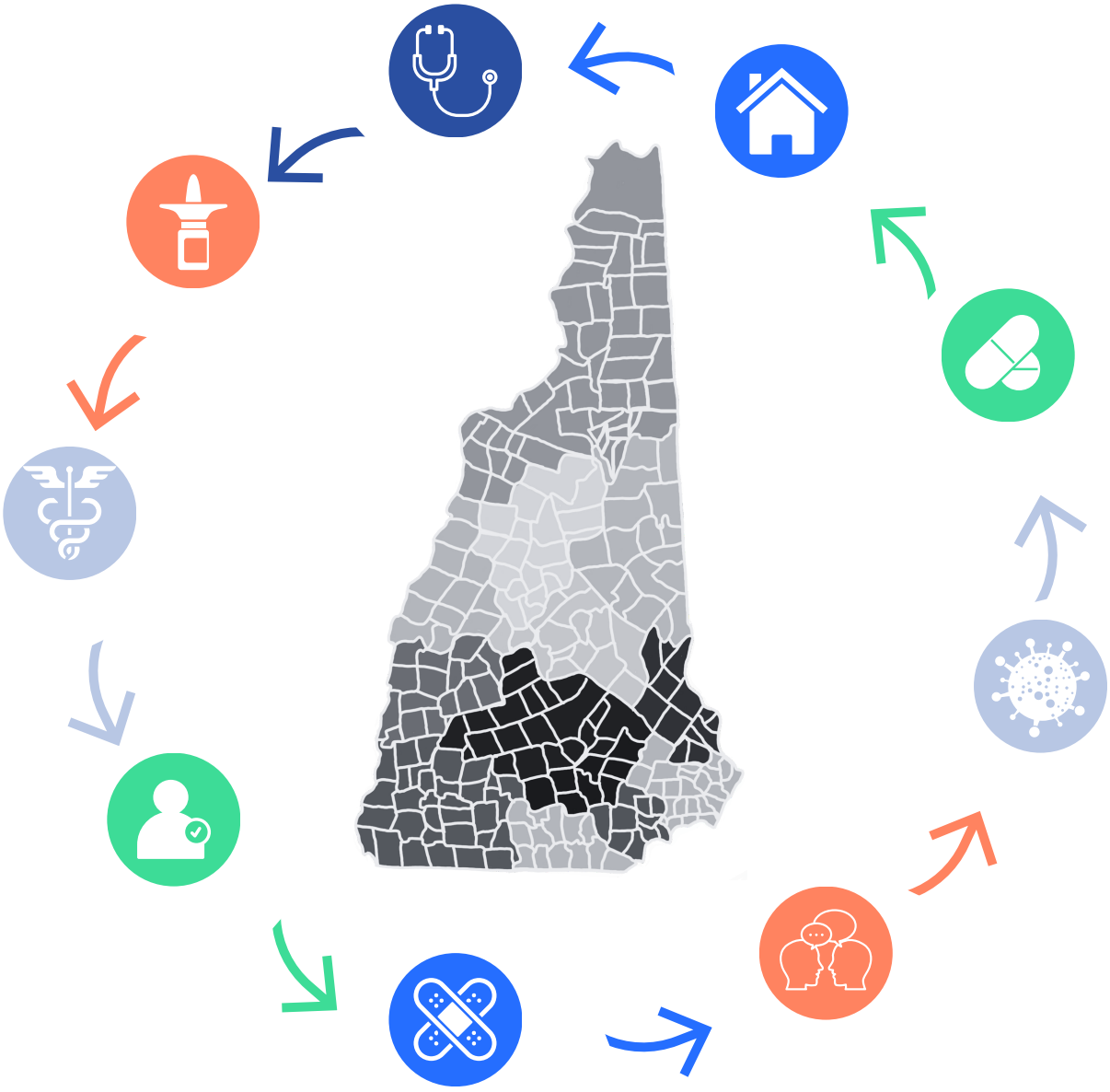
HARM REDUCTION PRACTICES AND EVIDENCE

AN EDUCATIONAL RESOURCE FOR NH DECISION-MAKERS



NH Nursing | HRETA Harm Reduction Education & Technical Assistance | NHHRC

OPPORTUNITIES TO STRENGTHEN COMMUNITIES & SYSTEMS

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PROJECT OVERVIEW

HARM REDUCTION ACADEMIC DETAILING PILOT PROJECT

This pilot project is funded by the National Association of County and City Health Officials (NACCHO) through the Centers for Disease Control and Prevention (CDC) to:

- Provide education on harm reduction (HR) strategies for substance use (SU) through academic detailing sessions
- Improve ability to integrate SU and HR evidence into their roles
- Improve the health of people who use drugs (PWUD)

HARM REDUCTION EDUCATION AND TECHNICAL ASSISTANCE PROJECT

The Harm Reduction Education and Technical Assistance (HRETA) project is a collaboration between the University of New Hampshire's Department of Nursing and the New Hampshire Harm Reduction Coalition. Since 2019, the HRETA team has:

- Engaged ~300 healthcare and community-based providers with Academic Detailing (AD), a one-on-one educational model to disseminate evidence-based practices
- Conducted more than 75 trainings attended by more than 600 professionals
- Collected surveys from 175 pharmacies
- Engaged staff from all 13 NH Regional Public Health Networks (RPHN)
- Created 10+ harm-reduction-focused resources

Special Thanks

Thank you to all who contributed their expertise to the creation of this project's key messages and resources, including NHHRC syringe service participants, NHHRC staff and leadership, members of the HRETA Steering Committee, representative NH elected officials, the NACCHO team, and NaRCAD.

HARM REDUCTION SEEKS TO PROMOTE PRACTICAL STRATEGIES

Harm Reduction (HR) comprises a practical, Humanistic approach to addressing stigmatized substance use and related issues. Though often thought of as *anti-abstinence* or *pro-drug*, HR is better understood as a lens for viewing stigmatized risk behavior apart from commonly held abstinence-only approaches. The term also describes a global social movement begun by people who inject/ed drugs and sex workers in response to the emerging AIDS epidemic. Since 1981, these communities have pioneered protective interventions such as syringe services programs (SSP) and peer-based distribution of naloxone (Narcan). Expansive implementation and scientific study of these and other harm reduction strategies to address problematic substance use (SU) continue to amass a consistent evidence basis. In 1993, harm reduction service leaders developed a set of principles and a national organization to guide harm reduction efforts in the U.S.:

8 GUIDING PRINCIPLES: HARM REDUCTION ...

from the National Harm Reduction Coalition [1]

