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We Should Promote Harm Reduction to Combat the Opioid Overdose Crisis

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70,652. That is how many people died from drug overdoses between July 2017 and June 2018.[1] At least 70% of these deaths involved opioids. Yet, the U.S. continues to struggle with how to halt the current opioid overdose crisis and prevent future drug crises. One potential reason for the continued rise in fatal drug overdoses is the U.S.'s failure to embrace harm reduction approaches that have proven successful in countries like Canada and Portugal. There are general schools of thought on how to approach, treat, and define recovery, but rarely do we in the U.S. consider what needs to happen before an individual is ready to quit using drugs. How do we keep them alive and healthy long enough to enter into recovery? The answer is to promote harm reduction approaches.

What is Harm Reduction?

Harm reduction is a toolbox of strategies and theories that can reduce negative consequences associated with drug use. It does not ignore the negative consequences of drug use, but rather, accepts that people use drugs for complex reasons and need advocacy and support to stay alive.[2] Harm reduction aims to provide services to individuals based on "where they are at" in the stages of change model,[3] which flows from "pre-contemplative" to "maintenance". One of the main pillars of harm reduction is to provide "low threshold" services to individuals seeking services and to incorporate input from consumers. People who inject drugs (PWID) face several obstacles to accessing medical or supportive care such as stigma about their drug use from medical and/or local communities, lack of medical insurance or being underinsured, lack of access to transportation, mental health issues (including past trauma), and legislation which hinders health care professional from providing long-term sustained treatment. Providers of harm reduction-based low threshold services acknowledge these barriers and attempt to eliminate them. Examples of low-threshold services include standing orders for Naloxone prescriptions at local pharmacies, Medication Assisted Therapy (Methadone, Suboxone, and Vivitrol) without the use of toxicology screening or mandated mental health counseling, Law Enforcement Assisted Diversion (LEAD) programs, and Syringe Exchange programs.

Program Example: Syringe Exchange Programs

One of the most successful programs under the umbrella of harm reduction is the Syringe Exchange Program (SEP). SEPs operate as a single point of access for PWID. They provide several services to those actively engaging in injection drug use such as clean, free needles and injecting equipment, safe injection counseling, matching an individual's drug of choice with the correct gauge needle, and a judgement-free space for an individual to talk about their struggles, needs, and aspirations. SEP employees are often the first person PWID can turn to and trust to talk about their use, which could be their first step to entering into recovery. Enrolling into a SEP is confidential,

and participants are given a unique identification card to carry to protect them from arrest should they be found in possession of syringes.

SEPs are also often the first opportunity for health professionals to talk to PWID about their risk for HIV and Hepatitis C Virus (HCV). For decades, injection drug users have had among the highest rates of new HIV infections in the world, and the recent opioid crisis is leading to new outbreaks in some parts of the U.S. For example, in 2015, an HIV infection outbreak spread through a network of PWID in a small rural community in Scott County, Indiana. Out of a population of 4,200, at least 194 people were infected, and nearly 95% of those were also infected with HCV.[4] The CDC has identified another 220 counties across the U.S. that are vulnerable to the rapid spread of HIV and HCV due to larger networks of PWID. SEPs have been found to be effective in reducing these outbreaks. For example, in 1990 in New York City, 50% of PWID were HIV positive, reflecting a 4% infection rate within the population. With the implementation of SEPs across the boroughs, by 2000, NYC saw a 30% decrease in new HIV positive infections.[5]

Innovation is the Key to Harm Reduction's Success

Harm reduction philosophies and programs save lives, but in order for us to combat the opioid overdose epidemic, communities must provide innovative and collaborative programing for PWID. The criminalization and incarceration of people who use drugs serves only to push people away from the services they need to survive. Harm reduction services should be further expanded into the criminal justice system by way of Opioid Courts, restructuring the sentencing for drug charges, and incorporating Law Enforcement Assisted Diversion (LEAD) programming into every community.

Opioid Courts

Opioid Courts are a new, emerging initiative in New York State that work to stabilize, treat, and potentially dismiss charges for individuals that enter into the justice system and are opioid dependent. The end goal of Opioid Court is to decrease overdose deaths and move people into recovery programs. They operate as a judicially-supervised triage program where participants are linked with medication assisted treatment and/or behavioral treatment within hours of their arrest. Defendants must make daily court appearances for a maximum of 90 days. This accountability is often what keeps them from relapsing. Buffalo, NY opened the first Opioid Court in New York State. Since its inception in May 2017, 432 individuals have passed through the court - 430 of them are alive today[6]. The key to this court's success lays in the fact that the Judge acknowledges that opioid dependence is a public health concern, one that cannot be solved through arrests.

Law Enforcement Diversion Programs

This same harm reduction approach is embraced by police departments that pair with community-based organizations through Law Enforcement Assisted Diversion (LEAD) programs. These programs are designed to steer low-level, largely repeat offenders into case management services. When there is probable cause that an individual committed a non-violent drug offense (example: criminal possession of a controlled substance in the fifth degree, non-violent penal law misdemeanor), the Officer has the discretion to offer that individual a referral to a case management program rather than arrest. If the individual agrees, they must meet with a case manager within 30 days of the referral and be willing to set goals and attempt to achieve them. Not only does a program like this allow individuals an opportunity to receive services to increase their health and well-being, but it serves as a cost saving tool. LEADS have been shown to decrease recidivism by 58% when compared to a group that went through the traditional criminal justice system.[7]

Where do we go from here?

Harm reduction approaches must be considered as a promising strategies to combat the opioid overdose crisis. Programs like SEP, LEAD, and Opioid Court have been shown to decrease incidences of overdose, HIV, and HCV, save communities significant medical care costs, and decrease the likelihood of justice involvement. European counties such as Portugal are proof of harm reduction's success. Known for having one of the highest overdose rates in Europe, in 2001 Portugal decided to decriminalize nonmedical drug use and focused almost exclusively on harm reduction. Since then, the country has seen a 75% reduction in heroin use and a 95% drop in HIV infections.

Harm reduction approaches work, and it is essential that we all work to end the stigma against harm reduction and the individuals who are reliant on these programs for survival. We must view drug use as the public health problem that is it, and not as a moral failing. Those with substance use disorders deserve opportunities to better their lives. Harm reduction approaches are proven safe and effective ways to do so.

Endnotes

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