Received: 22 March 2023 | Revised: 30 July 2023 | Accepted: 1 August 2023

DOI: 10.1002/hpja.789

Health Promotion Journal of Australia | Australian Health Promotion Association | WILEY

RESEARCH ARTICLE

'I went for rehab many times and it never worked, but the harm reduction process has given me renewed hope'. Perceptions on the effectiveness of harm reduction and community-based opioid substitution therapy

Tichaenzana Nyashanu[1] | Andrew Scheibe[2] | Maretha Visser[1]

[1]Department of Psychology, Faculty of Humanities, University of Pretoria, Pretoria, South Africa

[2]Community Oriented Primary Care Research Unit, Department of Family Medicine, Faculty of Health Sciences, University of Pretoria, Pretoria, South Africa

Correspondence
Tichaenzana Nyashanu, Department of Psychology, Faculty of Humanities, University of Pretoria, South Africa.
Email: nyashanut@outlook.com

Handling editor: Mark Robinson

Abstract

Issue Addressed: The accessibility of opioid substitution therapy (OST), one of the recommended treatments for opioid dependence, remains low.

This study sought to explore the perceived effectiveness of OST from the perspectives of peer outreach workers and OST clients in a community-based harm reduction programme.

Methods: The research was done within the Community-Oriented Substance Use Programme (COSUP) in Tshwane, South Africa. Fifteen peer educators (13 males and 2 females) took part in two focus group discussions. Thereafter, there were semi-structured interviews in which 15 OST clients (11 males and 4 females) participated. A convenience cross-sectional study was used. Interviews were audio-recorded. Using thematic analysis, themes were examined to evaluate how OST and the harm reduction approach were perceived to contribute to the improved health status of people with opioid dependence.

Results: Peer outreach workers and COSUP clients significantly endorsed OST as an effective treatment for opioid dependence. Participants perceived greater effectiveness of OST compared to abstinence-centred inpatient rehabilitation programmes. However, there were sentiments that more community education on OST was needed to motivate people with opioid dependence to access services and to address misconceptions about OST.

Conclusions: There is a lack of multi-level and multi-sectoral engagement of various stakeholders in opioid dependence services, needed to accelerate utilisation of OST services.

So What? The research unpacks the need for an integrated approach to service use optimisation, and the need to evaluate the role that increased awareness and community education on harm reduction strategies can play in enhancing the utilisation of OST services.

KEYWORDS
abstinence, Community-Oriented Substance Use Program, harm reduction, heroin, opioid substitution therapy, perceived effectiveness, treatment

1 | INTRODUCTION

The 2021 World Drug Report of the United Nations Office on Drugs and Crime has indicated that approximately 275 million people used drugs worldwide in 2020, with an estimated 36 million people reported to have a drug use disorder.[1] Globally, there has been a rise in the use of opioids and opioid use disorders (OUDs).[2] Research suggests that people in low and medium-income countries (LMICs) are more likely to use heroin than prescription opioid analgesics.[3] In LMICs, low-grade heroin is deemed easier to access and cheaper than prescription opioid analgesics.[4]

Regular use of heroin, and other opioids, can lead to the development of OUDs. Although the relationship is complex and intersecting, opioid use conditions can be associated with health and socio-economic problems. In 2020, heroin and other opioids accounted for more than half of deaths and years of life lost due to drug use.[5] In addition to the potential health risks, OUDs are accompanied by economic costs that come as lost productivity and expenditure on health care and law enforcement.[6,7] The other social and economic consequences associated with OUDs relate to challenges with family and social relationships, academic performance, crime, increased risky sexual behaviour and accidental injuries and deaths.[6,8]

1.1 | Different approaches to managing opioid dependence

In the midst of assessing and evaluating the perceptions of the effectiveness of different substance use interventions, the abstinence versus harm reduction dichotomy takes centre stage, a topic that has generated considerable debate.[9] According to Radez et al.,[10] perceived effectiveness of treatment is one of the factors that consistently acts as a barrier/facilitator to treatment of OUD.