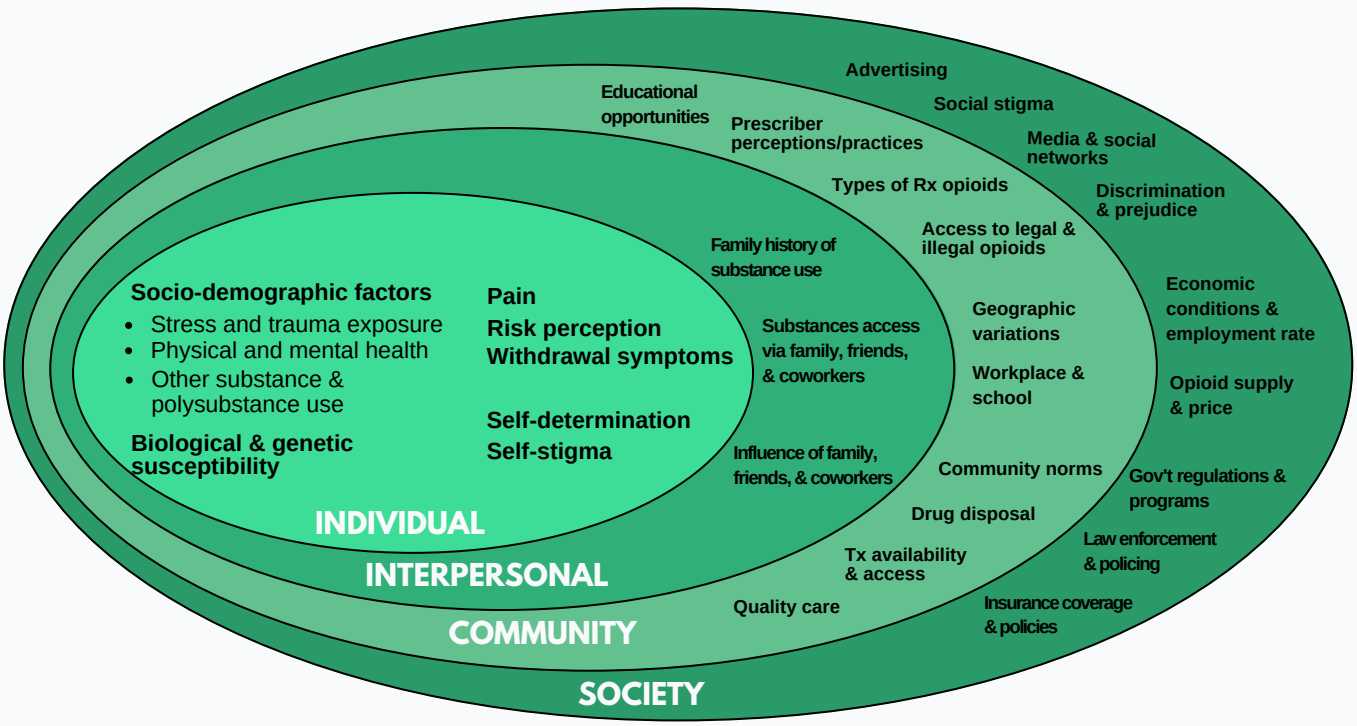
- Accepts that drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them
- Understands drug use as complex and acknowledges that some ways of using drugs are safer than others
- Establishes quality of individual and community life and well-being as the criteria for successful interventions and policies
- Calls for non-coercive provision of services for PWUD
- Ensures that PWUD have a real voice in the creation of programs an policies designed to serve them
- Affirms PWUD as the primary agents of reducing the harms of their drug use and seeks to empower PWUD to share information and support each other
- Recognizes that poverty, class, racism, social isolation, past trauma and sex-based discrimination affect people's vulnerability to and capacity for effectively dealing with drug-related harms
- Does not attempt to minimize or ignore the real and tragic harm and danger that can be associated with drug use

LOOKING BEYOND THE DRUGS

Harm reduction views behaviors and risks around SU in context. Public attitudes and policy historically emphasize 'addictive' properties of a given substance and individual responsibility for avoiding or overcoming a problematic relationship with it; meanwhile, actual predictors of SU harms to individuals, families, and communities remain less explored. The Socio-Ecological Model (SEM) [4] offers four domains of influence on one's behavior, such as substance use, as well as the multi-level interventions that can be used to modify entire communities' susceptibility to problematic SU [Fig 1.]

1. ***Individual*** Biological and personal history factors (ex. knowledge, skills, attitudes, education, income)
2. ***Interpersonal*** Formal/ informal social networks & support systems (ex. family, coworkers, friendships)
3. ***Community*** Ex. accessible, relevant, & attractive care options; employment opportunities; locals' attitudes and norms re: SU, SUD
4. ***Society*** Ex. Local, state, and national laws or policies; economic conditions

FIGURE 1. SOCIO-ECOLOGICAL FRAMEWORK OF THE OPIOID CRISIS: MAJOR FACTORS OF OPIOID MISUSE [4]



EXTERNAL DRIVERS OF SU PROBLEMS

Substance Use and Trauma

There is a clear association between experiences of trauma and problematic substance use:

- People with Post-Traumatic Stress Disorder are **14 times more likely** to have a substance use disorder than those without [7].

It is common for people to attempt to manage trauma symptoms through substance use including physical, emotional, and cognitive symptoms [7].

- The majority of PWUD interviewed for this project cited experiences of trauma and symptoms as the primary reason for drug use initiation.

