

Year 12\_nº 31\_Jan/Dec 18

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**Theme:** Mental Healthcare: Benefits of Addiction Treatment for Individuals, Communities and Governments

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**Susana Henriques**  
Professor at CIES - IUL Centro de Investigação e Estudos de Sociologia-ISCTE-IUL (Portugal)



**Natalie Broughton**  
Master Student at Liverpool John Moores University (United Kingdom)

## Substance and non-substance addictions: rethinking prevention



What are we talking about when we speak of substance and non-substance addictions? Why is prevention important to society? What are the impacts of prevention on general health? These questions were the guidelines for structuring this paper, in which the conceptualization of prevention and prevention practices are systematically discussed. Furthermore, some emerging challenges in the development of preventive strategies are raised. The present paper starts with a theoretical debate, supported with empirical evidence and literature. This aims to highlight the complexity of preventive strategies in today's society, is sustained of "...the importance of the involvement of individuals as agents of the construction of (and reflection on) contexts of action" (Abrantes, Henriques, Pereira and Veloso, 2014:2).

### Substance and non-substance addictions

In the understanding of addictions as compulsive behaviours, addiction has traditionally been associated with the use of psychoactive substances. However, in recent years, challenges have emerged which have made it necessary to broaden this approach and the subsequent responses. This led to the adoption of the term 'Addictive Behaviours and Dependencies' (SICAD, 2013). Public policies have reflected this trend, with the introduction of the National Plan for Reducing Addictive Behaviours and Dependencies 2013-2020 (SICAD, 2013) and the Guidelines for Health Education (Pereira and Cunha, 2017). In these guidelines, Addictive Behaviours and Dependencies are defined as "...«addiction processes»... impulsively and compulsively characteristic behaviour in relation to different activities or actions" (Pereira and Cunha, 2017: 58).

Psychoactive substances, either naturally or synthetically occurring, are those which change the functioning of the central nervous system when consumed. It can be legal or illegal to consume, grow or manufacture psychoactive substances, depending on the national legal framework and international conventions. "Addiction... is the repeated behaviour which produces

pleasure and relieves tension, especially in the early stages, can lead to a loss of control, severely disturbing daily life, family, work and social routines, which can exacerbate over time and lead to an addiction" (Pereira and Cunha, 2017: 70). This repeated behaviour may or may not be motivated by a substance, as in the case of gambling or technology dependencies.

Gambling-related issues may arise from gambling itself, which involves betting systems and financial risk, or from gaming, which involves interactivity with others and indicators of success and game progression (Vilar, Duran and Torrado, 2017; Clark, 2014). Problems associated with technology dependence involve the abusive or uncontrolled use of digital platforms and networks, such as social networks and online games.

### Importance of prevention in society and its health impacts

Traditionally, prevention relied predominantly on the distribution of information leaflets and on the promotion of play activities. Aimed mostly at young people, such preventive actions aimed to increase the individual's level of information and occupation. Although there is no general evaluation for the efficacy of these strategies, it can be argued that they had little impact (if any) in changing behaviours and attitudes of the target group (UNODC, 2015; EMCDDA, 2011). Thus, the relationship between the cost of such strategies and their benefits and outcomes must be questioned.

In recent years the concept of prevention has evolved; it is now understood as a complex process which is established as part of the educational mission, and is present in areas such as the development of critical thinking, and in preparation of the conscious, autonomous and ethical decision-making process. In order to improve the quality of preventive actions, but also to demonstrate the social and economic impact of such strategic, holistic and integrated approaches, recent decades have seen the development of the science of prevention.



According to Spoth et al. (2006), for each 1 spent on prevention, approximately 10 will be saved from the health, social and criminal burden of addiction. The World Health Organization estimates that non-communicable diseases now account for around 60% of all deaths worldwide. These are deaths that are not due to bacterial or viral infections, or to parasitic diseases; rather, these are deaths resulting from lifestyle decisions (WHO, 2018).

This growing recognition of the health implications of lifestyle choices is the basis, both of and for, public health and welfare policies. Improvements in health not only have direct impacts on wellbeing, but also on the growth of income levels, and consequently on investment in education, training and productivity. As such, the importance of introducing and sustaining science-based prevention interventions is paramount.