1.1.1 | Abstinence-based and harm reduction approaches

Global research observes that abstinence outcomes remain the preferred goal of many substance use interventions.[11] One of the aims of abstinence-centred approaches is to ensure that the individual using substances avoids future use.[12] Abstinence-centred approaches work best for those who are highly self-motivated to be abstinent from drugs.[13] However, some researchers surmise that abstinence outcomes are a high standard to achieve and not always easy to attain.[11] Furthermore, research shows that the majority of people using drugs would not utilise services if they were expected to abstain immediately.[14] This is partly because of the presence of complex underlying issues such as childhood trauma, mental health challenges, unemployment, lack of housing and other socio-economic challenges.[14,15]

Harm reduction is a public health strategy that was initially developed with the primary objective to reduce harms associated with certain behaviours, particularly for adults who had substance use problems and who were not able or ready to stop using drugs.[16] Harm reduction operates from the perspective that drug use is inevitable in society.[16] The flexibility and practicality of the harm reduction paradigm, pivoted by principles of pragmatism, humanism, individualism, autonomy, incrementalism and accountability without termination, appeals to many people who use drugs.[17] Opioid substitution therapy (OST) is often a core part of harm reduction interventions for people with opioid dependence.[18]

1.2 | Opioid substitution therapy

OST is the recommended treatment for opioid dependence.[19] OST refers to the prescription of an agonist or partial agonist medication by a trained medical provider at an appropriate dose to a person with opioid dependence.[20] While the psychosocial interventions vary, methadone and buprenorphine are the most widely used medications in OST.[18]

In addition to reducing the use of illicit opioids, OST minimises withdrawal symptoms and cravings. According to the WHO,[19] the pharmacological approach to OST in opioid dependence treatment is based on either opioid withdrawal management or maintenance.

When OST is used as a maintenance therapy, the process starts off with screening and assessment to diagnose opioid dependence and management. The client is then started on a low dose of medication, which is slowly increased until the person reaches a dose that provides physical and psychological stability (i.e., comfortable and without withdrawal symptoms or cravings).[18] Improved health and well-being is the primary goal.[21] However, discontinuation needs to be considered after factoring issues such as the level of patient's motivation to discontinue and adequate psychosocial support services.

When OST is of short or limited duration, individuals may experience increased anxiety and depression and pain sensitivity.[21] Most clients resume illicit opioid use within 6 months of commencing withdrawal, while in agonist maintenance treatment most patients will cease illicit opioid use or use it less frequently, with only 20%–30% ongoing regular heroin use.[22] In a National Treatment Outcome Research Study (NTORS) project where patients were followed-up after treatment during the first 12 months of the study, 60% used heroin after treatment, with the first occasion of heroin use usually occurring very soon after leaving treatment.[23] According to Meldon Kahan et al.,[21] the reduced tolerance for opioids during recovery

paired with strong cravings can result in a return to use, overdose and possibly death.

1.3 | Opioid use disorders and management in Tshwane, South Africa

South Africa is an integral part of drug trafficking networks with a comparatively active local drug use market.[24] Gauteng province has one of the highest prevalence of heroin use in the country, alongside other provinces such as the Western Cape and KwaZulu-Natal.[4] According to the South African Community Epidemiology Network on Drug Use (SACENDU), which is the country's drug use and treatment surveillance system, heroin was the primary substance of use among 32% (1034 / 3279) of people accessing drug dependence treatment in Gauteng province at facilities part of the SACENDU network between January to June 2020.[4] Other substances for which dependence treatment was sought during this period include 34%, alcohol 11% and methamphetamine 10%.[4]

Despite the high prevalence of harmful substance use, treatment utilisation remains low and this has created a wide treatment gap.[25] For instance, SACENDU Report Phase 48 shows that while there has been a steady rise in the number of people using different substances, there has been a decline in people accessing treatment between 2019 and 2020 in most SANCA centres across Gauteng.[4] In South Africa, very few people who inject drugs (mostly heroin) have access to OST.[26] Almost all of these treatment facilities provide abstinence-based interventions for opioid dependence.

COSUP is a harm reduction programme that provides OST. COSUP mainly uses methadone (and buprenorphine-naloxone to a lesser extent) in its OST programme and offers group and individual-based psychosocial services for people on OST. Additionally, COSUP operates a needle and syringe programme and provides HIV and TB screening. However, because the paper is specifically on OST, there is no expanded detail given on the other approaches to managing opioid dependence. In line with global recommendations, people on OST are able to access NSP at COSUP sites. Peer educators, also called peer outreach workers, work for COSUP to identify and refer people with opioid dependence for treatment. As people with lived experience of substance use and OST, they have insights into the barriers that people experience in trying to seek help and treatment for opioid dependence in Tshwane. COSUP works with social workers, medical doctors, clinical associates, community health workers and peer outreach workers. A peer coordinator manages and coordinates the activities of the 17 peer educators stationed at the 17 COSUP sites operating as one service in Tshwane.[27]

This study sought to examine the perceptions of peer outreach workers and OST clients on the effectiveness of OST for the treatment of opioid dependence in Tshwane. The findings from the study may help to develop or support existing interventions to achieve treatment goals. Although there is substantial literature on the effectiveness of OST for people who are opioid dependent, in Africa, Harm Reduction is still trying to gain some traction and 'acceptance' (as evidenced by COSUP being the only publicly funded programme in South Africa). With the ultimate aim of identifying treatment barriers and improving service delivery, the novelty of this work comes from finding the nexus of service user and service provider perspectives on the effectiveness of OST, in a context where the harm reduction approach is still yet to gather some significant momentum.