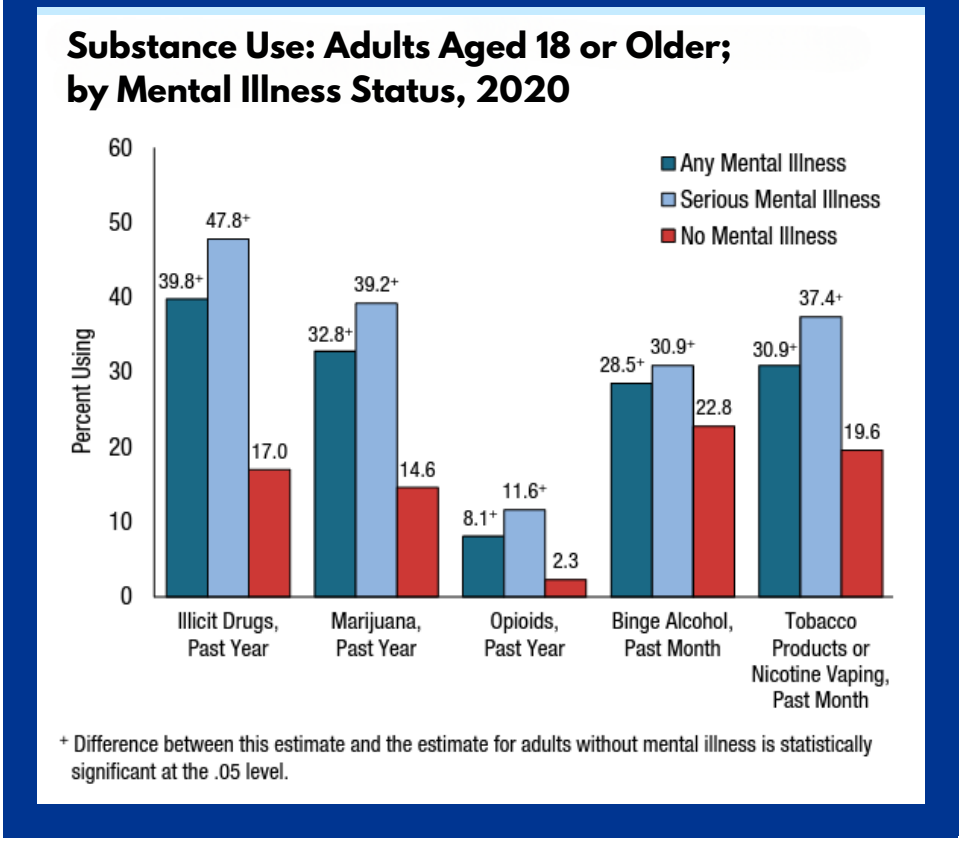
SUD itself is also often traumatic

Substance Use and Mental Health

Around half of individuals who experience a SUD during their lives will also experience a co-occurring mental disorder and vice versa. [9]

- Co-occurring disorders can include anxiety disorders, depression, attention-deficit hyperactivity disorder (ADHD), bipolar disorder, personality disorders, and schizophrenia, among others. [8]

Figure 2. Substance Use by Mental Illness Status. SAMHSA [9]

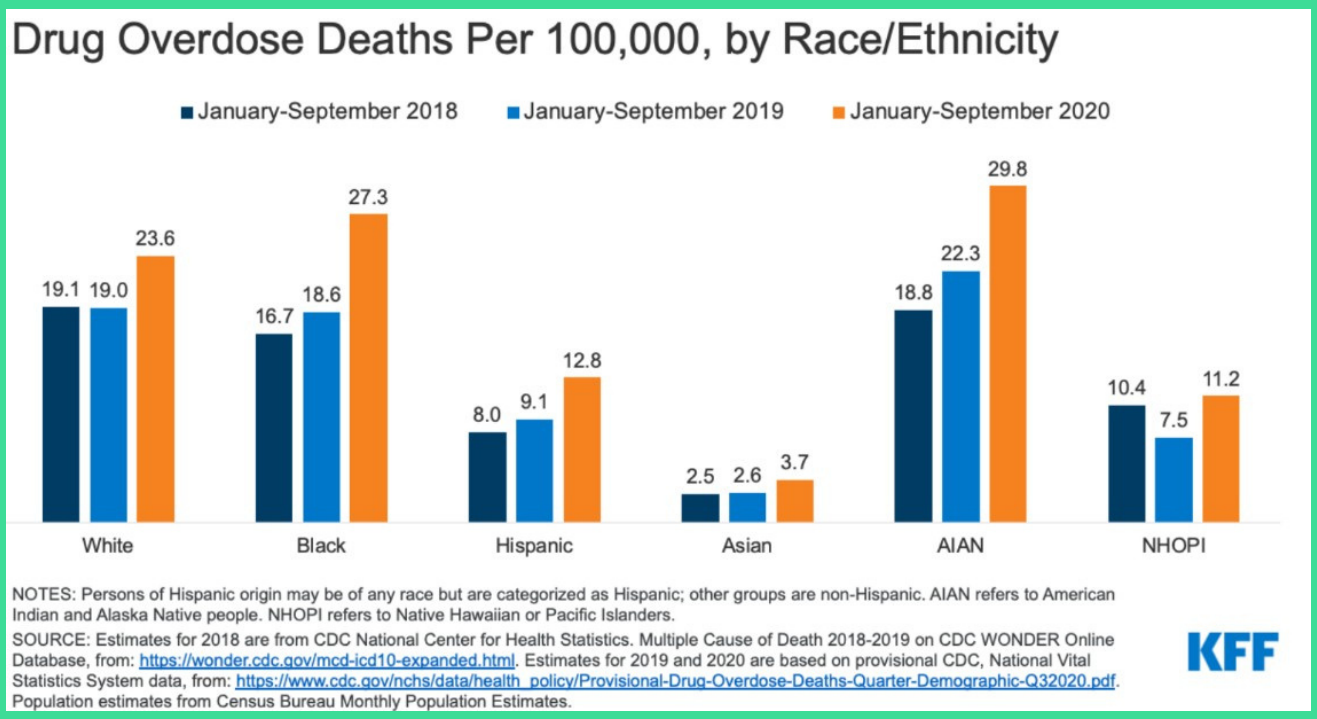


SU PROBLEMS DO DISCRIMINATE

Disproportionately Impacted Populations

Overdose deaths disproportionately impact Black, Indigenous, and People of Color (BIPOC) communities and people with a mental health disorder. Between 2018 and 2020, drug overdose death rates increased across all racial and ethnic groups, but **increases were larger for American Indian and Alaska Native (AIAN), Black, and Hispanic people compared to their White counterparts.** Reflecting these increases, drug overdose death rates were highest for AIAN (29.8 per 100,000) people, followed by Black (27.3 per 100,000) and White (23.6 per 100,000) people as of 2020. [6]

Figure 3. Drug Overdose Deaths per 100,00, by Race/ Ethnicity from KFF [6]



Substance Use and Stigma

Stigma held about substance use and PWUD is persistent, pervasive, and often rooted in the belief that addiction is a personal choice reflecting a lack of willpower and a moral failing. Rates of stigma are extremely high in the general public, within institutions, and within professions whose members interact with PWUD often while in distress. Negative beliefs about PUWD have detrimental effects on treatment and treatment outcomes, research, policies and society as a whole. [10]

NH PEOPLE WHO USE DRUGS WANT YOU TO KNOW:

New Hampshire Syringe Service Participants were asked:
"What do you want local decision makers to know about substance use?"

Persisting stigma...

"I had a friend who stopped hanging out with me when he found out I use drugs, he wouldn't talk to me. People bail out. Doctors suck, once they find out you've been red flagged they won't give you the meds you need to be a normal human being" (35F)

Persisting discrimination..

"[We are] treated like pariahs, regarded as less than even though we are just as much citizens as everyone else is. Some people still in civilian life that think the case. They system has failed us, it's not us failing the system. Great deal of institutionalized cruelty at city and state level. Civilians realize the mistake." (44M)

Persisting criminalization...[viii]

"People definitely would use [drug checking] service but cops are going to pick everyone off for warrants like they do at the methadone clinic" (Not Disclosed)

Gratitude for available services...

