



HARM REDUCTION

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OBJECTIVES

- Define Harm reduction.
- Understand how harm reduction theory is applied clinically.
- Explore how to analyze the spectrum of Harm Reduction efforts, including pros and cons of its application.

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.” –Harm Reduction Coalition

“Policies and programs which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individuals drug users, their families and their communities”. -International Harm Reduction Association

<https://www.youtube.com/watch?v=W7epsLmN604>

I DON'T PROMOTE DRUG USE.
I DON'T PROMOTE CAR
ACCIDENTS EITHER, BUT I STILL
THINK SEATBELTS ARE A GOOD IDEA.

Harm Reduction - practicing common sense since the 1980's.

HISTORY

- Term coined in 1980s in Amsterdam and UK by drug users and providers who wanted to address rising HIV rates.
- Semblances of HR can be found in medical writings in the UK as early as 1926 in ref to treating OUD.
- Generally contrasted with “zero tolerance”, “war on drugs”, and abstinence only approaches.



HARM REDUCTION PRINCIPLES

- Harm Focus: Does not ignore or minimize the dangers associated with any drug use, rather attempts to find ways to decrease the severity and tragedy of these dangers.
 - Overdose
 - Infection
 - Lung disease
 - Illegal activity and Incarceration
 - Addiction
 - Sex work and victimization
 - Psychosis
 - Trauma (aggression, accidents)



HARM REDUCTION PRINCIPLES

- **Realism:** Accepts that drug use is part of the world and not something that will likely be eradicated
- **Flexibility:** Does not entail one specific approach, generally is flexible to individual people and communities/cultures
- **Pragmatism:** Identifies that some ways of using drugs are safer than others
 - Cessation of drug use is not the goal
 - Balance of risk and benefit

HARM REDUCTION PRINCIPLES

- **Social Justice:** Attempts to give a voice to drug users, allowing them to define their own trajectory (meet them where they are)
 - Recognizes that realities of power discrepancies make some people more vulnerable to drug use and its related harm (poverty, class, racism, social isolation, past trauma, sex-based discrimination)
 - Hopes to create community level organization to influence drug users to share safe resources

**HARM REDUCTION
VALUES LIFE, CHOICE,
RESPECT AND COMAPSSION
OVER JUDGMENT, STIGMA,
DISCRIMINATION AND
PUNISHMENT.**

STIGMA AND ACCESS

- Language is important
 - implies blame or moral failing
- What is your patient's social identity? (what inequities face your patient?)
 - Education
 - Trauma
 - Employment, Housing
 - Health and Disability
 - Gender/sex/race/ethnicity
 - Family and social dynamics
- Protecting people who seek help
- Treating as a medical condition with understanding patients may distrust medical system
- Allowing patients to make their own informed decision

**There is no war on drugs,
because you can't war on
inanimate objects.**

**There's only a war on drug
addicts, which means we are
warring on the most abused
and vulnerable segments
of society.**

Dr. Gabor Maté



THE MIND PROJECT

STIGMA AND ACCESS

- Feelings are not Facts
 - Abstinence based programs do not help, but they make those in control **feel** better based on historical ideals
 - Conflicts arise around moral, religious, personal values
- Misinformation that harm reduction increases drug use, drains resources, threatens public safety

