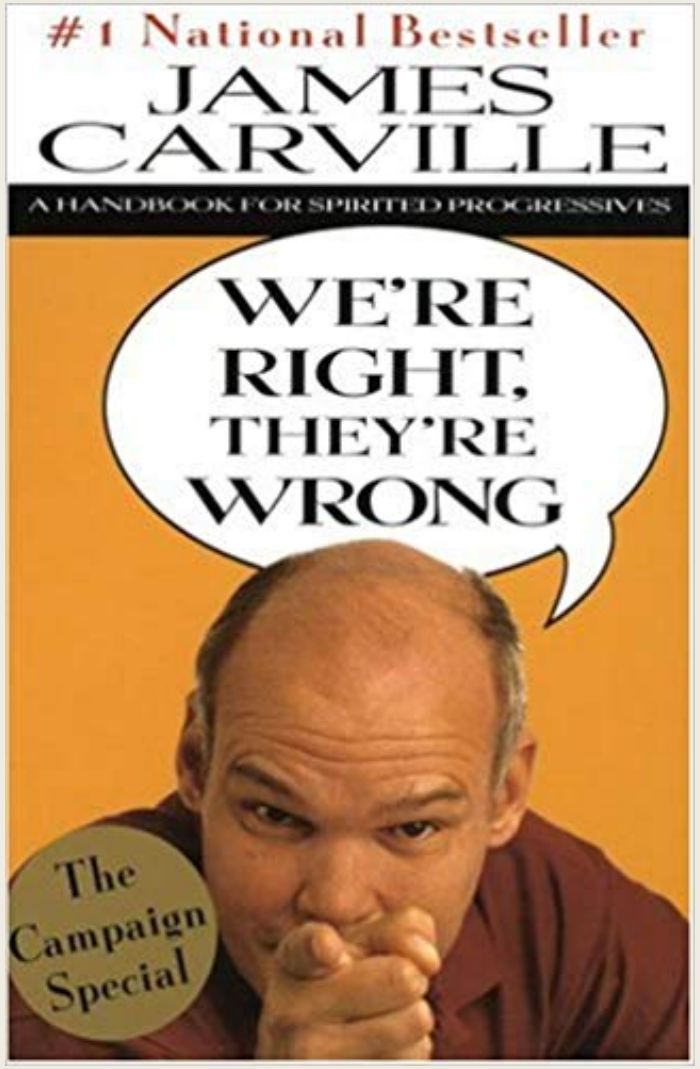
ADVOCATING FOR HARM REDUCTION

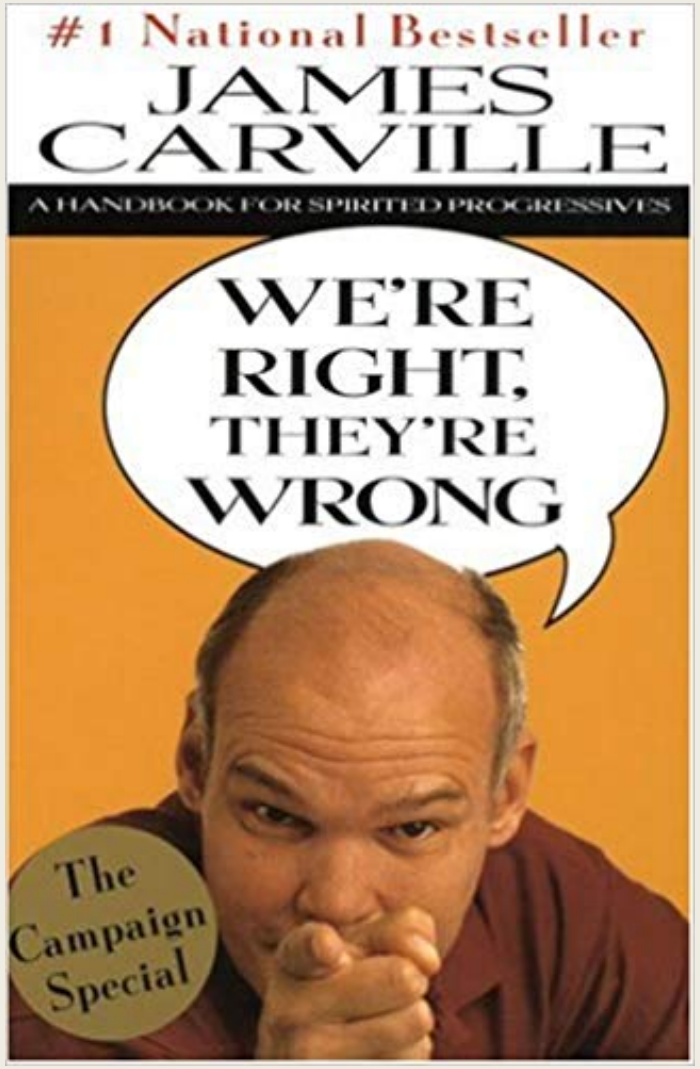
Sherry Nykiel, MD
Acting Medical Director
Chief of Addiction Psychiatry