"If this [syringe services program] wasn't here people would be running around confused, not knowing where to turn. They would be lost. The whole thing is not good to start with but people [can come here] and see a person who will help show them a direction" (59M)

What people don't realize about substance use...

"They [people who use drugs] don't know why until we've been in recovery. [They learn] it's PTSD, trauma, bad experiences" (41M)

"People who don't use don't know why people do drugs. I was molested by my uncle for 3-4 years, he's dead now. Traumatic experiences- I've been using drugs for 18 years now, I don't know what living a sober life is like because I was so young" (30M)

"Misinformation that 'we can just stop'... Ask a chronic gambler, shopper, someone who overeats, smokes cigarettes if they can 'just stop'..they'd laugh. The needle would move from punishment to rehabilitation. Putting me in jail only gives me a better contact list and puts off the number of months or years til I get high." (44M)

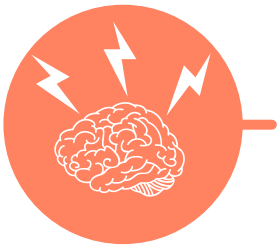
"The fact that people overdose, they think PWUD are bad because they are harming themselves, pretty much committing suicide. Non-users tend to judge PWUD because they put themselves in danger and that's bad but people don't use to get high, they use to get better, to self-medicate" (31M)

How should policymakers get PWUDs' feedback?

"On the spot or through HR workers, safest way. People need more education on addiction, everybody is judging, just keeps us where we are" (39F)

ADDRESSING STIGMA

STIGMA AND PEOPLE WHO USE DRUGS



Stigma held against people who use drugs (PWUD) can include inaccurate ideas that they are immoral, dangerous, untrustworthy, and incapable of change or managing treatment. Stigma might be harmless if not for its associated action: discrimination. Beliefs that conceptualize addiction as a set of antisocial characteristics have profound implications for how PWUD are treated in all contexts and directly impact their health outcomes.

USE PERSON-FIRST LANGUAGE (PFL)

Repeated studies demonstrates that stigma/bias transmits through language, and that discrimination follows. [11]. When talking about SU, use (and encourage your peers to use) person-first language (PFL). PFL affirms the identities of people who use drugs as human beings over their status as a substance user. PFL maintains the integrity of individuals as whole human beings by removing the language that equates people to their condition [12] (see below) and helps destigmatize people who use/d drugs.

SAY THIS

- Person who uses drugs/ person with a substance use disorder
- Person in recovery
- Chooses not to at this point
- Medication is a treatment tool

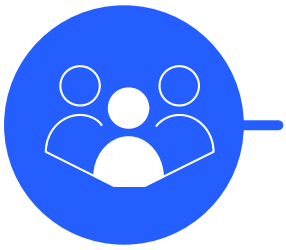
- Had a setback
- Maintained recovery
- Positive drug screen

NOT THAT

- Addict, junkie, druggie

- Ex-addict, ex-junkie
- Non-compliant/bombed out
- Medication is a crutch/ substituting one drug for another
- Relapsed
- Stayed clean
- Dirty drug screen

LIVED EXPERIENCES OF STIGMA IN NH



Stigmatizing attitudes and beliefs about SUD held by healthcare workers, community members, and society at large cause PWUD feelings of shame, limit their access to care and resources, and ultimately worsen their health conditions. Below are quotes from NH syringe services program (SSP) participants about how they perceive treatment because of their status as a person who uses drugs. [16]

"Hospitals treat us horribly. Seen my friends risk their lives with bad infections because they don't want to go to the hospital. They'll just find something wrong with you so they can boot you." (48, F)

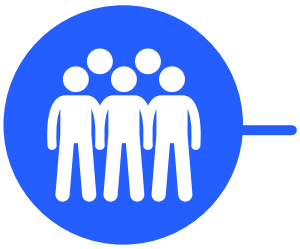
"[We are] treated like pariahs, regarded as less than even though we are just as much citizens as everyone else is...the system has failed us, we have not failed the system. There is a great deal of institutional cruelty at the city and state level." (44, M)

"We get sh*t on, disrespected. Sometimes for true reasons but a lot of it is perceiving addicts as no good. This is not good, especially if someone is trying to help themselves, they just give up because they are treated so badly." (59, M)

"I went to 5 rehabs last year and now there is a note at [hospital name] that I don't have pysch problems, it's drugs so I can't get help or admitted. The best I ever felt was after being admitted to psych, I got stabilized and I can't get back there" (23, F)

ENGAGE WITH & LISTEN TO PWUD

SEEK MEANINGFUL ENGAGEMENT WITH PEOPLE WHO USE DRUGS TO INFORM POLICIES



PWUD are effective change agents and successfully reduce their individual risk behaviors and advocate for risk reduction among their peers. In order to make decisions to improve health outcomes of your constituents, and to make services more relevant to target populations, PWUD should be consulted [34]. **Directly engaging PWUD and recognizing their expertise and self-determination reduces stigma and strengthens the success of policies, programs, and the community.** Avoid tokenism, where PWUDs' influence is limited and work toward full collaborative involvement. When faced with difficult decisions in complex contexts, better decisions and more effective action are likely to result from combining specialized knowledge with community values and local knowledge and representation. [35]

PUBLIC INVOLVEMENT [36, 37]

IS...

CONSULTATION - a two-way relationship in which government asks for, and receives, citizens' feedback on policy proposals. Could take the form of organized public meetings or deliberative polling.

PARTICIPATION - a relationship based on partnership with government in which citizens actively participate in defining the process and developing the policy. Ex: referenda, citizens' juries, citizens' panels, or direct delegation of authority to citizens to make decisions.

IS NOT...

INFORMATION - a one-way relationship in which government disseminates information to citizens. It is crucial that policy makers get feedback to account for the views and experiences of those affected by policy decisions.

PUBLIC OPINION RESEARCH - a process by which policy makers capture the opinions of specific sectors or groups of the population through mechanisms like surveys or focus groups, to inform policy making.