CONTROVERSY

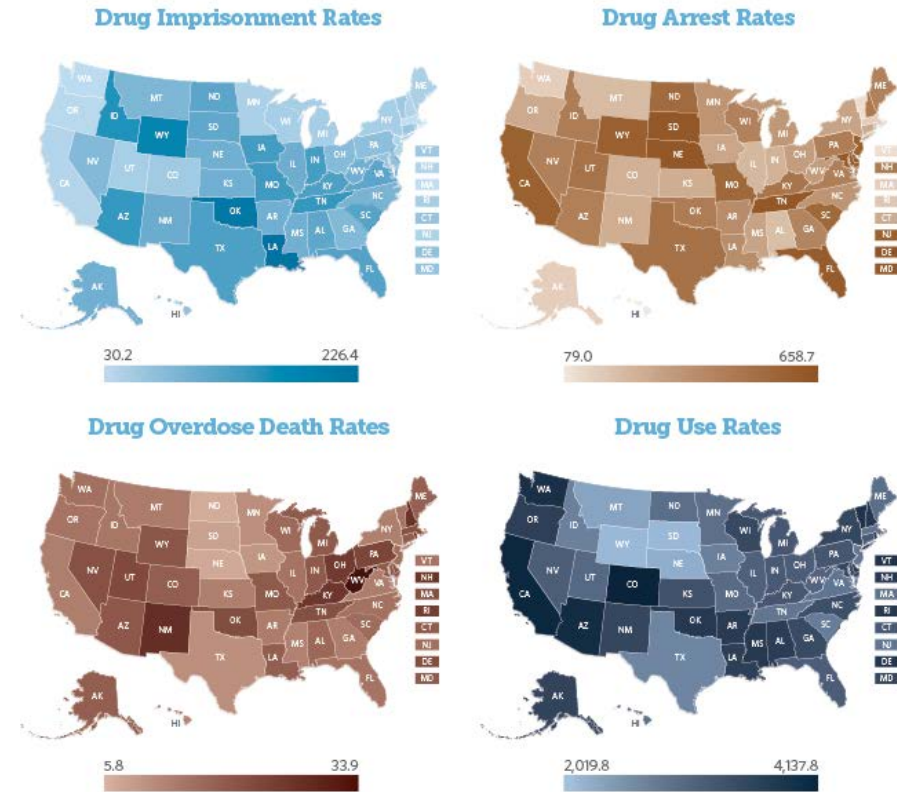
- Myth: HR is enabling of drug users
 - MMT, when compared to abstinence and placebo treatment, reduces drug use, retains patients in treatment, prevents infection, reduces mortality and crime
- Myth: HR encourages new drug use
 - Needle exchange- research to date shows no evidence that drug use increases in areas with needle programs, most evidence shows drug use, crime, etc decline
 - When programs are shut down, crime and drug use increase
 - Twisted message: Harm focused principle *never* advocates that drug use is harm free
- Myth: HR promotes legalization of drugs
 - No consensus message from HR world
 - Decriminalizing drugs may cause drug users less harm by improving their access to “normal” life (e.g. jobs)
 - Imprisonment for drug offenses do not correlate with drug use rates

DRUGS AND PUNISHMENT

- “Putting more drug-law violators behind bars for longer periods of time has generated enormous costs for taxpayers, but it has not yielded a convincing public safety return on those investments. Instead, more imprisonment for drug offenders has meant limited funds are siphoned away from programs, practices, and policies that have been proved to reduce drug use and crime.”
 - Pew Charitable Trusts Public Safety Performance Project

Drug Imprisonment Not Correlated With Drug Use, Arrests, or Overdose Deaths

4 measures of drug problems by state



Note: All rates are per 100,000 residents.

Source: Pew’s analysis of 2014 data from 48 state corrections departments, the federal Bureau of Justice Statistics National Corrections Reporting Program (for California and Maine), the Federal Bureau of Prisons, the Centers for Disease Control and Prevention, the Federal Bureau of Investigation’s Uniform Crime Reporting (UCR) Program, and the Substance Abuse and Mental Health Services Administration’s National Survey on Drug Use and Health. See the “Data and methodology” section for more information.

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UTAH OPINION

- “73 percent of state voters—including 74 percent of Republicans, 73 percent of independents, and 71 percent of Democrats—favored a bipartisan commission’s recommendation to reclassify simple drug possession from a felony to a misdemeanor.”
- “70 percent believed that “prison is not the best place for people who are addicted to drugs. Requiring offenders to get treatment and increasing community supervision rather than sending them to prison will more effectively stop the cycle of addiction and make our communities safer.”
- “85 percent expressed support for “shorter prison sentences for inmates who complete rehabilitative substance abuse and mental health treatment programs while in prison.”
 - Mellman Group Public opinion poll



“JUST SAY NO?”