A healthy and safe population carries the improvement of their lifestyles. This is the field of science-based prevention, as part of a broader effort to ensure the necessary conditions for the development of those who are less vulnerable and more resilient, acting for the social empowerment of individuals and groups.

### Challenges of prevention

The work of evidence-based prevention allows strategies to be developed which are appropriate for the particular vulnerabilities of the target group. This adaptation takes place on two levels: the first is related to the scope of the intervention, and the other is related to the context. In terms of the scope, prevention can be directed at society as a whole (environmental or universal prevention); directed at vulnerable groups at greater risk of developing problems related to addictive behaviours (selective prevention); or it can focus on interventions directed at individuals at risk (indicated prevention). The contexts of interventions are diverse, ranging from families,

schools and communities to workplaces, nightlife settings, and the media.

In each preventive intervention, there are specific issues and challenges relating to the characteristics of the group and the context, but also in relation to the strategies that are used and their scientific support, both theoretical and methodological.

Effective evidence-based interventions should identify and implement policies and practices which are adapted to the needs of targeted individuals, as well as monitor the quality of the intervention and the outcomes for the participants.

In this scenario of increasing complexity and demand, professionals and decision-makers in the field of prevention need specialised training that allows them to develop evidence-based prevention strategies adapted to different groups and their contexts. Such is the case of training programmes based on the Universal Prevention Curriculum (UPC) and the adapted version to the European context (EUPC).

Information regarding the required skills and responsibilities of prevention professionals is recent and somewhat limited, which has led to poorly-defined and inconsistent descriptions of such expert job roles (Gabrhelik, et al., 2015). The term 'prevention professionals' generally applies to professionals who are responsible for the planning, implementation, and monitoring of prevention interventions and/or policies within a defined geographical area. These individuals may supervise other prevention workers who help to deliver or monitor prevention interventions.

In this context, some of the fundamental skills required for professionals are: i) general, personal and social skills, such as communication and interaction; ii) intervention skills, such as preventive strategies, personal and social development, decision-making processes, and project management (including monitoring and evaluation procedures); iii) multi-disciplinary skills necessary for adapting preventive strategies to the needs of targeted individuals and contexts, including diversity sensitivity (cultural, gender and other diversities). ●●●



Of the competencies presented above, those related to the monitoring and evaluation of preventive interventions are especially important. This is because they are the most directly related to the production of results and scientific evidence, which sustain the balance between the initial design of the intervention and its adaptation. Evaluation is a form of research which allows the short-, medium- and long-term outcomes of prevention to be systematically analysed, in addition to the factors related to these outcomes. "To evaluate is to value and judge rigorously, logically and coherently the state, evolution and effects of problems, actions, devices and organizations upon which we are intervening" (Guerra, 2007: 206). Ideally, all stages of the preventive intervention should be evaluated (i.e. the planning, development, implementation and follow-up), allowing information to be gathered to improve the intervention and its quality.

More specifically, monitoring and evaluation allows: the measurement of results and impact; verification of which segments of the population responded best to the intervention; comparison

of costs and benefits; and comparison of the effectiveness between interventions. As evaluation should be based on research, in this paper we stand for several forms of knowledge production – knowledge for action and knowledge in action, in the expression of Guerra (2007). This means that it is necessary to diversify methodologies and approaches in order to evaluate preventive interventions.

This diversity implies not only collating results from several sources, but also the mobilization of less common methodologies which can prove to be very effective in uncovering information that is difficult to access through more traditional methods. The case of visual methods can be used as an example (Henriques and Candeias, 2013).

Here, it is important to mention an additional challenge faced by prevention and prevention professionals at the present moment: the scientific dissemination of results and the knowledge produced. This challenge is particularly pertinent to the Portuguese reality and language, because there are very few publications in this academic field. ●



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**Trevor Hallewell**

Program Manager, WHOS, and President at Queensland Network of Alcohol and other Drugs Agencies (Australia)

## The Harm Reduction Journey of an Australian Therapeutic Community Organisation

WHOS® (We Help Ourselves) was established 1972 in Sydney, Australia. We have been offering help and support to people with substance use and alcohol problems continuously for over 45 years. Our services are based on the Therapeutic Community (TC) model of care. The service was originally set up and run by ex-users, self funded by people seeking help with their substance use issues. The name We Help Ourselves reflects the self help nature of our programs.