UNDERSTAND THE IMPACTS OF HR STRATEGIES

Harm reduction interventions – specifically **syringe services programs (SSPs)**, **naloxone**, **drug checking**, **sterile injection supplies**, and **safe disposal** – have proven to prevent death, injury, disease, overdose, and future problematic substance use. Harm reduction services can: [14]

- **Reduce overdose deaths**, promote linkages to care, facilitate co-location as part of a comprehensive, integrated approach
- **Lessen harms associated with drug use** and related behaviors that increase the risk of infectious diseases, including HIV, viral hepatitis, and bacterial and fungal infections
- Harm reduction can **reduce overdose deaths** by connecting individuals to naloxone and overdose education, counseling, and promote linkages to care and referrals to treatment for substance use as part of a comprehensive, integrated approach
- **Reduce infectious disease transmission** among people who use drugs, including those who inject drugs, by providing testing, sterile injection supplies, and a safe method of disposal, equipping them with accurate information, and facilitating referrals to resources and treatment
- **Reduce stigma** associated with substance use and co-occurring disorders
- **Promote a philosophy of hope and healing** by utilizing those with lived and living experience in the management of harm reduction services, and connecting those who have expressed interest to treatment, peer support workers, and other recovery support services [14]

HARM REDUCTION STRATEGIES

HR Strategy	Overview	Supporting Research
Overdose Education and Naloxone Distribution (OEND)	Naloxone is an opioid antagonist that can quickly and safely reverse the potentially fatal effects of an opioid overdose	Access to an OEND can result in long-term increases in knowledge about: • preventing opioid overdose • safely and effectively responding to an opioid overdose and improvements in participants' attitudes toward naloxone. [17]
	Distribution programs seek to train and equip individuals who are most likely to encounter or witness an overdose—especially people who use drugs (PWUD) and first responders—with naloxone kits, which they can use in an emergency to save a life	OEND reduces fatal overdoses by training PWUD and potential bystanders on how to prevent and respond to overdoses. 40% of overdoses occur with someone present and 80% occur in a home. Have friends and family that possess naloxone is associated with a reduction of overdose deaths. [17]
	Effective approaches include community distribution programs, co-prescription of naloxone, and equipping first responders. It is often more effective to provide naloxone to PWUD, as they are most likely to be present when an overdose occurs and can quickly act if they have naloxone. Moreover, PWUD face barriers to calling 911 in the aftermath of an overdose due to the potential of criminal legal system consequences. [16]	
Syringe Services Programs (aka needle exchange programs)	Syringe services programs (SSPs) are community-based prevention programs that can provide a range of services, including linkage to substance use treatment; access to and disposal of sterile syringes and injection equipment; screening for and treatment for infectious diseases; and linkage to health care including substance use treatment, medical, mental health, and social services.	SSPs reduce HIV and HCV incidence by 50%, and can reduce HCV transmission by 50-80%. [21,22]
		People who regularly use an SSP are **5x likelier to access substance use treatment** and **3x likelier to reduce or stop injection drug use** than those who do not [23]
	SSPs can reduce rates of fatal and nonfatal overdoses through the provision of naloxone to respond to overdoses and education to prevent overdoses.	Naloxone provision at SSPs has been shown to reduce overdoses and related hospital admissions [18,24]
	Provision of sterile injection equipment can reduce overdose as reusing equipment and/ or not having supplies often leads to rushing consumption of a drug and using more at once due to limited supplies	Syringe services programs protect first responders by reducing needle-stick injuries in the community. One in three will experience a needle-stick in their career. A comparison of cities with and without a programs demonstrated **8x more improperly disposed of syringes when a program was not available** [24]

HARM REDUCTION STRATEGIES (cont'd)

HR Strategy	Overview	Supporting Research
Drug Checking (rapid test strips)	Rapid drug checking tools, such as fentanyl and xylazine test strips, provide PWUDs with additional information about their product to reduce overdose risk and empower people to make informed decisions. Test strips are often provided with syringe services or adapted to a variety of settings [18,19]	Fentanyl test strips used by PWUD prior to using a substance is associated with behavior modifications after a positive result; including discarding the substance(s), using a smaller quantity, ensuring they have naloxone first, and/or using with someone else present [17,24]
Drug Checking (comprehensive)	Comprehensive drug checking services utilize portable spectrometry devices to provide point-of-service analysis of the contents of a drug sample. Drug checking programs have been collaboratively designed, like the Massachusetts Drug Supply Data Stream, with public health and public safety to generate critical health and safety information for PWUD and communities	By helping people understand the contents of their drugs, drug checking services reduce morbidity and mortality associated with drug use, including fentanyl and emerging contaminants. [20]
		Community drug checking programs have resulted in reduction of overdoses and early awareness of emerging contaminants. [20,25]
Medications for Opioid Use Disorder (MOUD)	Methadone is an opioid with a long effect time making other opioids less effective and reducing overdose risk. People taking methadone to treat SU must receive the medication at a specific clinic. [26]	Buprenorphine and methadone have the strongest evidence base that shows reductions in overdose and opioid morbidity. [27]
	Buprenorphine is an opioid with very high affinity for opioid receptors and partially activates receptors and blocks other opioids, reducing overdose risk. It is most often combined with naloxone, further reducing overdose risk. [27]	The evidence base for naltrexone is not as strong as it is for buprenorphine and methadone. Studies have found that while naltrexone does reduce the risk of overdose. [29,30,31]
	Naltrexone blocks opioid receptors and is used after opioid detoxification to prevent set backs. It has no abuse potential and there is no withdrawal when the medication is stopped. However, few clients continue this medication. [32]	Behavioral health interventions can complement MOUD treatment, but are not necessary for MOUD treatment, alone, to be effective. [29]
Overdose Prevention Sites (aka supervised consumption/ injection sites)	Overdose prevention sites are designated sites where people can use pre-obtained drugs under the safety and support of trained personnel. [18,19] Overdose prevention sites also provide counseling on harm reduction practices, and facilitate referrals to services, education, etc.	Overdose prevention sites reduce fatal overdoses in the immediate vicinity of the facility. [33]
		Overdose prevention sites facilitate referrals to treatment and other supportive services, which can result in cessation of injection drug use. [34]

UNDERSTAND NH'S SUD INFRASTRUCTURE

ORGANIZATIONS WORKING DIRECTLY WITH PWUD AT THE COMMUNITY LEVEL IN NH's SUBSTANCE USE SERVICE LANDSCAPE

Together, these organizations make up a considerable portion of low-barrier SUD harm reduction infrastructure in the Granite State and include Syringe Service Programs (SSPs), Recovery Community Organizations (RCOs), the Doorway Programs, and the Regional Public Health Networks (RPHNs). These organizations, often in collaboration, expand access and linkage to treatment, support, and other essential SUD services.

Syringe Services Programs (SSPs): **community-based prevention programs that can provide linkage to SUD treatment, access to and disposal of sterile syringes and injection equipment, testing, screening for infectious diseases and linkage to medical care, mental health, and social services.**

Recovery Community Organizations (RCOs): peer-led/ run agencies that provide services to support people in their recovery from SUD. All RCOs in the state are low-barrier and no cost. They support multiple pathways to recovery and offer peers recovery coaching, support, mutual aid groups, and family support programs. Most include harm reduction services and help PWUD navigate systems.. All RCOs in the state are low-barrier and no cost. They support multiple pathways to recovery and offer peers recovery coaching, support, mutual aid groups, and family support programs. Most include harm reduction services and help PWUD navigate systems.