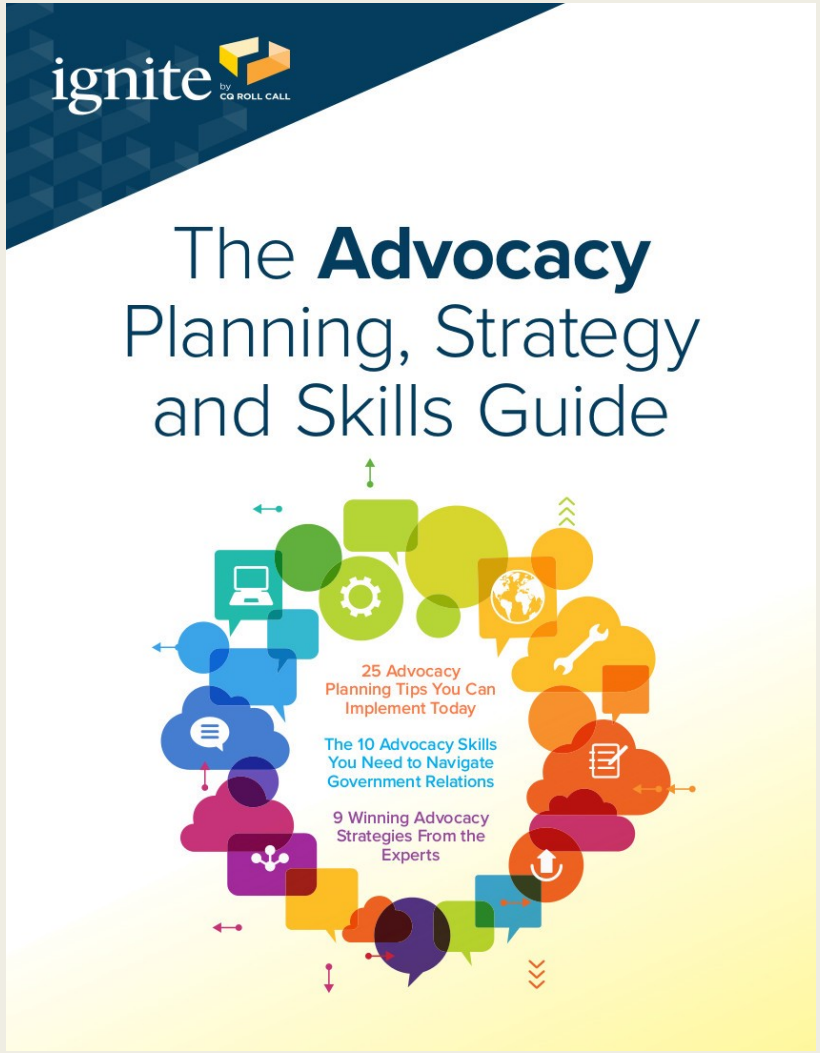
Becoming politically active

Becoming politically active



Becoming politically active





Becoming politically active

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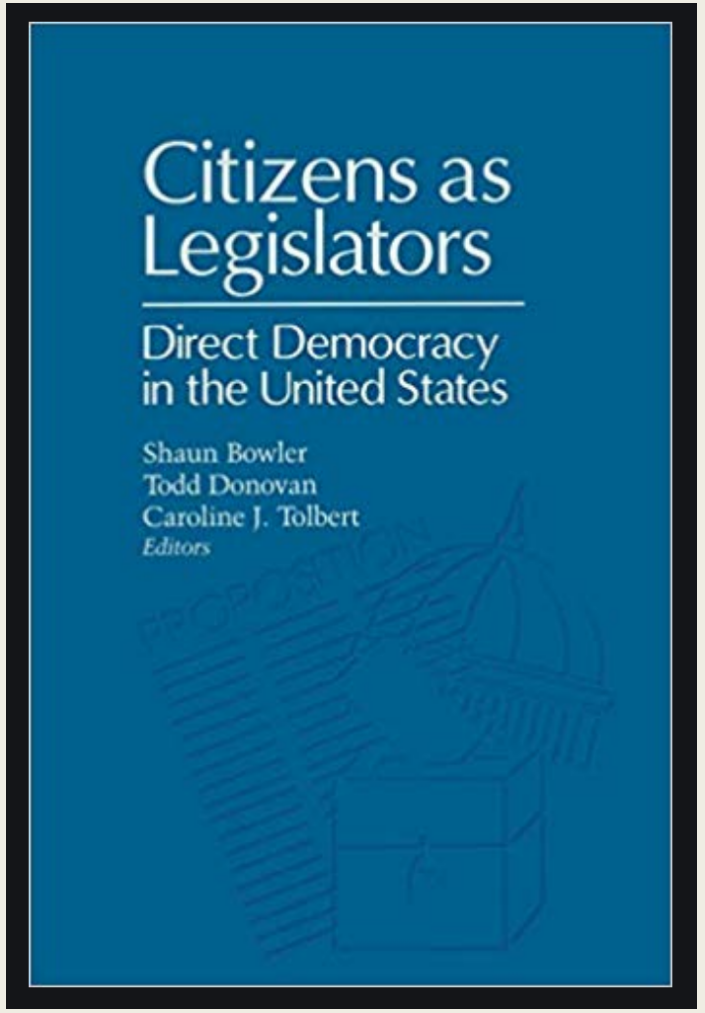
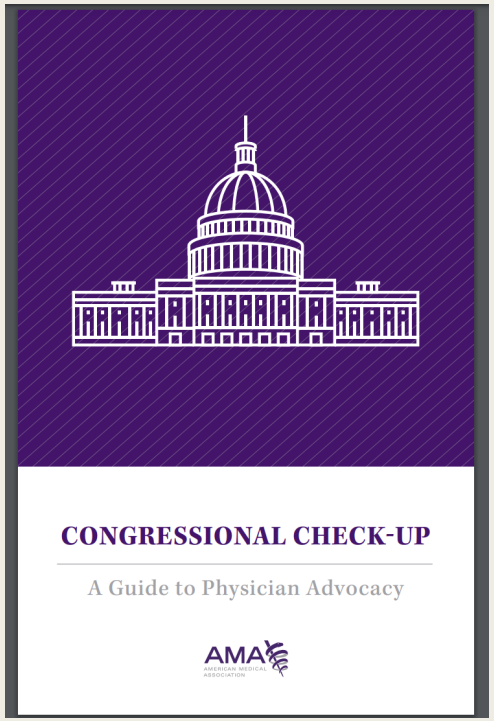
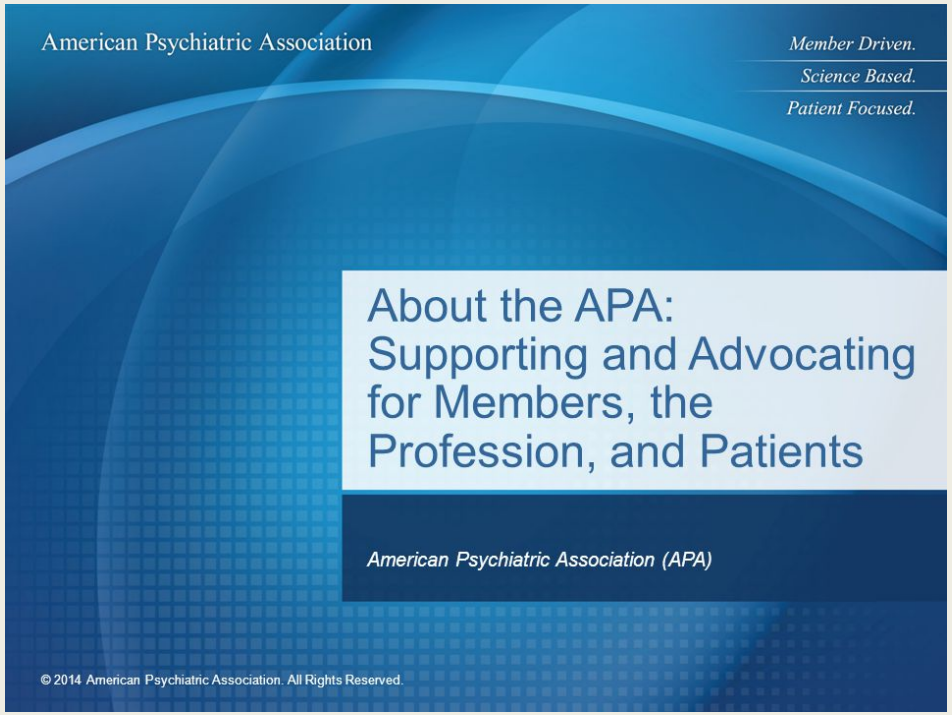
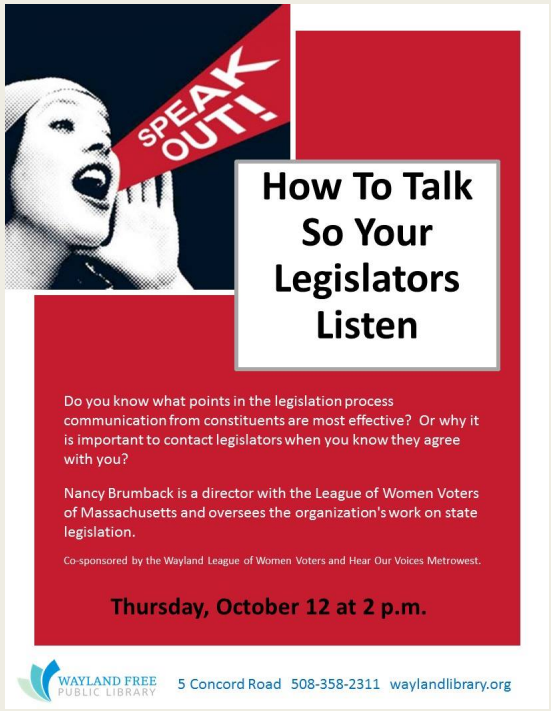