2 | MATERIALS AND METHODS

This qualitative study consisted of focus group discussions (FGDs) and semi-structured interviews (SSIs) that were sequentially administered. The current study is nested within a larger doctoral project focusing on barriers to substance use treatment utilisation within COSUP (author named on title page).

This research covered the COSUP sites located across Tshwane, South Africa.

The COSUP facilities included some urban sites, such as those in the inner city and central parts of Tshwane, as well as others in the city's peri-urban areas and outskirts. Participants had varied socio-economic backgrounds, but most of them resided in low- and middle-income residential areas such as Mamelodi, Soshanguve, Lusaka, Laudium, Sunnyside, Eersterust and Daspoort.

2.1 | Focus group discussions

Convenience sampling was used to recruit participants. To be eligible, participants had to be peer outreach workers attached to COSUP at the time of the research. There were no age or gender specifications for eligibility.

All 17 of COSUP's peer educators were invited (telephonically) by the peer coordinator to participate in the study. Fifteen (88.2%) peer educators availed themselves for the study, while the other two (11.8%) declined to participate, citing time constraints. Fifteen peer educators (13 males and 2 females) took part in two focus group discussions. The age range was 29–44 years and the black race constituted the entire sample. Following a detailed explanation about the research, the researcher obtained informed consent from all participants. The participants were assigned into two groups, based on their availability for two scheduled FGDs. The two groups consisted of eight and seven participants respectively and lasted 1 h and 15 min and 1 h and 30 min, respectively. The FGDs were done in Tshwane in October 2020.

With the aid of two multilingual psychology postgraduate research assistants, the researcher used a semi-structured FGD guide to lead the discussions, whilst also taking notes. The FGD guide was in English, but participants could have questions translated and could respond in a language of their choice. All participants, however, were fairly conversant in English and sparingly used Setswana and isiZulu (two local languages) words in their responses. The FGDs were explorative in nature and focused on obtaining the participants' general perceptions of the effectiveness of OST in COSUP. Examples of questions asked were:

What were your main reasons for participating in this substance use treatment program?

What is your view on the effectiveness of this treatment program, especially for young adults?

Do you think there are other useful intervention strategies for substance use disorder treatment?

With the permission of the participants, the focus group sessions were audio-recorded. The participants were nominally tagged as peer 1, peer 2 and so on to anonymise them.

2.2 | Semi-structured interviews

Face-to-face individual SSIs were then used to complement the FGDs. The SSI is an open-ended interactive approach in an interview setting, with some follow-up prompts designed to obtain in-depth qualitative data from study participants.[28] The phenomenological approach was employed to seek reality from individuals' narratives of their lived experiences.[29]

A convenient sample was drawn from young adults (18–29 years) receiving OST at two selected COSUP sites at the time of the research. The peer educators at these sites, one in the inner city and the other in a peripheral high-density residential location, were asked to approach clients to volunteer to participate in the SSIs. All 216 eligible potential participants were informed and the ones who agreed and availed themselves first were then invited to participate. The sample was made up of 11 males and 4 females. All participants were from the black ethnic race.

The SSI guide focused on key questions about the effectiveness of OST. Examples of questions on the SSI guide were:

Do you think that OST used in COSUP is an effective treatment for you? Explain.

What is your opinion about the effectiveness of substance use treatment methods, especially for opioid dependence?

The researcher worked in collaboration with the same two multilingual psychology postgraduate research assistants that supported the implementation of the FGDs. The participants preferred to be interviewed in English and a few in Setswana and isiZulu. The interviews took between 45 and 60 min each. With the consent of the participants, the interviews were audio-recorded.

2.3 | Data analysis

The two research assistants were responsible for the translations during the SSI. The audio-recorded data in English, isiZulu and Setswana for FGDs and SSIs were transcribed by the researcher and two research assistants and then analysed using thematic analysis, in English. The six steps identified by Braun and Clarke[30] were used to identify and analyse patterns of meaning or re-occurring themes in the dataset. The themes characterise perceptions in participants' accounts connected with the research question. The themes from the FGDs and SSIs were compared to detect convergence and divergence in the results. To improve the trustworthiness of the results, the data interpretation was done by the researcher and his research assistants and congruency was established.

2.4 | Ethics

The study was approved by the relevant study committee, shown on the title page. Written informed consent was received from participants. Participants were not remunerated for participating to minimise response bias that sometimes may be created by remunerating participants.

