatest challenge when providing services to methamphetamine users is overcoming distrust and paranoia. Providers may experience difficulty developing rapport with clients. Demonstrating an understanding of methamphetamine vocabulary and use practices, and showing patience with impulsive, unfocused, and suspicious behaviors can help demonstrate provider knowledge and acceptance.

Trying to convince clients what is real and what is not is rarely successful and almost always frustrating. Instead, counselors should help clients recognize patterns of paranoia and identify ways to reduce anxiety and harmful outcomes of paranoid behavior such as arrest, violence, or self-injury. An effective counseling probe might be, “I don’t see people following you, so tell me when they appear and leave. How does it change when you are high or crashing? What helps you feel safer?” This approach validates clients’ emotional experiences without necessarily “buying into” their delusions.

Counselors can also structure counseling settings to minimize paranoia, for example, by facing clients away from doors or windows, closing window curtains, dimming bright lights, and avoiding sitting behind desks. Some clients may be suspicious of note taking or other clinical documentation. Ask clients at the outset if they feel comfortable and make appropriate accommodations.

Conclusion

As the epidemic of methamphetamine use continues, counselors are likely to encounter more clients who are using. Despite the challenges of working with these clients, there is an opportunity for behavior change success, particularly when harm reduction approaches are tailored to meet the unique needs of clients.

Comments and Submissions

We invite readers to send letters responding to articles published in *FOCUS* or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals. Send correspondence to rmarks@itsa.ucsf.edu or to Editor, *FOCUS*, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.

Recent Reports

Harm Reduction for Injection Drug Users

Hilton BA, Thompson R, Moore-Dempsey L, et al. Harm reduction theories and strategies for control of human immunodeficiency virus: A review of the literature. *Journal of Advanced Nursing*. 2001; 33(3): 357–370. (University of British Columbia.)

Key harm reduction strategies include methadone maintenance, dispensing of illegal drugs, and needle exchange programs, according to a review of the literature exploring approaches to reduce the negative consequences of injection drug use. Other harm reduction methods include: HIV testing, vein maintenance, and safe sex and wound care programs.

Methadone maintenance programs, first introduced in North America in the 1950s, aim to reduce the negative consequences of heroin addiction by treating patients with a synthetic opiate that has properties similar to heroin and morphine. According to studies, methadone users commit fewer crimes than heroin addicts and are less likely to contract HIV or hepatitis. Despite this success, methadone may be unappealing to some clients, since it does not always produce the same “high” as heroin. Furthermore, methadone may be a less successful option for people such as teenagers and sex workers at highest risk for HIV.

Harm reduction initiatives in Switzerland have experimented with programs dispensing heroin and other illegal drugs in conjunction with social services such as housing and employment case management. These programs seek to provide a safer alternative to potentially lethal street heroin. The experiment resulted in improved health among participants along with decreased criminal activity and rates of HIV infection. A similar strategy, which reduced incidence of HIV infection and drug overdose, designated “tolerance areas,” safe zones where injection drug users can congregate, receive clean equipment, and inject.

Other projects have experimented with offering non-injected forms of substances such as heroin via aerosols and cigarettes. To supplement its methadone maintenance

program for heroin users, a British program offered oral amphetamines to amphetamine injectors and had overwhelmingly positive results: after three years, more than half of the users had stopped injecting, and 85 percent had not used or shared injecting equipment during the program.

Finally, needle exchange programs provide sterile injection equipment and function as a gateway to other resources such as medical care and housing that clients

may otherwise not access. Furthermore, the use of fine pore filters in syringes has been proven effective in decreasing bacterial infections associated with injection drug use. Limiting the number of needles that can be exchanged per visit reduces the availability of clean needles that exchangers might distribute to other users who do not access the program. Australia and Europe have

recently introduced the first 24-hour automated needle dispensing machines to increase availability.

Efficacy of Needle Exchange Programs

Ksobiech K. A meta-analysis of needle sharing, lending, and borrowing behaviors of needle exchange program attenders. *AIDS Education and Prevention*. 2003; 15(3): 257–268. (Medical College of Wisconsin.)

Needle exchange programs are effective in reducing risky needle-sharing behaviors among injection drug users, according to a comprehensive literature review and meta-analysis.