Becoming politically active

- Don’t reinvent the wheel – educate yourself with available resources

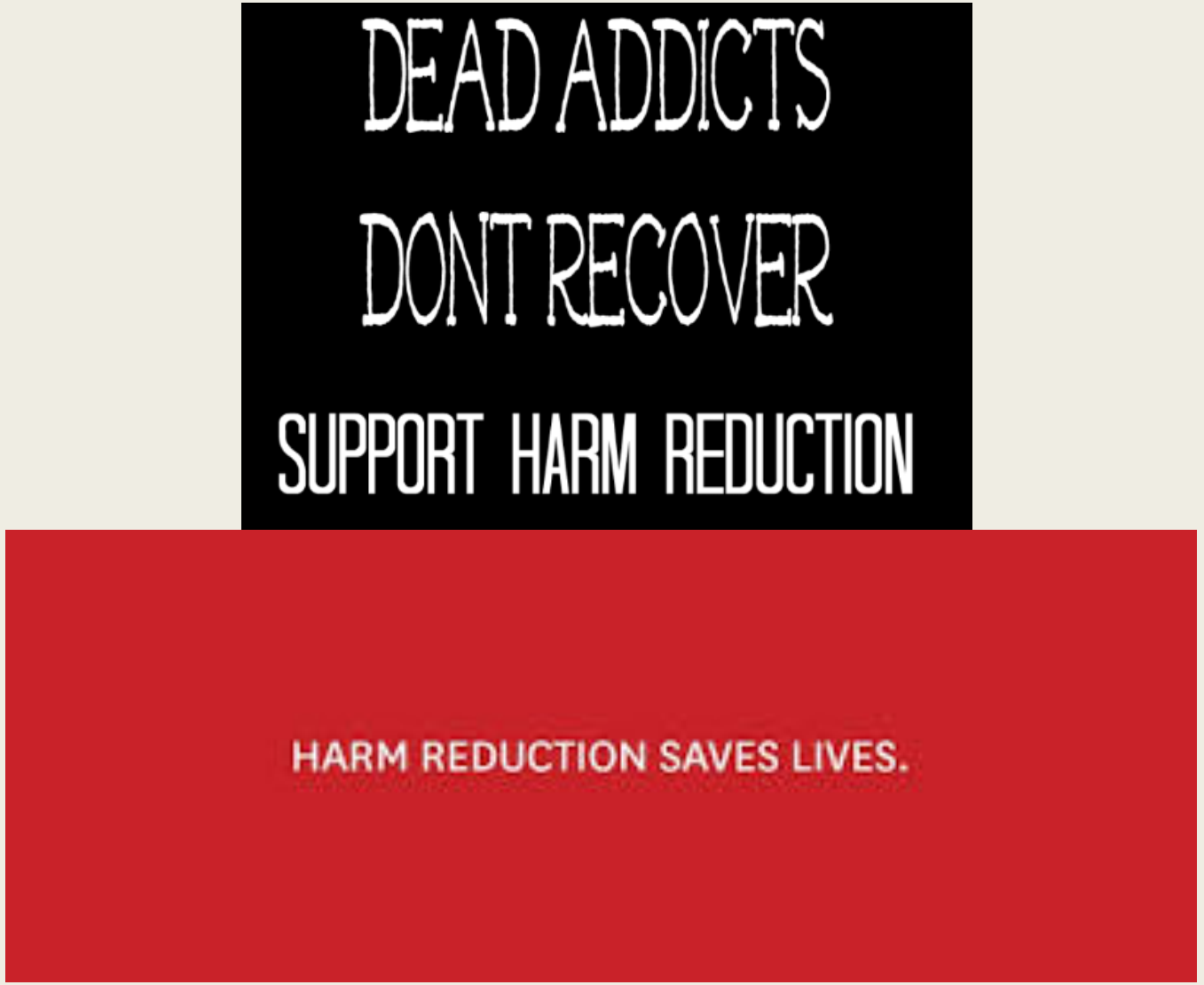




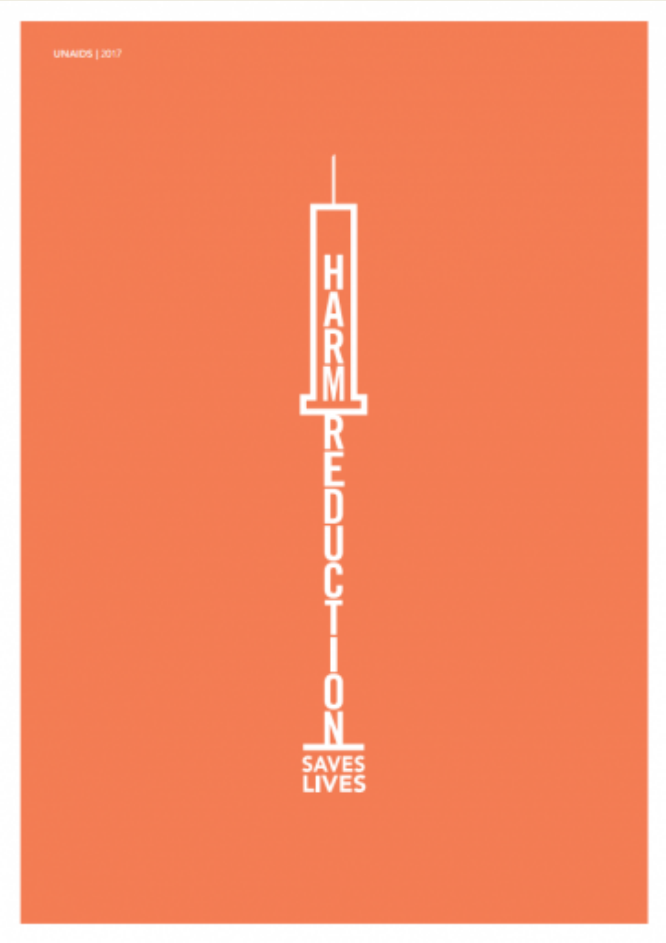


Becoming politically active

What do you care about?



What is harm reduction?



https://www.aidsactioneurope.org//en/publication/harm-reduction-saves-lives

What is harm reduction?

- “Harm reduction refers to policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws. Harm reduction is grounded in justice and human rights - it focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support.”

https://www.hri.global/what-is-harm-reduction

What is harm reduction?

- “**Harm reduction** is a set of practical strategies and ideas aimed at **reducing** negative consequences associated with drug use. **Harm Reduction** is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.”

https://harmreduction.org/about-us/principles-of-harm-reduction/

What is harm reduction?

- “Harm reduction is a range of public health policies designed to lessen the negative social and/or physical consequences associated with various human behaviors, both legal and illegal.”

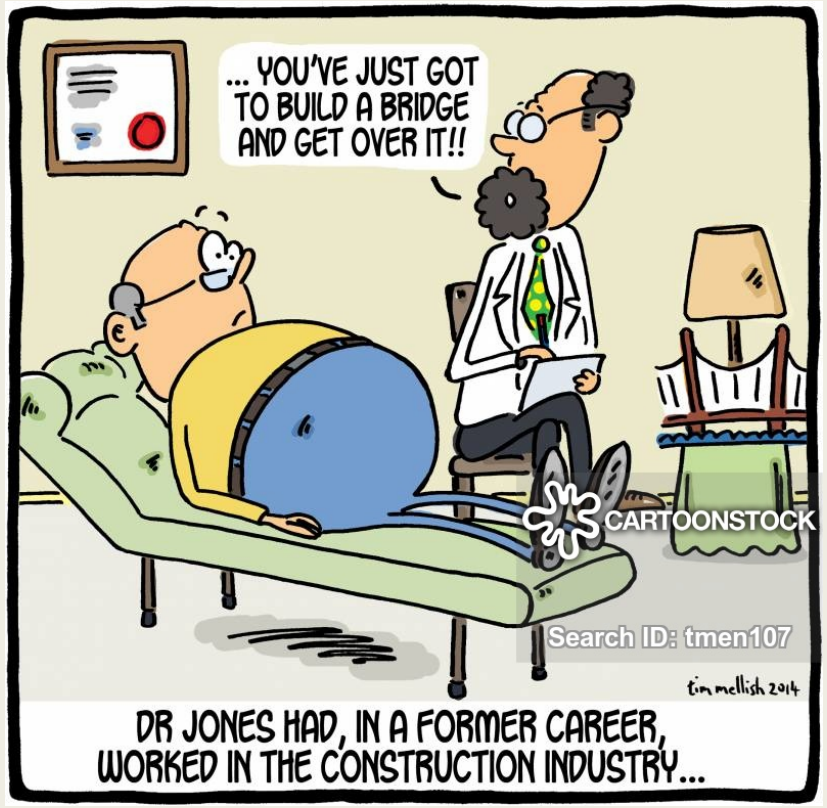
https://en.wikipedia.org/wiki/Harm_reduction

What is harm reduction?