Today WHOS operates with a main campus in Sydney, which houses a Men's program and a Women's program both functioning as abstinence based TCs. We also have the OSTAR (Opioid Substitution To Abstinence Residential) program, where the objective is to provide a modified TC approach, for clients wanting to adopt a lifestyle free from Opioid Substitution dependence. At this site WHOS also runs a modified TC for people on Opioid Substitution Treatment, who want help in stabilising their lifestyle but continue with their OST program. We also run two 26 bed mixed gender programs in regional Australia, one in the Hunter region of New South Wales and the other in the Sunshine Coast region of South East Queensland. Both of these programs provide abstinence based treatment as Therapeutic Communities.

We Help Ourselves has always had a strong focus on abstinence models of treatment. In 1986 it was recognised that many of our clients would not achieve or maintain abstinence post discharge. HIV/AIDS forced us to understand that abstinence and harm reduction are not polar opposites: abstinence is part of harm reduction. It took the terrible HIV/AIDS epidemic to reaffirm to us that our clients don't get better according to the practitioner's timetable. The reality is that relapse happens. It's our responsibility to give them a safe environment to recover in, and the information and a safer means to protect themselves, other users, their partners, and the wider community.

"Are we here to help the drug-dependent or only those who do it our way?" - Executive Director, WHOS, 2005 (Ref: 1) to help our clients protect themselves, including providing access to condoms and sterile needles and syringes. We initially referred to these changes as "common sense", but later found that others called it "harm reduction". Numerous abstinence focused drug treatment centres around the world did not provide the information or the means for drug users to avoid Blood Borne Virus (BBV) and Sexually Transmitted Infections (STI) or drug overdose, in particular during their stay in treatment.

WHOS staff worried that providing condoms and injecting equipment might send conflicting signals to clients. Some clients indeed said they were confused: sex and drug use within the program were not permitted, but condoms and syringes were available. Therefore it was explained that while there were

program guidelines, not everyone followed them all the time. WHOS' position was that if clients did break program guidelines we hope it was done as safely as possible. WHOS wanted the clients to be prepared, to avoid HIV and other infectious diseases. Abstaining from sex and injecting drug use despite the availability of condoms and syringes became a lesson for clients in coping with risky relapse situations. WHOS did not experience a drop in admissions after it introduced harm reduction; rather, as word spread, more Intravenous Drug Users sought treatment at WHOS for ensuring the health and safety of clients.

In 2018, and over 30 years on, WHOS harm reduction strategies are well embedded into its 7 programs across NSW and QLD. Each service has dedicated Harm Reduction Workers who facilitate the education program to the clients. Education groups are provided on BBV, STI's Overdose Prevention/CPR/administration of Naloxone, Infection Control, Safer Sex and Relapse Prevention. Harm Reduction Workers are overseen by the WHOS Nurse Manager who ensures workers skills are updated and education and resources provided to clients are current and evidence based.

All WHOS services have well established partnerships with harm reduction services in their areas. At the Rozelle site WHOS programs in partnerships with Sydney Local Health District and other community agencies have established an onsite Liver Clinic to induct clients on to hepatitis C treatment whilst in program and an onsite Women's Sexual Health Clinic.

Residential programs for individuals on Opioid Substitution Treatment were introduced in 1999, 2009 and 2012 to offer support for reduction and stabilisation. A day program for OST clients in these programs was also established to further commit



WHOS to harm reduction initiatives.

WHOS' journey from an 'abstinence only' based therapeutic community to a therapeutic community based organisation that integrates Harm Reduction initiatives in response to the challenges of the HIV/AIDS epidemic has stood the test of time and new challenges continue to enforce the commitment to harm reduction for WHOS.

The transition illustrated clearly that the process of change, while rarely easy, can be managed and is best achieved by identifying common ground between different viewpoints and taking small steps (World Health Organisation, 2006) Ref: 1. The WHOS Harm Reduction Program was awarded a commendation for the "Excellence in Health Promotion" at the NADA Awards in 2016. ●