3 | RESULTS

The major themes identified from the FGDs and SSIs were about:

1. the practicality of OST
2. a holistic and transformative package
3. flexibility and client-centeredness of OST when implemented using the harm reduction approach
4. perceived ineffectiveness of abstinence-centred rehabilitation
5. strategies for improving OST.

3.1 | Practicality of OST

Both the COSUP peer educators and the COSUP clients considered the way in which OST was provided through COSUP to be efficacious, producing a lower return to heroin use rates than abstinence-centred approaches that the participants had experienced or witnessed. Compared to COSUP clients, the peer educators showed greater awareness and appreciation of the practicality of OST, since many of the peer educators had been to abstinence-centred treatment services before being exposed to OST and harm reduction in COSUP.

The peer educators drew comparisons between the enhanced effectiveness of OST in COSUP, compared to their experiences of abstinence-centred treatment services:

I had been to rehab to kick my habit and failed. But when I tried COSUP [OST], it worked the first time (FGD 1, peer 4).

… it has helped me quite a lot because now I'm at a point where I am 100% clean. And like my friend whom I am sharing this journey with here at COSUP, it has taken him

to a point of even being employed, so I highly recommend COSUP (SSI, COSUP client 7).

3.2 | OST with a harm reduction orientation experienced as a holistic and transformative package

Generally, most of the participants considered the COSUP approach, which includes OST, to be holistic because they felt that it went beyond the treatment of their opioid dependence. Participants reported how COSUP clients were linked to vocational training, community advisory groups and care planning with social workers. Peer educators and clients expressed that their own lives and those of others were transformed for the better since they participated in OST provided by COSUP.

They help us quit using heroin and also help us get certificates, for example life skills… (SSI, COSUP client 10).

The peer educators perceived the treatment as holistic since it improved their health and social functioning.

This program has restored our health, and we also now have normal relationships with other people in the community. We are now treated as complete human beings in our communities (FGD 2, peer 4).

Participation in the COSUP programme contributed to several participants perceiving themselves to be productive members of society. In addition to being employed by COSUP, these individuals reported having stopped using heroin and that they felt that they had become a source of inspiration to many people desiring to quit. COSUP is non-judgemental and non-discriminatory. These individuals reported to have voluntarily attained abstinence, without a condition of abstinence being set as a requirement for their employment.

This program is very fair, we stopped using drugs on our own without being forced to. And there was no discrimination to say if you do not quit drugs then you don't get a job (FGD 1, peer 5).

… since I got to this program, I have seen my life change a lot (FGD 1, peer 6).

Participants reported that in addition to treatment services, COSUP had also provided some life-changing and self-development opportunities for individuals who participate or have participated in the programme. There were examples of participants that had moved from being COSUP clients to becoming peer outreach workers in the programme.

For me, they [COSUP] have done an extra mile for my life because I have seen bigger changes in my life ever since I came to COSUP. … I found a job through COSUP, so it has made a huge impact on my life (SSI, COSUP client 3).

John [pseudo name] started off as a client, but now is a peer educator (SSI, COSUP client 5).

3.3 | OST with a harm reduction orientation experienced as being flexible and client-centred

Participants mentioned that COSUP's OST programme was flexible enough to accommodate those who may want to cut down and not necessarily abstinence as an immediate goal, whilst providing a pathway for eventual abstinence as a potential long-term goal. This approach was noted by some participants to differ from the expectations of substance use treatment approaches that they had been through, where abstinence was the only 'acceptable' treatment goal.

To my understanding harm reduction is one of the new programs in South Africa. … to those who don't want to stop using but want to cut down. Actually, they will get back on their feet and stop using, so I would say it's a good initiative (FGD 2, peer 7).

So, I feel like the program has been extremely useful and in terms of this, as a strategy for either cutting down or ending your substance use (FGD 2, peer 5).

The participants contend that the user-friendliness and systemic approach of the OST provided by COSUP as part of a harm reduction programme was one of the main advantages over abstinence-focused programmes. COSUP peers highlighted how the user-friendliness of COSUP's approach supported people to attain their heroin use goals.

When you look at harm reduction, they have been doing extremely well because of the way it has been designed to be user friendly to the substance user… (FGD 2, peer 5).

I went there [COSUP] and it was soothing new for me… better solution from what I was doing over and over again (FGD 1, peer 4).

When you look at harm reduction, they have been doing extremely well because of the way it has been designed to be user friendly to the substance user, not only to the user, but family to the user (FGD 2, peer 5).

3.4 | Perceived ineffectiveness of abstinence-centred rehabilitation

According to the peer outreach workers in COSUP, the abstinence-centred rehabilitation programmes result in high-return-to-use rates.