- A set of practical strategies and ideas aimed at **reducing** negative consequences associated with drug use without necessarily stopping use

Using analogy to educate

- Use a similarity or comparison between two different things or the relationship between them
- Can be used to explain something unfamiliar by associating it with or pointing out its similarity to something more familiar or to make a pointed, powerful comparison



Is this harm reduction?

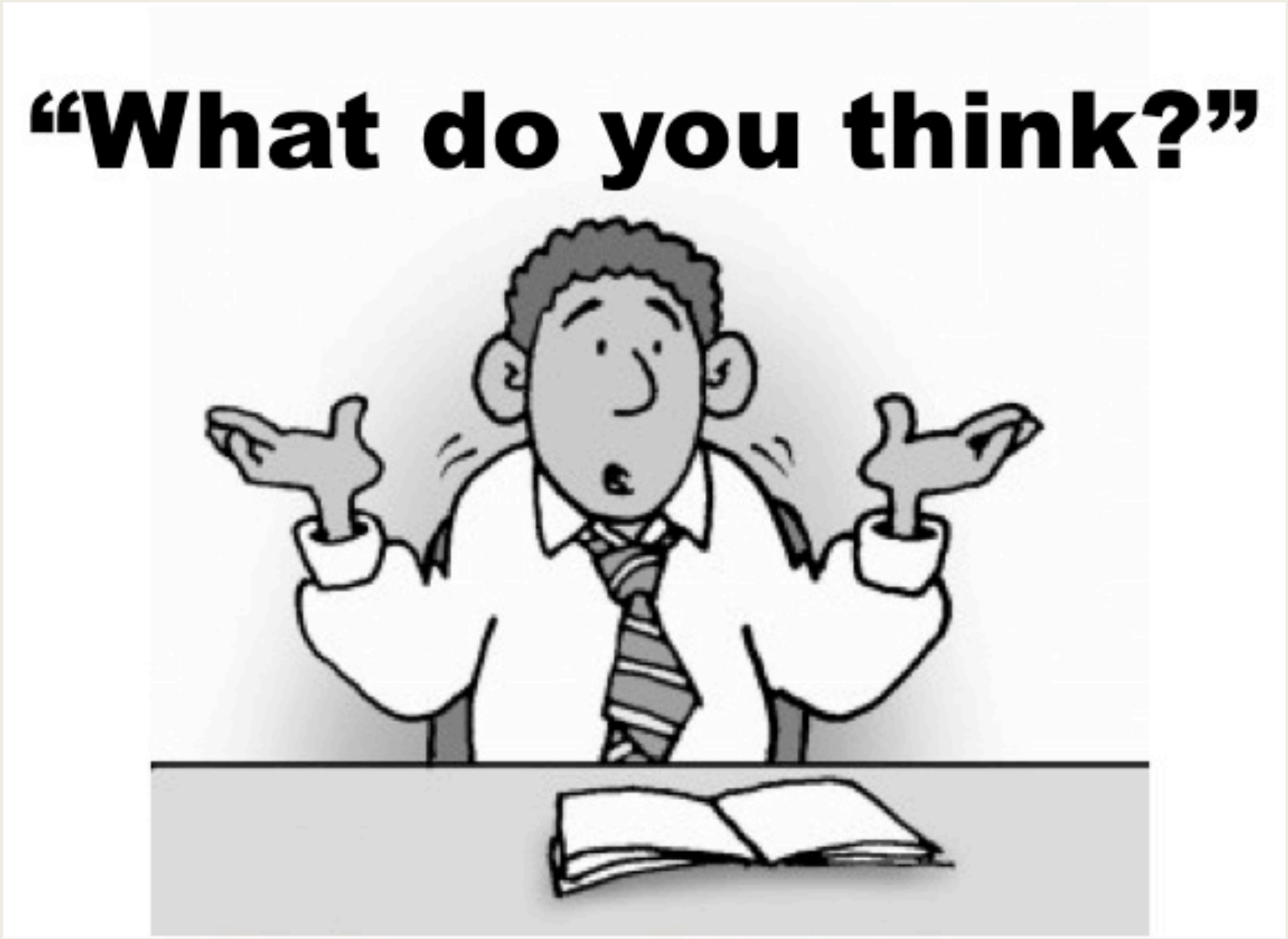
- ✓ Naloxone education and distribution
- ✓ Fentanyl test strips
- ✓ Syringe exchange programs
- ✓ Safe injecting sites

- ✓ Wearing a helmet when riding a bike
- ✓ Wearing a seatbelt when driving or riding in a car
- ✓ Buying energy efficient appliances
- ■ ~~Abstinence only sex education~~

Is this harm reduction?

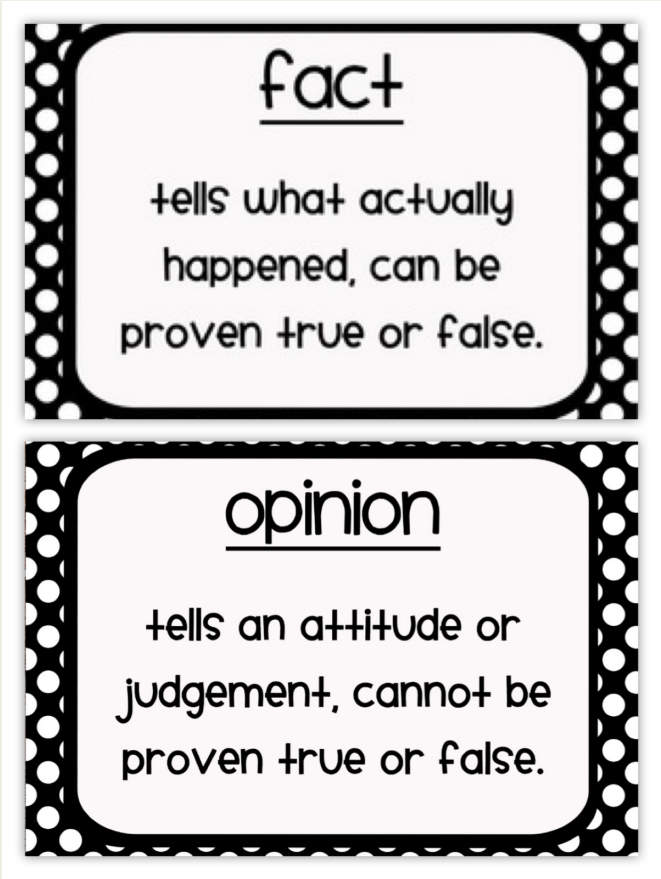
- ✓ Methadone for opioid use disorder
- ✓ Buprenorphine for opioid use d/o
- ✓ Naltrexone for alcohol use disorder
- ✓ Naltrexone for opioid use disorder