Researchers reviewed the findings of 47 studies, published between 1988 and 2001, identifying effects that were present in a sufficient number of studies to be included in a quantitative, statistical analysis across studies. Fifty-three percent of studies were longitudinal, comparing needle sharing behaviors over time, while 36 percent were cross-sectional, comparing participants' behavior with other injection drug users' behavior. An additional three studies (6 percent) compared the behavior of participants who exchange frequently with those who exchange infrequently. One study compared stationary needle exchange programs with mobile sites.

Harm reduction addresses multiple aspects of a person's life, rather than simply focusing on substance use.

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Participation in needle exchange was associated with lower levels of needle-sharing behaviors that might lead to HIV transmission. Nation of origin, sample size, type of study (longitudinal versus cross-sectional), length of study, and year of publication did not diminish the significance of this correlation.

Needle risk behaviors fell into three categories—needle sharing, needle borrowing, and needle lending—although these categories are not universally applied or similarly defined by all the studies. When broken down into three separate meta-analyses, however, each of these behaviors either decreased over time (in the longitudinal studies) or was present in lower levels among needle exchange program participants than among other subjects.

Harm Reduction Therapy

Marlatt GA, Blume AW, Parks GA. Integrating harm reduction therapy and traditional substance abuse treatment. *Journal of Psychoactive Drugs*. 2001; 33(1): 13–21. (University of Washington, Seattle.)

Abstinence prerequisites and other barriers of traditional substance abuse treatment fail to accommodate a significant segment of the injection drug user population, according to a review of eight harm reduction therapy principles. Alternately, harm reduction seeks to reduce the negative health and social consequences associated with substance abuse irrespective of the client's motivation toward abstinence.

Unlike traditional treatment programs, which view substance use as a societal evil, harm reduction views substance use as a public health issue. Harm reduction therapy avoids stigmatic labels, refrains from making presumptions or judgments about what constitutes appropriate substance use, and does not operate on the precept that abstinence is the only option for substance users. Instead, therapy focuses on the client's goals which may or may not include abstinence. While harm reduction does consider abstinence to be an ultimate goal on the continuum of progress, it actively encourages it only for clients who express motivation and readiness for such a goal.

Harm reduction seeks to deliver services in a non-judgmental manner with respect for diversity among clients. Staff members should be culturally educated about issues regarding race, gender, and sexual orientation. They must also be aware of how these cultural factors may affect clients' experiences with substances and perspectives toward treatment.

Harm reduction therapy also focuses on peer users support and input, as opposed

to the "top-down" approach characteristic of most traditional treatment programs. Drug users are most aware of their needs and of resources that would be most beneficial to themselves and their peers.

Harm reduction therapy further differs from traditional programs based on perspectives on relapse. Relapse is traditionally linked with a sense of failure, which discourages clients and undermines their sense of determination and progress. Harm reduction therapy views setbacks as a natural component of the recovery process. Rather than developing a program for relapse prevention, harm reduction therapy focuses on relapse management.

Harm reduction therapy seeks to address multiple aspects of a person's life, rather than simply focusing on substance use. Because so many other factors interact with a person's substance use, it is important to use a more comprehensive approach, addressing issues related to areas such as health care, housing, and employment. Through networking with community resources, harm reduction therapy can employ a more thorough approach than is typically used in traditional treatment.

Next Month

There is an elephant in the room in the Black community, according to **Robert Fullilove, EdD**. It is the widespread belief that the HIV epidemic represents a conspiracy to rid the world of Africans and African Americans. In the February issue of *FOCUS*, Dr. Fullilove, Associate Dean for Minority Affairs at the Columbia University School of Public Health, further asserts that Black communities are hindered in their practical responses to the prevention and treatment of HIV by a preoccupation with theories about the origins of the epidemic. He offers insights into ways AIDS agencies can gauge the extent to which conspiracy theories influence client populations and can develop programs that reach individuals who might otherwise avoid services.

Also in the February issue, **Eve D. Mokotoff, MPH**, HIV/AIDS Epidemiology Manager and **Loretta Davis-Satterla, MSA**, Director, Division of HIV/AIDS-STD, both at the Michigan Department of Community Health, discuss recent data about increased risk to female partners of behaviorally bisexual African American and Latino men.

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