These views were informed by their personal experience of accessing services.

> *… they [people] have estimated that rehab facilities have a high failure rate* (FGD 2, peer 5).

> [The] *reason why I came to COSUP is I had been to rehab four to five times and finished the programme. Maybe three times or two times I was kicked out because the rehab situation wasn't working for me. I was relapsing* (FGD 1, peer 4).

Another weakness that participants perceived in the abstinence-centred facilities that they had attended or were aware of, is that very few (if any) utilised pharmacotherapy, specifically agonist medications, which most participants considered to be effective.

> *… in my view I think it is methadone that helps people quit because I've been to rehab but they didn't provide methadone* (SSI, COSUP client 13).

3.5 | Strategies for improving OST

Participants offered some concerns about the COSUP programme and recommendations for improvement.

3.5.1 | Enhancing community awareness on OST

Peer educators reiterated that clients have been known to approach harm reduction services and OST with scepticism. Several peer educators thought that this was likely due to a lack of adequate information and community misconceptions about OST. For example, several COSUP outreach workers mentioned that some clients viewed OST as replacing one addiction (opioid dependence) with another (methadone dependence). Most peer educators held the view that communities are not sufficiently 'educated on' harm reduction services, particularly OST.

> *… our communities, they don't have full information. For example, when they see people giving services, helping people to save lives, they used to say you are promoting drugs. At COSUP, when we give the guys methadone, they say we are promoting drugs. So, let's teach our communities…* (FGD 2, peer 1).

The COSUP peer outreach workers stated that there were also some people in the community with a perception that OST is ineffective.

> *They [people in the community] would say they know people who were using methadone, but they are still smoking and things like that*. (FGD 1, peer 4).

Participants were of the view that the communities have not yet sufficiently come to grips with what harm reduction entails. Several participants alluded to an information gap on these services and where to find them in Tshwane.

> *A lot of people don't know it [COSUP]* (SSI, COSUP client 10).

> *Let's give them information because many people don't have information. Even others who are on the program, they don't get to spread out information as to how they arrived at OST and using methadone* (FGD 2, peer 1).

3.5.2 | Optimising the registration and treatment initiation processes

The registration and treatment processes are considered by the clients to be tedious. There was a general view among peer outreach workers that the registration and treatment initiation processes can be done more efficiently.

> *The reason for some of the guys not participating in this program is because of the long wait. At least if they try to make this application shorter as possible* (FGD 1, peer 8).

> *Another obstacle [to treatment] is the procedure of registration into the treatment program* (FGD 2, peer 5).

SSI participants (COSUP clients) reported that COSUP clinical staff members had informed them that resource constraints, specifically personnel and access to methadone, contributed to the inefficiency and limited accessibility.

> *… there are no resources. There is a shortage of clinical associates and sometimes the methadone is not enough for everyone at the same time* (FGD 1, peer 6).

Several participants perceived that the fragmentation of the service contributed to the excessive time from engagement to initiating OST. Fragmented service results from sub-optimal coordination to facilitate synchronised linkage to care and treatment. For example, clients may be required to see doctors, clinical associates and social workers at different times and in different places.

> *… they are made to wait for a long time for sessions where they must see doctors, they must see clinical associates, they must see the social workers. So, for them they won't wait for that long. That's why they won't come* (FGD 1, peer 8).

This creates a long process that reportedly frustrated clients and demotivated them to seek help.

3.5.3 | Peer-led interventions

COSUP clients expressed the importance of peer-led interventions in communities to motivate people with opioid dependency to access treatment and harm reduction services. The participants observed that although the peer educators are already in the community, increasing their presence may heighten the awareness of change that is possible because of treatment services and motivate people with opioid dependence to seek help.

> *… we need more peer-led interventions in line with harm reduction because sometimes substance users get motivated by seeing the other person that he used to hustle with. He sees that change is possible* (SSI, COSUP client 4).

4 | DISCUSSION

The results suggest that OST provided through a harm reduction approach at the COSUP site was perceived by peer educators and clients to be efficacious. Generally, participants perceived COSUP's approach to yield enhanced treatment outcomes compared to abstinence-centric treatment approaches.

Peer outreach workers have significant insights into the processes at COSUP because they interact with clients with different backgrounds, needs and motivations. They have had the opportunity to experience COSUP as service providers and none of them is still on treatment. On the other hand, the accounts given by COSUP clients mostly relate to their experiences of being service users, on OST. This is invaluable information from COSUP clients which communicates clients' current experiences as service users. As noted in the results section, although there were some significant perceptual similarities between the peer outreach workers and the clients, there were also some differing views from these two groups. Overall, this comparison helped to build a narrative that gives an insightful perspective on the perceived effectiveness of OST provided in COSUP in relation to overall well-being.