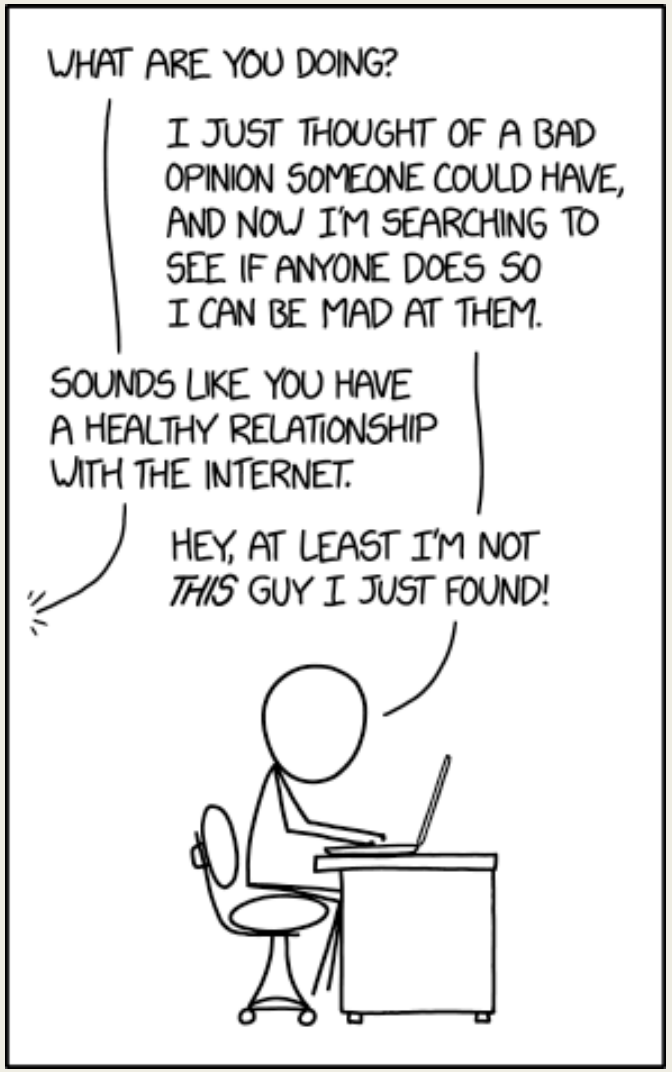
- ✓ Lipitor for high cholesterol
- ✓ Lisinopril for high blood pressure
- ✓ Insulin for diabetes mellitus
- ✓ Albuterol for asthma


“What do you think?”

Opinion vs. Fact

- What is your opinion about harm reduction?
- Does your opinion differ from the facts about harm reduction?

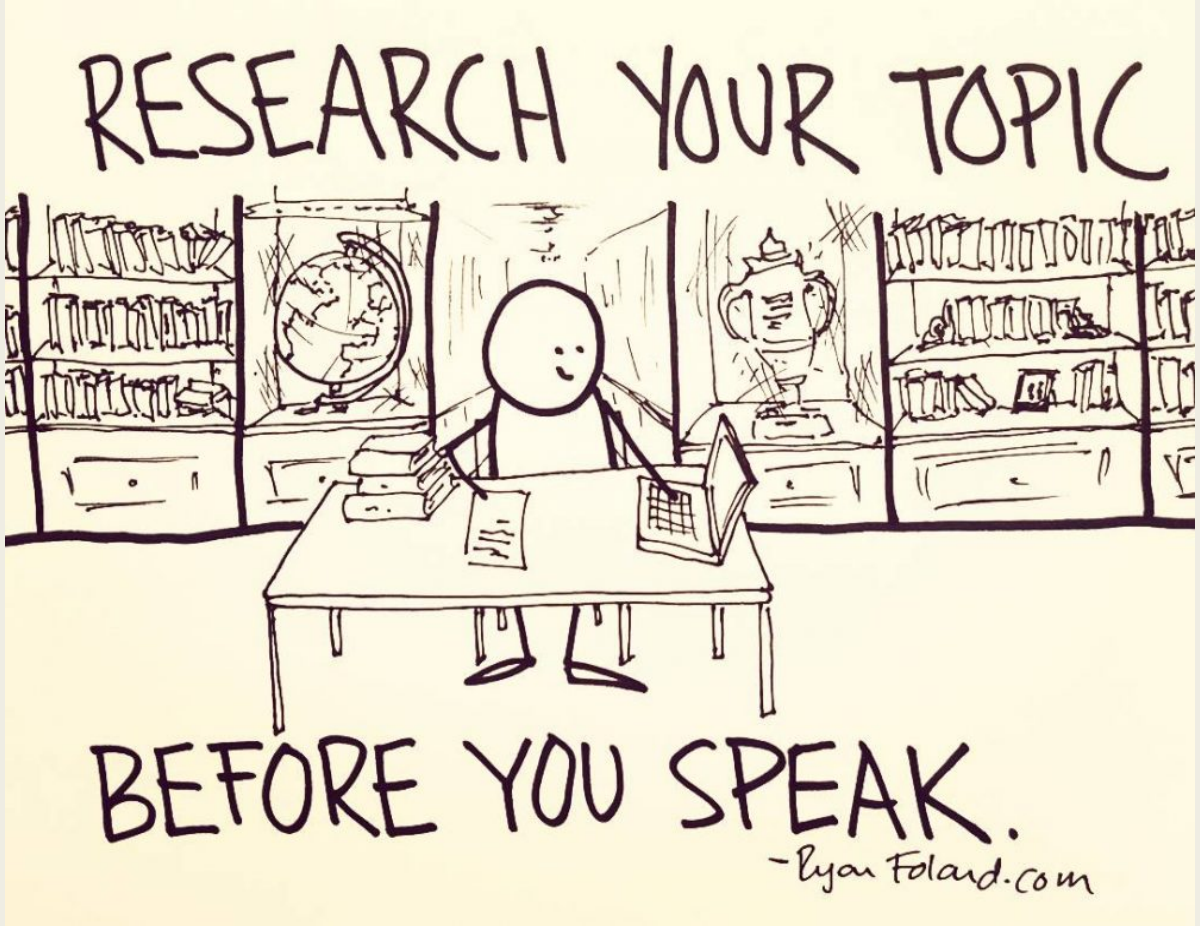




Personal opinions are not supported by personal or professional fact

Opinion vs. Fact

IF I OFFERED YOU $100,000 TO JUMP OUT OF A PLANE WITH NO PARACHUTE WOULD YOU DO IT?...I BET YOU SAID NO... BUT WHAT IF I TOLD YOU THE PLANE WAS ON THE GROUND... MORAL OF THE STORY... KNOW ALL THE FACTS BEFORE YOU OPEN YOUR MOUTH.



Facts about harm reduction

Naloxone Education & Distribution

Research on overdose education and naloxone

There is a growing body of research evidence that shows overdose education and naloxone distribution:

Are feasible:

- Piper et al. Subst Use Misuse 2008: 43: 858-70
- Doe-Simkins et al. Am J Public Health 2009: 99: 788-791
- Enteen et al. J Urban Health 2010: 87: 931-41
- Bennet et al. J Urban Health 2011: 88: 1020-30
- Walley et al. JSAT 2013: 44: 241-7 (Methadone and detox programs)

Are cost effective:

- Coffin et al. Ann Int Med 2013

Improve knowledge and skills to prevent overdose deaths:

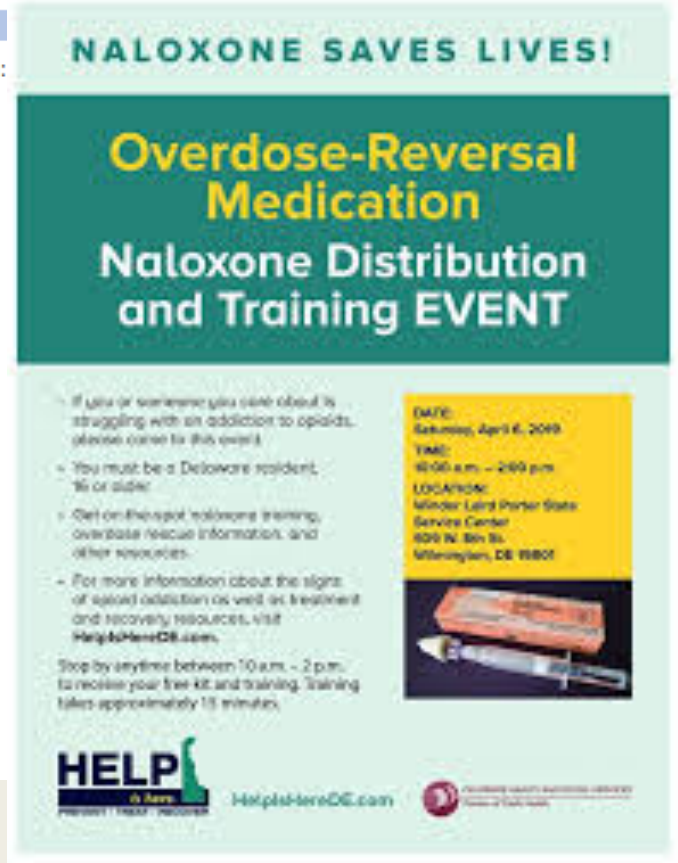
- Green et al. Addiction 2008: 103: 979-89
- Tobin et al. Int J Drug Policy 2009: 20: 131-6
- Wagner et al. Int J Drug Policy 2010: 21: 186-93