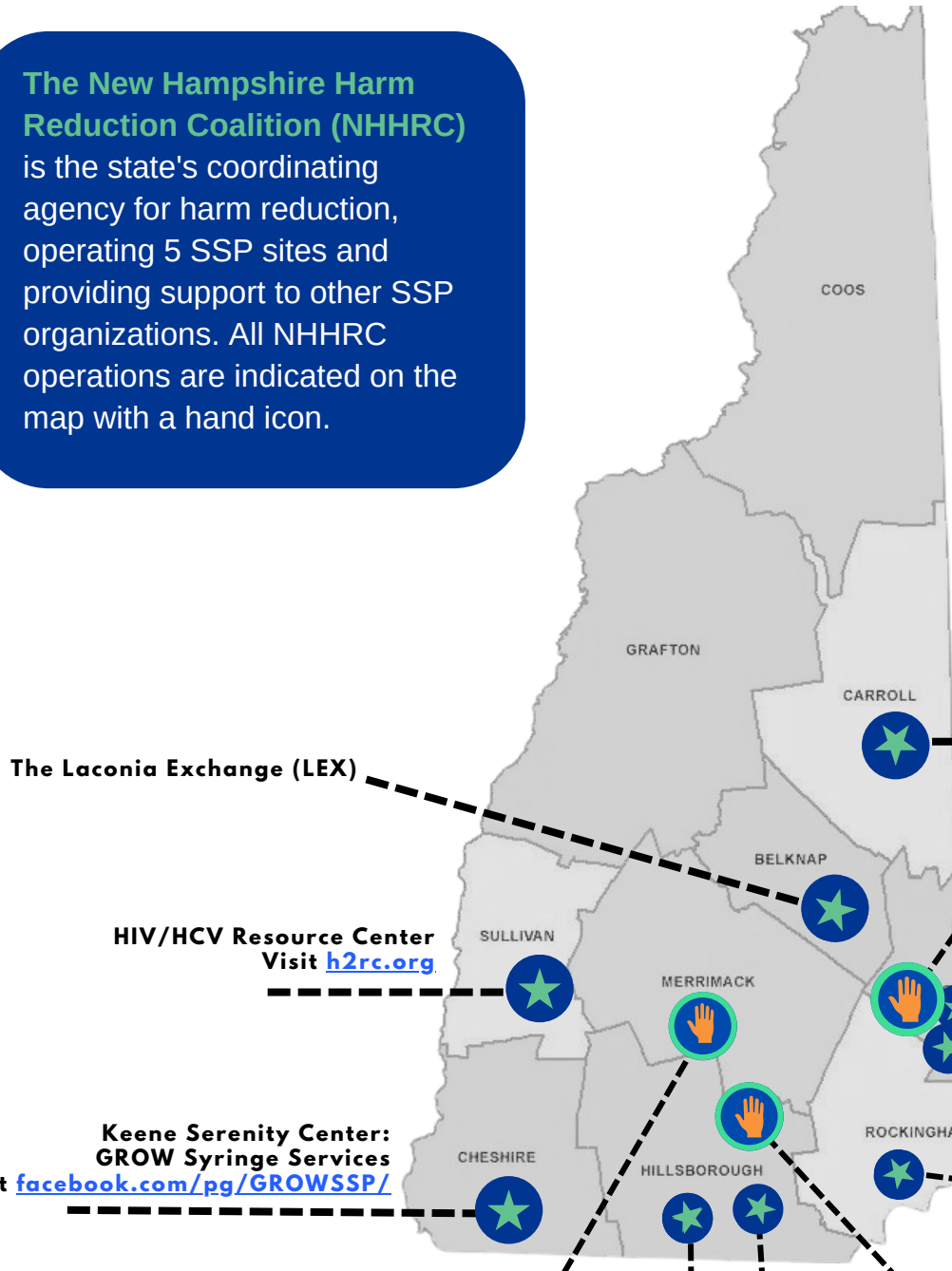
The Doorway Programs: **a single-point of entry for people seeking help with substance use including treatment, support, or resources for prevention and awareness. The Doorways have expanded MAR, peer recovery supports, access to recovery housing, evidence-based prevention programs, workforce opportunities and training & education in NH.**

Regional Public Health Networks: **geographically based public agencies serving broad health interests. They bring together local health departments and health officers, health care providers, social service agencies, schools, public safety & EMS, behavioral health and leaders in the private, public, and nonprofit sectors to coordinate and deliver comprehensive essential public health services.**

SYRINGE SERVICES PROGRAMS IN NH

The New Hampshire Harm Reduction Coalition (NHHRC) is the state's coordinating agency for harm reduction, operating 5 SSP sites and providing support to other SSP organizations. All NHHRC operations are indicated on the map with a hand icon.

There are **twelve registered Syringe Services Programs** (SSP) locations in New Hampshire. They can provide sterile supplies, safe disposal, Narcan, support, and referrals.



Mt. Washington Valley Support Recovery Coalition
Visit mwvsupportrecovery.org

The Laconia Exchange (LEX)