The philosophy behind harm reduction is compatible with the needs of most health service users. Based on the principles of harm reduction,[17] the quality of individual and community life and well-being should not be necessarily premised on cessation of all drug use as the criteria for a successful outcome. Instead, the focus of treatment should be on the non-coercive and non-judgemental provision of services and resources.[17] According to the participants, this could explain why many COSUP clients were able to remain on OST, attain their substance use treatment goals and achieve other improvements in life such as becoming employed.

A gap in information on how methadone is purported to treat people is exacerbated by the situation that in South Africa (and in COSUP), people are not being provided with agonist (methadone) at sufficient doses, which stands at between 60 and 120 mg methadone per day.[19] A study in COSUP[31] revealed a median dose of 20 mg and this is substantially below the recommended therapeutic range. To a certain extent, sub-optimal dosing was perceived to contribute to low retention and therefore reduced the effectiveness of the intervention.[31] However, it needs to be emphasised that many clinicians report that some patients can be stabilised on lower methadone doses to optimal effect because individual responses to methadone treatment vary substantially.[32] It needs to be reiterated that the paper did not assess individual doses, but across COSUP, and these variations in individual responses to methadone doses may explain why the OST intervention could still have been effective. According to Trafton et al.,[32] effective and ineffective methadone dosages overlap substantially and dosing guidelines should lean more towards appropriate processes of dosage determination rather than solely specifying recommended dosages, implying that OST can be optimised by titrating until heroin abstinence is achieved.

Since the participants identified a low community understanding of effective management of OUD, potential clients and community members may better appreciate OST and have realistic expectations if they are made to understand that opioid dependence is a chronic condition that requires (long term) maintenance treatment.[19] OST reduces illicit opioid use, with concurrent use of illicit opioids among people on OST often linked to under-dosing (sub-optimal dosing), efforts should be made for agonist prescribing to follow recommended practice.[33] Return to illicit opioid use at prior intervention levels is very common in abstinence-based rehabilitation (with or without detoxification) and is also likely in contexts where OST is terminated early.[34] The duration of OST treatment can range from several months to lifelong, depending on a range of individual, social and clinical factors.[19]

Reports from this study of repeated admission to abstinence-centred rehabilitation facilities and return to pre-intervention patterns of illicit opioid use were shown. Literature concurs that clients report greater autonomy in entering treatment for substance use services that are associated with harm reduction principles, and they have been observed to stay on treatment and achieve enhanced outcomes compared to the traditional forms of abstinence-centred interventions.[35]

In view of the limited funding available in primary health care (PHC) settings, service providers like COSUP can enhance clients' retention and adherence to OST by making use of clinical associates as a less costly alternative to medical doctors, although being mindful of maintaining an adequate complementary staff of medical doctors to authorise and supervise the clinical associates in dispensing methadone and able to provide good value.[36,37] In this way, COSUP may be able to address fragmented service that has resulted in clients having to see certain health personnel only in certain places where their availability is only at certain times. Clinical associates have generalist training that enables them to deliver PHC, patient consultations, counselling, skilled clinical procedures, pharmacotherapy and surgical assistance adherence counselling.[37] The patient registration process needs to be improved so that treatment initiation, maintenance and completion may be enhanced.

4.1 | Limitations

The study was not able to include a comparison group of peer educators or clients in an abstinence-centred programme due to logistical and resource constraints. The lack of a comparison group could have contributed to information bias on the comparative effectiveness of the different approaches. However, some of the peer educators had previously received treatment from abstinence-centred facilities so that they had some knowledge to compare the effectiveness of different treatment processes. The sample sizes were relatively small, partly owing to the small number of peer educators working in COSUP and time and resource limitations. It is possible that the relatively small sample size could have been a limiting factor as other perspectives could have emerged with a much bigger sample.[38] The sample size could have been bigger, but due to limited funding, the research was not able to remunerate participants, and this possibly hampered the participant recruitment exercise. Saturation was possibly not achieved, thus limiting the deeper understanding of issues. Gender differences, which are an important factor in OUD and OST, were not explored in this research, as there was only a small number of females involved in each group of participants.[39] During this research, the researcher had been exposed to the harm reduction working environment and this might have influenced the researcher's perspective on the findings. There was a possibility of information bias from the peer outreach workers since they are employed by COSUP and could have provided the information they felt their employer would want to hear. To avoid/minimise reporting bias from peer outreach workers and clients, the researcher highlighted that the information reported will not be identifiable to any participant.