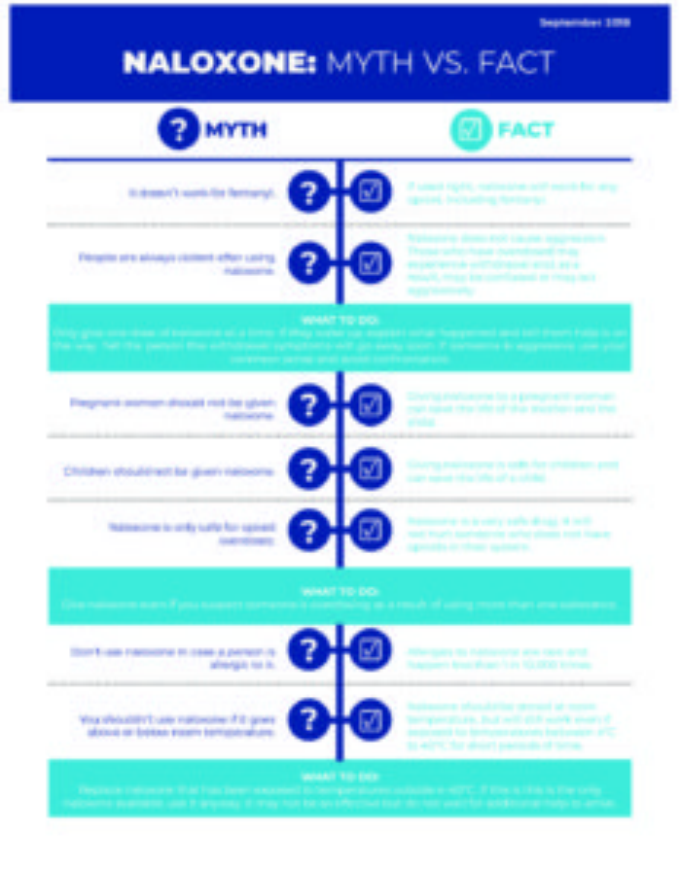
Reduce overdoses in communities:

- Maxwell et al. J Addict Dis 2006: 25: 89-96
- Evans et al. Am J Epidemiol 2012: 174: 302-8
- Walley et al. BMJ 2013: 346: f174

Do not increase drug use:

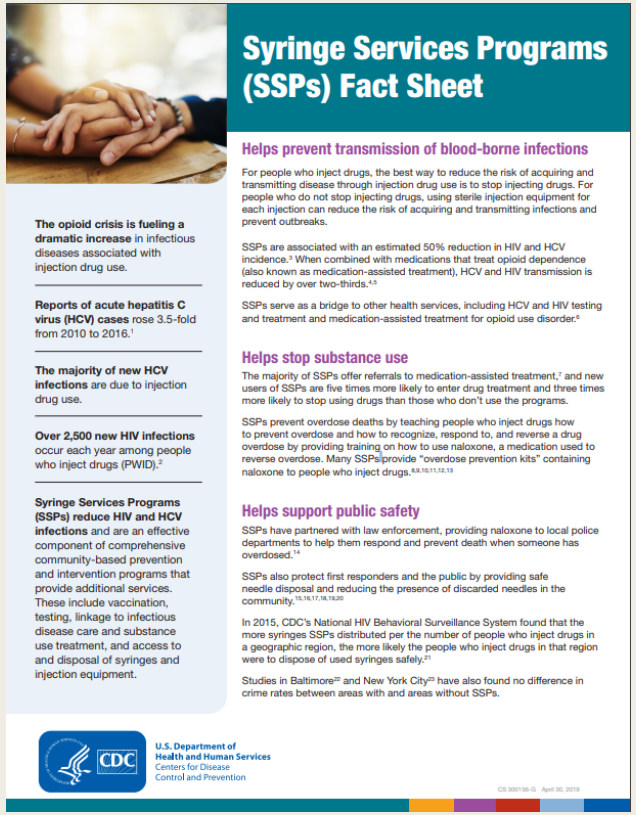
- Seal et al. J Urban Health 2005: 82: 303-11
- Doe-Simkins et al. BMC Public Health 2014: 14: 297





http://stopoverdose.org/docs/naloxonequickfacts.pdf

Syringe Services Programs



Syringe Services Programs (SSPs) Fact Sheet

The opioid crisis is fueling a dramatic increase in infectious diseases associated with injection drug use.

Reports of acute hepatitis C virus (HCV) cases rose 3.5-fold from 2010 to 2016.[1]

The majority of new HCV infections are due to injection drug use.

Over 2,500 new HIV infections occur each year among people who inject drugs (PWID).[2]

Syringe Services Programs (SSPs) reduce HIV and HCV infections and are an effective component of comprehensive community-based prevention and intervention programs that provide additional services. These include vaccination, testing, linkage to infectious disease care and substance use treatment, and access to and disposal of syringes and injection equipment.

Helps prevent transmission of blood-borne infections

For people who inject drugs, the best way to reduce the risk of acquiring and transmitting disease through injection drug use is to stop injecting drugs. For people who do not stop injecting drugs, using sterile injection equipment for each injection can reduce the risk of acquiring and transmitting infections and prevent outbreaks.

SSPs are associated with an estimated 50% reduction in HIV and HCV incidence.[3] When combined with medications that treat opioid dependence (also known as medication-assisted treatment), HCV and HIV transmission is reduced by over two-thirds.[4,5]

SSPs serve as a bridge to other health services, including HCV and HIV testing and treatment and medication-assisted treatment for opioid use disorder.[6]

Helps stop substance use

The majority of SSPs offer referrals to medication-assisted treatment,[7] and new users of SSPs are five times more likely to enter drug treatment and three times more likely to stop using drugs than those who don't use the programs.

SSPs prevent overdose deaths by teaching people who inject drugs how to prevent overdose and how to recognize, respond to, and reverse a drug overdose by providing training on how to use naloxone, a medication used to reverse overdose. Many SSPs provide "overdose prevention kits" containing naloxone to people who inject drugs.[8,9,10,11,12,13]

Helps support public safety

SSPs have partnered with law enforcement, providing naloxone to local police departments to help them respond and prevent death when someone has overdosed.[14]

SSPs also protect first responders and the public by providing safe needle disposal and reducing the presence of discarded needles in the community.[15,16,17,18,19,20]

In 2015, CDC's National HIV Behavioral Surveillance System found that the more syringes SSPs distributed per the number of people who inject drugs in a geographic region, the more likely the people who inject drugs in that region were to dispose of used syringes safely.[21]

Studies in Baltimore[22] and New York City[23] have also found no difference in crime rates between areas with and areas without SSPs.

CDC U.S. Department of Health and Human Services Centers for Disease Control and Prevention

CS 300156-G April 30, 2019

AIDScience Vol. 1, No. 16, December 13, 2001

The effectiveness of needle exchange programs: A review of the science and policy

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[2]Joseph L. Mailman School of Public Health, Columbia University, New York, New York, United States.

Abstract

Needle exchange programs (NEPs) permit injection drug users (IDUs) to exchange potentially contaminated syringes for sterile ones, with the aim of decreasing the circulation of contaminated injection equipment and reducing the spread of blood-borne pathogens in the community. Since the first NEP was introduced in Amsterdam in 1984, at least 46 regions, countries, and territories reported having at least one NEP by December 2000. Surprisingly, only one-third of countries where HIV has been reported among IDUs and only 40% of countries where injection drug use is known to occur have introduced at least one NEP. There are also considerable variations in NEP availability and coverage within and between countries, and sometimes within states or cities. This review discusses the history, science, and politics surrounding the implementation and evaluation of NEPs in both developed and developing countries, and suggests alternative mechanisms to increase coverage of sterile syringes among IDUs. We also suggest areas for further research to guide future attempts at interventions that aim to reduce the global spread of blood-borne infections.