- Counterintuitive that people disobey in the face of authority and clear negative outcomes of drug use
 - Clearly not using drugs should be preferable and those who use anyway do so out of some personal flaw....right?
- Fear and alarmism only increase shame and stigma without arming people with tools
- Programs that emphasize social interactions, rather than education work better
 - Education around behavioral norms may be most helpful to prevention
 - Repeated sessions that evolved through development help to reinforce lessons
 - Peer involvement



HARM REDUCTION SAVES MONEY

- Decreases cost of emergency services and hospitalization
- Preventing expensive treatments costs for diseases like HIV
 - saving approx \$500,000 for every case of HIV averted
- Preventing unwanted pregnancy
- Preventing costs to legal system
 - Most people return to drug use after jail/prison
 - Costs range from misdemeanors, court costs, jail/prison costs, etc
- Other non-financial costs saved to families, children, communities that manage other aspects of addiction directly/indirectly

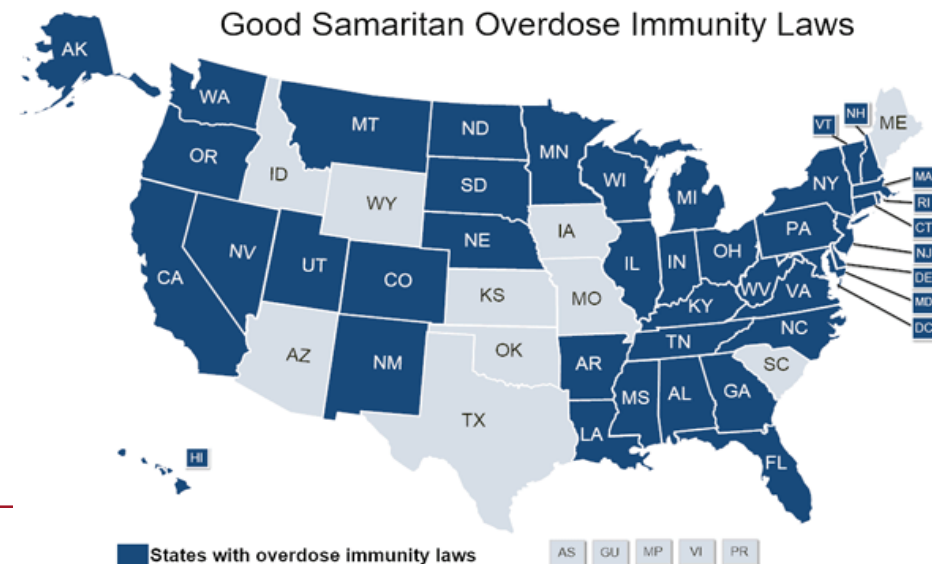
EXAMPLES OF HARM REDUCTION EFFORTS

- Needle exchange
 - Utahharmreduction.org, OneVoicerecovery.com
 - Utah Syringe Exchange
- Wet shelters
- Free taxicab programs
- Supervised injection facilities (SIF)
- Safe consumption sites (SCS)
- Suboxone, methadone
- Narcan trainings and distribution
- Safe sex programs, Condom distribution , legalizing sex work
- Drug decriminalization efforts
- Motivational interviewing (?)
- Drug checking
 - Dancesafe.com, Bunkpolice.com, lunarlaboratories.com sell kits
- Fentanyl test strips
 - Can be detected “nearly 100% of the time”- Johns Hopkins 2018
 - Test kits considered paraphernalia in some states



NALOXONE (NARCAN)

- Indication: Opioid overdose
 - Know the signs of opioid overdose!
- Opioid antagonist- reverses overdose by more strongly preferring the opioid receptor for 60-90 mins
- Naloxone prevents death, it does not lead to increased drug use
- Providing kits and education can get people into treatment
- Call 911!