NHHRC: Hand Up Health Services
Visit nhhrc.org

HIV/HCV Resource Center
Visit h2rc.org

The Doorway at WDH
Visit wdhospital.org

SOS Recovery
Visit sosrco.org

Insubordination Station
Visit insubordinationstation.com

Keene Serenity Center: GROW Syringe Services
Visit facebook.com/pg/GROWSSP/

SOS Recovery
Visit sosrco.org

NHHRC: Concord
Visit nhhrc.org

NHHRC: Queen City Exchange
Visit nhhrc.org

Another Day Harm Reduction
Visit anotherdayhr.org

Revive Recovery Center (formerly SSANA)
Visit reviverecovery.org

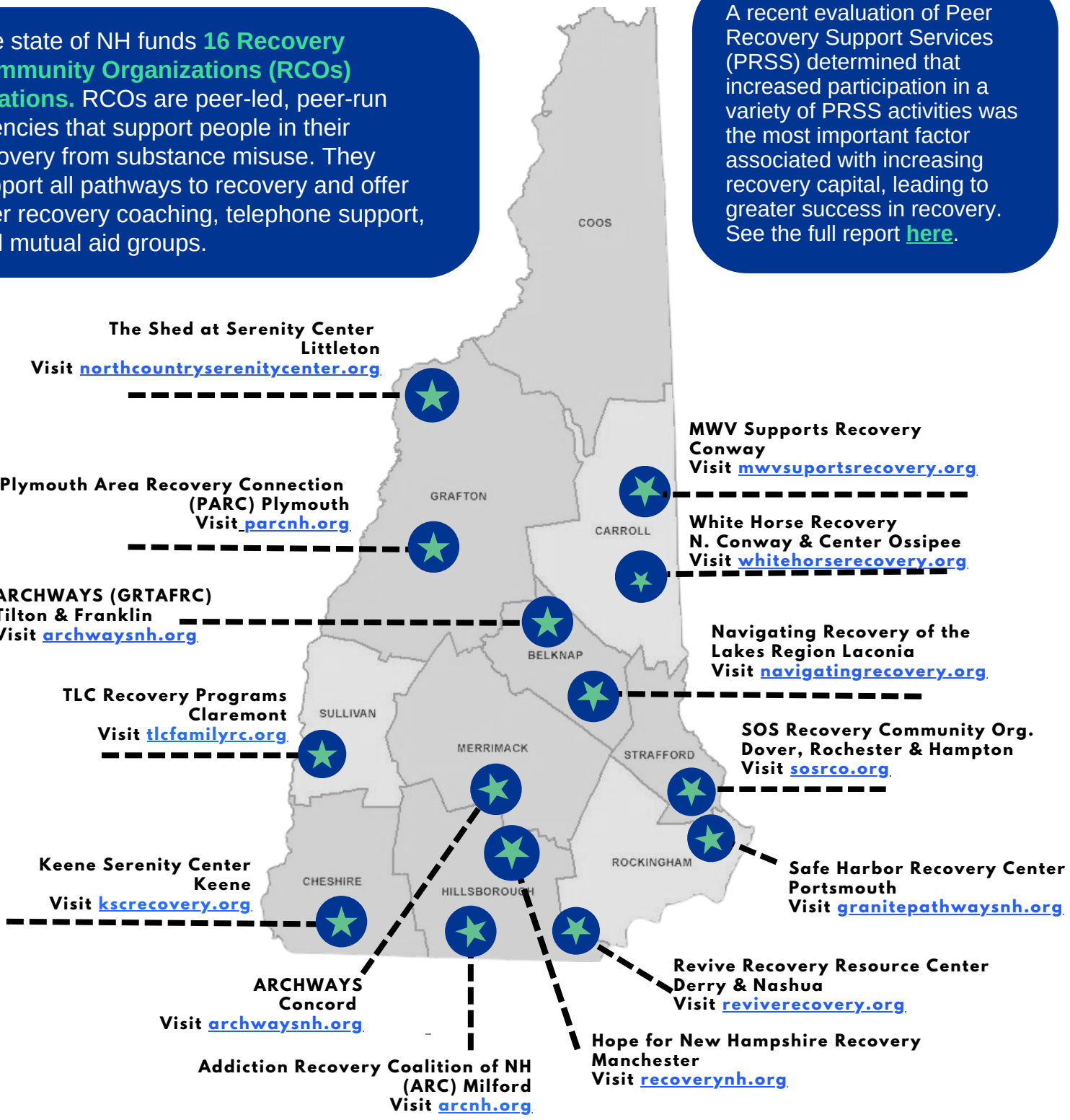
https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/nh-registered-syringe-services-programs.pdf

RECOVERY COMMUNITY ORGANIZATIONS (RCOs)

Connect to the Doorway by calling 211 or visiting www.thedoorway.nh.gov

The state of NH funds **16 Recovery Community Organizations (RCOs) locations.** RCOs are peer-led, peer-run agencies that support people in their recovery from substance misuse. They support all pathways to recovery and offer peer recovery coaching, telephone support, and mutual aid groups.

A recent evaluation of Peer Recovery Support Services (PRSS) determined that increased participation in a variety of PRSS activities was the most important factor associated with increasing recovery capital, leading to greater success in recovery. See the full report **here**.