Introduction

Multiperson use of needles and syringes contributes to a considerable illness burden in both developed and developing countries. Use of nonsterile syringes can occur within the context of illicit drug injection and is associated with transmission of blood-borne pathogens, including HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV), human T cell lymphotropic viruses, and even malaria. Syringe sharing, or even reuse of syringes by the same person, increases the risk of endocarditis, cellulitis, and abscesses.

From the public health perspective, it is important to ensure that persons who cannot or will not cease injection of illicit drugs are not at risk of these infections. In the United States alone, injection drug use accounts for approximately half of all new HIV infections annually, either directly through needle sharing between injection drug users (IDUs), or indirectly through sexual transmission among IDUs and their sexual partners (*1*). Although the incidence of vertical HIV transmission has decreased dramatically in developed countries since the advent of antiretroviral therapies offered to HIV-infected mothers, the majority of perinatally acquired HIV infections in North America can be traced back to a parent who was an IDU.

The urgency of providing IDUs with widespread access to sterile injection equipment is apparent on a global level when examining the link between initiation of injection and HIV infection (Table 1). In 1992, there were 80 countries, regions, and territories reporting injection drug use, of which 52 (65%) also reported HIV among IDUs. In 1999,

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Myth: Supporting injection drug users is not an efficient use of public resources

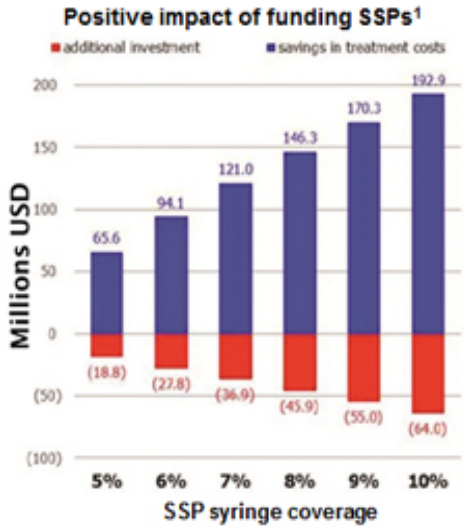
FACT CHECK SSPs are highly cost-effective

The Evidence:

A recent study has shown that an investment of $64 million would result in an estimated

$193 million in savings

by preventing 500 new HIV infections.[1]



[1]Nguyen, T. Q., Weir, B. W., Pinkerton, S. D., Des Jarlais, D.C., & Holtgrave, D. (2012). Increasing investment in syringe exchange is cost-saving HIV prevention: modeling hypothetical syringe coverage levels in the United States (MOAB0204). Presented at the XIX International AIDS Conference, Washington, D.C. Session available online at http://pag.aids2012.org/Abstracts.aspx?SID=1988&AID=17268.

Syringe Services Programs: Myth vs. Fact

amfAR

Syringe Services Programs

Why aren't needle exchanges legal in PA? Advocates, scholars and politicians are asking

Syringe programs have been shown to reduce HIV infection and combat harm.

Prevention Point's syringe exchange program in action PREVENTION POINT

Michaela Winberg

Mar. 22, 2018, 9:00 a.m.

Supervised Injection Facilities

- 2014 systemic review concluded:
  - *“All studies converged to find that SIFs were efficacious in attracting the most marginalized people who inject drugs, promoting safe injections conditions, enhancing access to primary health care, and reducing the overdose frequency. SIFs were not found to increase drug injecting, drug trafficking or crime in the surrounding environments. SIFs were found to be associated with reduced level of public drug injections and dropped syringes.”*

Potier et al., "Supervised injection services: What has been demonstrated? A systematic literature review," 48.

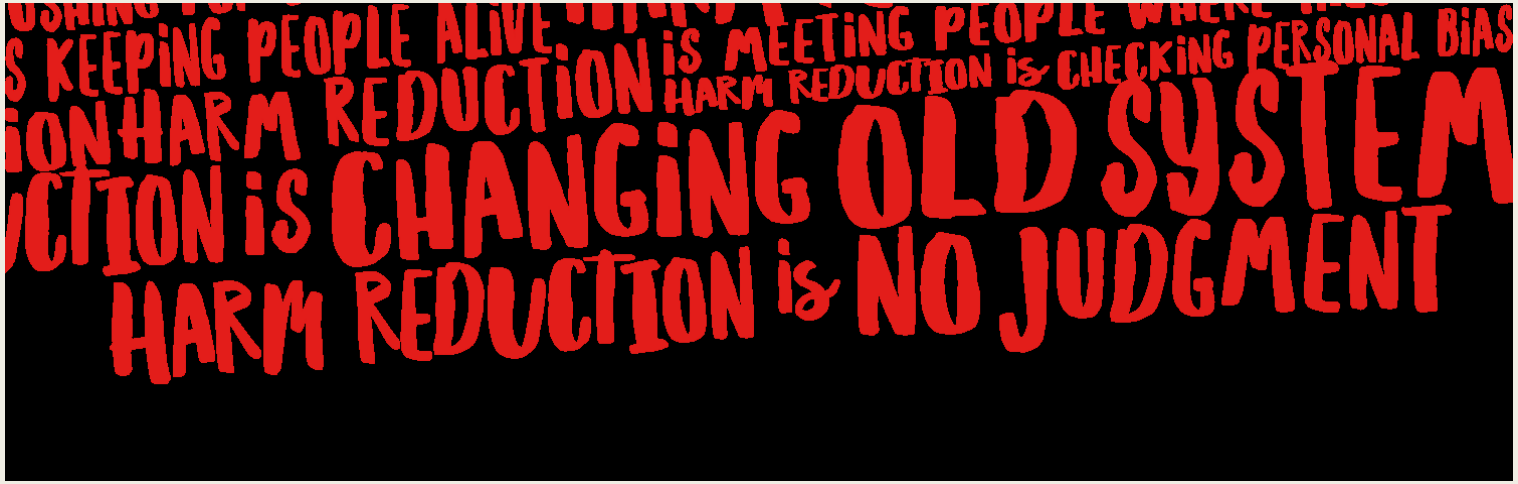
Medications for Addiction Treatment

- Agonist-based treatments for OUD are most effective and most stigmatized
- Patients who use agonist-based medications to treat their OUD:
  - *Remain in therapy longer than those who don't*
  - *Are less likely to:*
    - Use illicit opioids
    - Contract a blood-born infection (Hepatitis C, HIV, etc.)
    - Die from an overdose

https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2017/02/the-case-for-medication-assisted-treatment

What is harm reduction?

- A set of practical strategies and ideas aimed at **reducing** negative consequences associated with drug use without necessarily stopping use
- A movement for social justice built on a belief in, and respect for, the rights of people who use drugs



Harm reduction and social justice

- The United States has chosen to frame substance use problems in terms of a medical and criminal model
- Policies are aimed primarily at drug supply reduction and to a much lesser extent drug demand reduction
  - *There seems to be a belief that social ills will be healed if we eliminate all non-medical drug use*
- Despite enormous expenditures for drug control enforcement and the severe infringement on social justice and human rights, illicit drug use continues

HARM REDUCTION:

A Social Work Practice Model and Social Justice Agenda

Jo Brocato and Eric F. Wagner

Efforts in the United States to eradicate drug use through supply reduction (that is, the War on Drugs) have increasingly violated the principles of social justice and human rights, both locally and globally. This has created ethical conflicts for social workers in policy making, practice, and research. Harm reduction has been conceptualized as a peace movement and is aligned with the humanistic values around which social work is organized. The authors examine how social workers may reduce the ethical conflicts associated with efforts to address substance abuse by adopting a harm reduction approach to policy, practice, and research. They examine current drug policies, the consequences of the policies, and, in particular, how the policies affect social workers as practitioners, agents of social control, and guardians of social justice.