5 | CONCLUSION

Corroborating with the findings of this study, the literature shows that harm-reduction models are perceived to be feasible and effective by people who work in these programmes and among clients. There is a need for future research to evaluate the relationship between increased knowledge about harm reduction services and OST and the utilisation of services. The findings of this study may influence the trajectory of health promotion strategies, governments and policymakers may be challenged to shake off value judgements and conservative health service delivery approaches and step up to support evidence-informed strategies that deliver positive results. However, as observed in this study and other related studies, there is a need to further educate communities on the harm reduction model, and this will contribute towards building community resilience. This can motivate more substance users to utilise services and improve their health status. In order to address fragmented services resulting from inadequate personnel, especially in low-resource settings such as South Africa, the expanded use of clinical associates may be considered as a plausible, less costly alternative, while maintaining the right balance with medical doctors in delivering PHC services[33] such as substance use treatment. The implementation of service needs to improve so that more people can receive appropriate treatment.

ACKNOWLEDGEMENTS

For this article, there were no contributions from anyone who does not meet the criteria for authorship.

FUNDING INFORMATION

This work was not funded.

CONFLICT OF INTEREST STATEMENT

There are no conflicting interests to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from University of Pretoria. Restrictions apply to the availability of these data, which were used under license for this study. Data are available from the author(s) with the permission of University of Pretoria.

ETHICS STATEMENT

The study was approved by the ethics committee of the University of Pretoria's Faculty of Humanities, prior to the commencement of the research (Reference number 20795913 HUM012/0820).

ORCID

Tichaenzana Nyashanu https://orcid.org/0000-0002-9878-6894

REFERENCES

1. World Drug Report. United Nations Office on drugs and crime (UNODC). 2021 https://www.unodc.org/unodc/data-and-analysis/wdr2021.html
2. Kunnumpurath S, Julien N, Kodumudi G, Kunnumpurath A, Kodumudi V, Vadivelu N. Global supply and demand of opioids for pain management. Curr Pain Headache Rep. 2018;22(5):1–5.
3. Cicero TJ, Ellis MS, Kasper ZA. Increased use of heroin as an initiating opioid of abuse. Addict Behav. 2017;74:63–6.
4. Harker N, Lucas WC, Laubscher R, Dada S, Myers B, Parry CD. Is South Africa being spared the global opioid crisis? A review of trends in drug treatment demand for heroin, nyaope and codeine-related medicines in South Africa (2012–2017). Int J Drug Policy. 2020;83:102839.
5. Reuter P, Caulkins JP, Midgette G. Heroin use cannot be measured adequately with a general population survey. Addiction. 2021;116(10):2600–9.
6. Kumpfer KL. Family-based interventions for the prevention of substance abuse and other impulse control disorders in girls. ISRN Addict. 2014;2014:1–23.
7. Rehm J, Mathers C, Popova S, Thavorncharoensap M, Teerawattananon Y, Patra J. Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. The Lancet. 2009;373(9682):2223.
8. Collins MH, Ready J, Griffin JB, Walker KG, Mascaro N. The challenge of transporting family-based interventions for adolescent substance abuse from research to Urban Community settings. Am J Fam Ther. 2007;35(5):429–45.
9. Duk K. Clashes in culture? The 'professionalisation' and 'criminalisation' of the drugs workforce. Brit J Comm Just. 2010;8(2):31.
10. Radez J, Reardon T, Creswell C, Lawrence PJ, Evdoka-Burton G, Waite P. Why do children and adolescents (not) seek and access