NALOXONE (NARCAN)

In case of overdose:

1 Check responsiveness

Look for any of the following:

- No response even if you shake them or say their name
- Breathing slows or stops
- Lips and fingernails turn blue or gray
- Skin gets pale or clammy

2 Call 911 and give naloxone

If no reaction in 3 minutes, give second naloxone dose

3 Do rescue breathing and/or chest compressions

Follow 911 dispatcher instructions

>> STAY WITH PERSON UNTIL HELP ARRIVES.

How to give naloxone:

There are 4 common naloxone products. Follow the instructions for the type you have.

Nasal spray

This nasal spray needs no assembly and can be sprayed up one nostril by pushing the plunger.





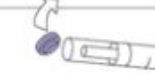
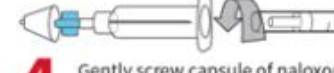

Auto-injector

The naloxone auto-injector needs no assembly and can be injected into the outer thigh, even through clothing. It contains a speaker that provides step-by-step instructions.



Nasal spray with assembly



This requires assembly. Follow the instructions below.

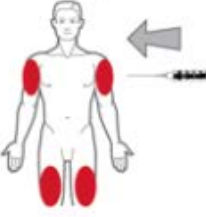
- 1 Take off yellow caps. 
- 2 Screw on white cone. 
- 3 Take purple cap off capsule of naloxone. 
- 4 Gently screw capsule of naloxone into barrel of syringe. 
- 5 Insert white cone into nostril; give a short, strong push on end of capsule to spray naloxone into nose: **ONE HALF OF THE CAPSULE INTO EACH NOSTRIL.** 

Push to spray.
- 6 If no reaction in 3 minutes, give second dose.

Injectable naloxone

This requires assembly. Follow the instructions below.

- 1 Remove cap from naloxone vial and uncover the needle. 
- 2 Insert needle through rubber plug with vial upside down. Pull back on plunger and take up 1 ml. 

fill to 1 ml
- 3 Inject 1 ml of naloxone into an upper arm or thigh muscle. 
- 4 If no reaction in 3 minutes, give second dose.

METHADONE MAINTENANCE TREATMENT (MMT) BASICS

- Schedule II
- Approved 1972 by FDA for opioid use disorder
- Long acting opioid (mu) that satisfies drug hunger and blocks high of other opioids
- Normalizes physiologic stress caused by other drug use
- Liver metabolism



METHADONE MAINTENANCE TREATMENT (MMT) BASICS

- Multiple drug interactions, some cause more problems than others
- Blackbox warning for overdose risk
- Cardiac risks- bradycardia, QT prolongation
- Been around so long, lots of opinions
- Limitations on who/why can prescribe
 - **Addiction** treatment must be provided in Federally recognized opioid treatment settings
 - Any provider with DEA can give for **pain**

METHADONE MAINTENANCE TREATMENT (MMT) BASICS

- Systematic reviews generally identify MMT as the “most effective” due to treatment retention, lower relapse rates and decrease in illicit drug use.
- Some patients require full agonism for relief
- Clinics have low threshold for treatment inclusion, AND more oversight than what’s provided in most outpatient clinics
 - Open door policy
 - Safe for most patients despite warnings
 - Accessible by homeless, uninsured, marginalized
 - Daily dosing
- Often most effective when combined with strategies that target vulnerable populations, assist with housing, provide mental health services, include public health initiatives, etc.

CAN WE TAKE HARM REDUCTION TOO FAR?

- Weighing risks and benefits of care can be difficult
- Limits and boundaries are okay, too
 - Examples?
 - Giving suboxone or methadone to patients using benzos, cannabis, etc....



Photo by Dan Wayland



“Ultimately we know deeply that the other side of every fear is a freedom.”

Marilyn Ferguson