Key words
harm reduction
practice
social policy
substance abuse

Substance use problems have been characterized by some scholars as a manifestation of deeper, more pervasive ills of society such as poverty, discrimination, and a widening technological gap. (Currie, 1993). As a nation, we have chosen to frame substance use problems in terms of a criminal and medical model. We approach the problems through policies aimed primarily at drug supply reduction and, to a far lesser extent, at drug demand reduction with, perhaps, the belief that the deeper social ills will be healed if we can eliminate all nonmedical drug use (see Office of National Drug Control Policy [ONDCP], 1997). The main criticism of current drug policy is that, despite the financial expenditures for drug control enforcement and the severe infringement on social justice and human rights, illicit drug use continues, and the needs of those who seek treatment are not being sufficiently met. With regard to civil liberties and justice, social workers have observed that

> the focus of politicians and the media on crime and the criminalization of many activities has masked the social problems that lie behind the growing crime rate. However, the emphasis on public fear has served as a rationale for diverting resources from programs that address those problems to the construction of prisons and the expansion of police power. They also have provided the justification for the infringement of defendants' rights and the erosion of many of the protections guaranteed in the Bill of Rights. (NASW, 2000c, p. 33)

Federal spending for drug control was $1.6 billion in 1985, $10.5 billion in 1991, and more than $19 billion in 2000. Even after adjusting for inflation, this represents an almost tenfold increase in federal drug control spending from 1985 to 2000. In 2000 policy provisions established by the Office of National Drug Control Policy continued to give the lion's share of the budget to interdiction and enforcement (67 percent), whereas a youth media campaign and treatment received the least (32 percent), (Drug Policy Foundation [DPF], 2000; ONDCP, 2000). A RAND study indicated that even these figures for spending on treatment may be inflated up to 60 percent in

CCC Code: 0360-7283/03 $3.00

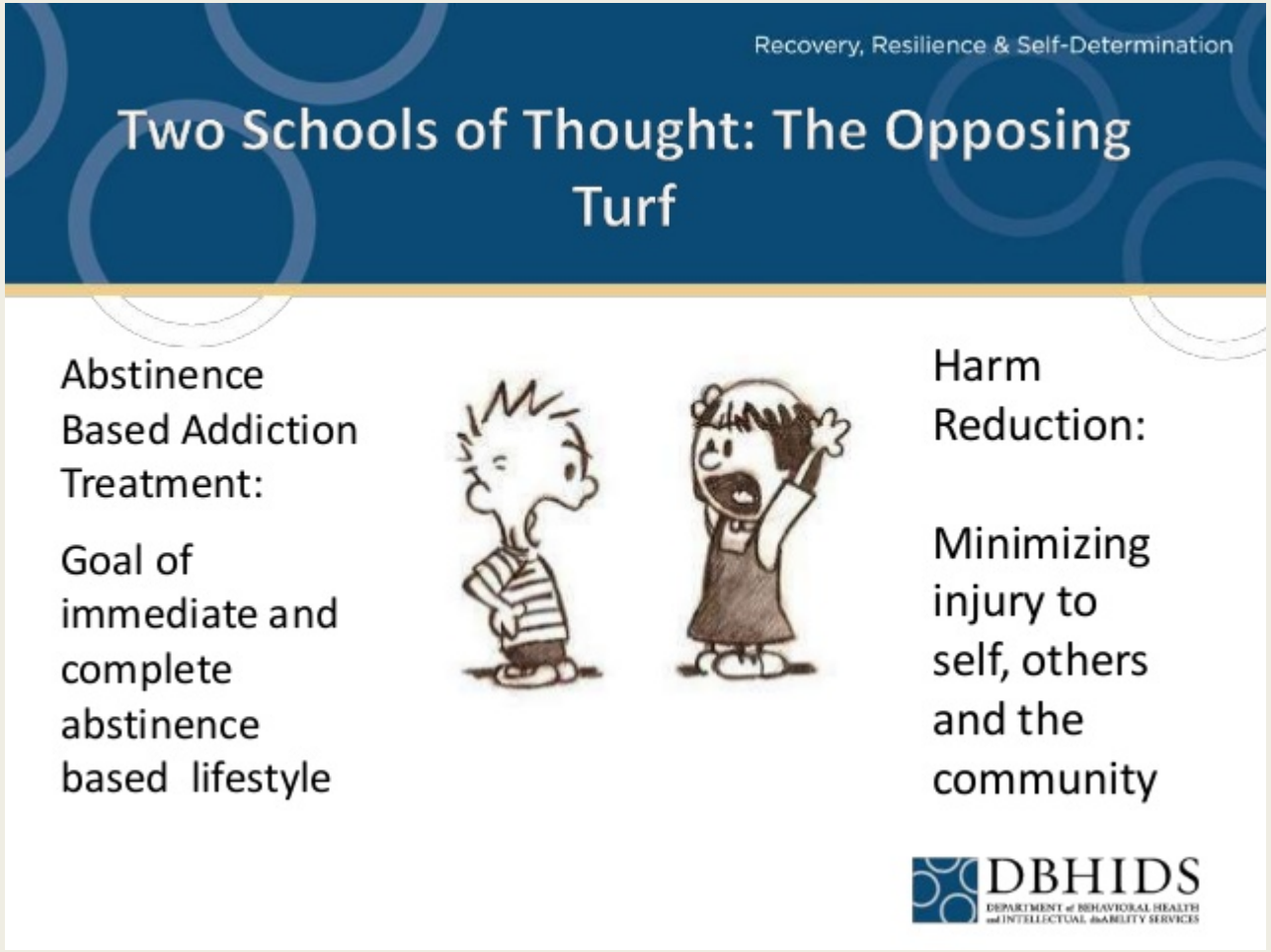
Harm reduction and social justice

(Lawmakers like things that save or make money)

Talking about “hot button” issues

Consider possible sources of participants views

Harm reduction vs. abstinence based treatment



Harm reduction vs. abstinence based treatment

- Abstinence-based treatment
  - *One must have a goal of abstinence to qualify for treatment*
  - *One must be abstinent in order to remain in treatment*

- **Low-threshold treatment programs**
  - *are harm reduction-based health care centers targeted towards drug users.*[1] *“*
  - *make minimal demands on the patient, offering services without attempting to control their intake of drugs, and providing counselling only if requested.*
  - *may be contrasted with "high-threshold" programs, which require the user to accept a certain level of control and which demand that the patient accept counselling .*[2]

1) *Islam, M. M.; Day, C. A.; Conigrave, K. M. (2010). "Harm reduction healthcare: From an alternative to the mainstream platform?". International Journal of Drug Policy. **21** (2): 131–133. doi:10.1016/j.drugpo.2010.01.001. PMID 20092999.*

2) *Waal, Helge. "Risk reduction as a component of a comprehensive, multidisciplinary approach to drug abuse problems" (PDF). The Pompidou Group. Retrieved 25 March 2012.*

Harm reduction vs. abstinence based treatment

- Can these approaches be integrated?

Find common ground

- Not only can harm reduction and abstinence based substance abuse treatments be integrated, their integration is more powerful than either approach alone

Talking about “hot button” issues

- Know yourself - before discussing difficult topics consider your own biases or confusion surrounding the issue
- If the conversation is foreseeable, prepare ahead of time
- Focus on patient stories (or bring a patient to speak if possible)
- Consider possible sources of participants views
- If the topic arises in response to an unpleasant news story, strike a balance between not tiptoeing around the event, and not dissecting every detail
- Foster a climate of mutual respect and curiosity, and set an early expectation of open and honest communication
- Provide methods of participation other than speaking
- Anticipate follow-up. Suggest others take helpful action if they feel strongly about the issue
- Be ready to defer the conversation
- Reflect, gather feedback, and refine your approach

www.educationworld.com/a_curr/difficult-discussions-classroom-tips.shtml
citl.indiana.edu/teaching-resources/diversity-inclusion/managing-difficult-classroom-discussions/

questions

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