professional help for their mental health problems? A systematic review of quantitative and qualitative studies. Eur Child Adolesc Psychiatry. 2021;30(2):183–211.
11. Parramore JD. Group treatment effectiveness for substance use disorders: abstinence vs. Harm Reduction (Doctoral dissertation, Old Dominion University). 2020.
12. Oksanen A. Deleuze and the theory of addiction. J Psychoact Drugs. 2013;45(1):57–67.
13. Testa JB. Harm reduction wellness support group for substance abusers (Doctoral dissertation, The Chicago School of Professional Psychology); 2016.
14. Lau N, Sales P, Averill S, Murphy F, Sato SO, Murphy S. A safer alternative: cannabis substitution as harm reduction. Drug Alcohol Rev. 2015;34(6):654–9.
15. Giano Z, Williams A, Hankey C, Merrill R, Lisnic R, Herring A. Forty years of research on predictors of homelessness. Community Ment Health J. 2020;56(4):692–709.
16. Marlatt GA, Witkiewitz K. Update on harm-reduction policy and intervention research. Annu Rev Clin Psychol. 2010;6:591–606.
17. Jepson J, Brusca C, Brown M, Navigator AS, Tellez R. Initial outcomes analysis. 2019.
18. Mauger S, Fraser R, Gill K. Utilizing Buprenorphine–Naloxone to treat illicit and Prescription-opioid Dependence. Neuropsychiatr Dis Treat. 2014;10:587.
19. World Health Organization. Department of Mental Health, Substance abuse, World Health Organization, international narcotics control board, United Nations Office on drugs, & crime. Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence. Geneva, Switzerland: World Health Organization; 2009.
20. Rao R. The journey of opioid substitution therapy in India: achievements and challenges. Indian J Psychiatry. 2017;59(1):39–45.
21. Meldon Kahan MD, Lori Regenstreif MD, Mark Weiss MD. Recommendations for the provision of opioid agonist therapy in publicly funded residential addiction treatment centres in Ontario. 2022.
22. Teesson M, Ross J, Darke S, Lynskey M, Ali R, Ritter A, et al. One-year outcomes for heroin dependence: findings from the Australian treatment outcome study (ATOS). Drug Alcohol Depend. 2006;83(2):174–80.
23. Gossop M, Stewart D, Browne N, Marsden J. Factors associated with abstinence, lapse or relapse to heroin use after residential treatment: protective effect of coping responses. Addiction. 2002;97(10):1259–67.
24. Goga K. The drug trade and governance in Cape Town. Institute for Security Studies Papers, 2014(263), 18. 2014.
25. Ngwenya N, Nkosi B, Mchunu LS, Ferguson J, Seeley J, Doyle AM. Behavioural and socio-ecological factors that influence access and utilisation of health services by young people living in rural KwaZulu-Natal, South Africa: implications for intervention. PloS One. 2020;15(4):e0231080.
26. Scheibe A, Young K, Moses L, Basson RL, Versfeld A, Spearman CW. Understanding hepatitis B, hepatitis C and HIV among people who inject drugs in South Africa: findings from a three-city cross-sectional survey. Harm Reduct J. 2019;16(1):1–11.
27. Scheibe A, Shelly S, Versfeld A. Prohibitionist drug policy in South Africa—reasons and effects. Revue internationale de politique de développement. 2020;12(27).
28. Halcomb E, Ashley C, Middleton R, Lucas E, Robinson K, Harvey S, Mclnnes S. Understanding perceptions of health, lifestyle risks and chronic disease in middle age. J Clin Nurs 2021;30(15-16):2279–86.
29. Deepa R, Panicker AS. A phenomenological approach to understand the challenges faced by medical students. Qual Rep. 2016;21(3):584.
30. Braun V, Clarke V. Reflecting on reflexive thematic analysis. Qual Res Sport Exerc Health. 2019;11(4):589–97.
31. Gloeck NR, Harris BN, Webb EM, Scheibe A. Factors predicting 6-month retention among people with opioid use disorders accessing outpatient methadone maintenance therapy in Tshwane, South Africa. South Afr Med J. 2021;111(1):68–73.
32. Trafton JA, Minkel J, Humphreys K. Determining effective methadone doses for individual opioid-dependent patients. PLoS Med. 2006;3(3):e80.
33. Mielau J, Vogel M, Gutwinski S, Mick I. New approaches in drug dependence: opioids. Curr Addict Rep. 2021;8(2):298–305.
34. Hser YI, Evans E, Grella C, Ling W, Anglin D. Long-term course of opioid addiction. Harv Rev Psychiatry. 2015;23(2):76–89.
35. Urbanoski KA, Wild TC. Assessing self-determined motivation for addiction treatment: validity of the treatment entry questionnaire. J Subst Abuse Treat. 2012;43(1):70–9.
36. Marcus TS, Heese J, Scheibe A, Shelly S, Lalla SX, Hugo JF. Harm reduction in an emergency response to homelessness during South Africa's COVID-19 lockdown. Harm Reduct J. 2020;17(1):1–8.
37. Louw M, Tshabalala Z, Capati J, Smalley S, Cooke R. Clinical associates in South Africa: optimising their contribution to the health system. South African Health Review. 2019;2019(1):183–92.
38. Vasileiou K, Barnett J, Thorpe S, Young T. Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. BMC Med Res Methodol. 2018;18(1):1–18.
39. McHugh RK, Votaw VR, Sugarman DE, Greenfield SF. Sex and gender differences in substance use disorders. Clin Psychol Rev. 2018;66:12–23.

How to cite this article: Nyashanu T, Scheibe A, Visser M. 'I went for rehab many times and it never worked, but the harm reduction process has given me renewed hope'. Perceptions on the effectiveness of harm reduction and community-based opioid substitution therapy. Health Promot J Austral. 2023. https://doi.org/10.1002/hpja.789