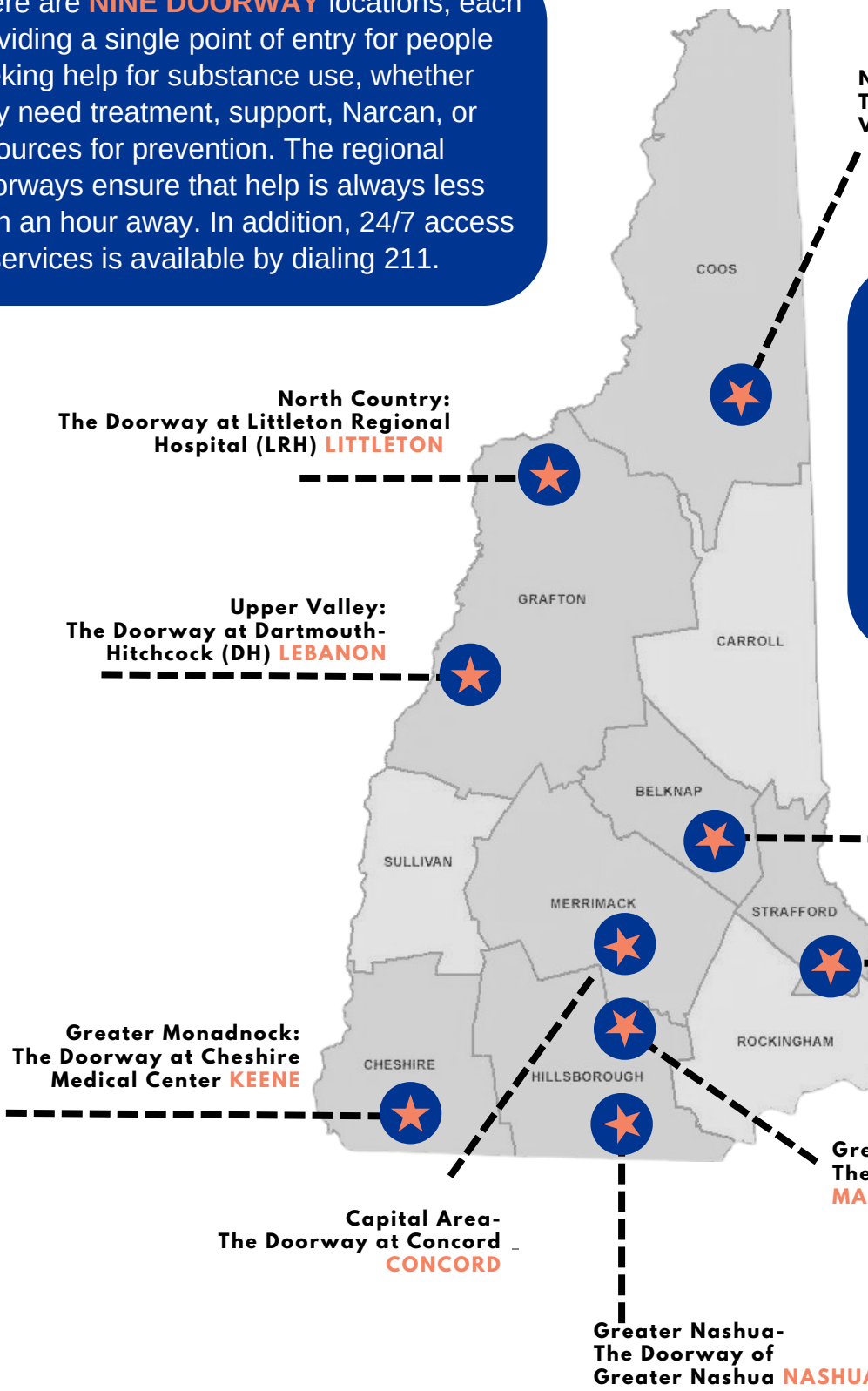


dhhs.nh.gov/programs-services/health-care/recovery-support-services

THE DOORWAY

211
Get Connected. Get Help.™
An Initiative of Granite United Way

There are **NINE DOORWAY** locations, each providing a single point of entry for people seeking help for substance use, whether they need treatment, support, Narcan, or resources for prevention. The regional Doorways ensure that help is always less than an hour away. In addition, 24/7 access to services is available by dialing 211.



North Country:
The Doorway at Androscoggin Valley Hospital (AVH) BERLIN

North Country:
The Doorway at Littleton Regional Hospital (LRH) LITTLETON

Upper Valley:
The Doorway at Dartmouth-Hitchcock (DH) LEBANON

Winnipesaukee-
The Doorway at Concord Hospital-Laconia
LACONIA

Strafford County-
The Doorway at Wentworth-Douglass Hospital (WDH) DOVER

Greater Monadnock:
The Doorway at Cheshire Medical Center KEENE

Greater Manchester:
The Doorway of Greater Manchester
MANCHESTER

Capital Area-
The Doorway at Concord
CONCORD

Greater Nashua-
The Doorway of Greater Nashua NASHUA

NH'S Doorway program receives funding from the US Substance Use and Mental Health Administration State Opioid Response (SOR) grant. This federal support enables NH to expand MAT, peer recovery support services, access to recovery housing, and evidence-based prevention programs

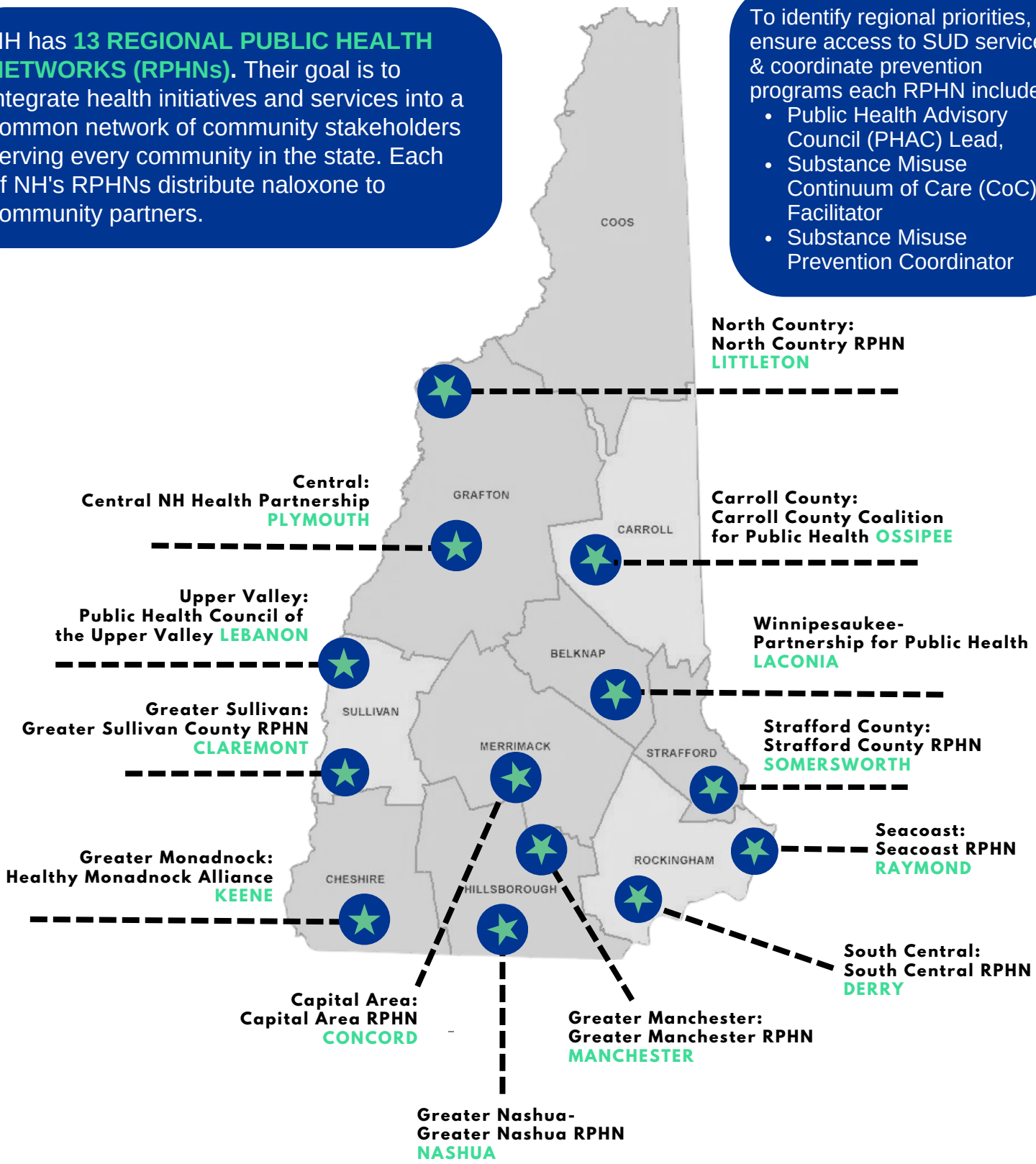
Connect to the Doorway by calling 211 or visiting www.thedoorway.nh.gov

REGIONAL PUBLIC HEALTH NETWORKS (RPHNs)

NH has **13 REGIONAL PUBLIC HEALTH NETWORKS (RPHNs).** Their goal is to integrate health initiatives and services into a common network of community stakeholders serving every community in the state. Each of NH's RPHNs distribute naloxone to community partners.

To identify regional priorities, ensure access to SUD services & coordinate prevention programs each RPHN includes:

- Public Health Advisory Council (PHAC) Lead,
- Substance Misuse Continuum of Care (CoC) Facilitator
- Substance Misuse Prevention Coordinator



NHRPHN.org

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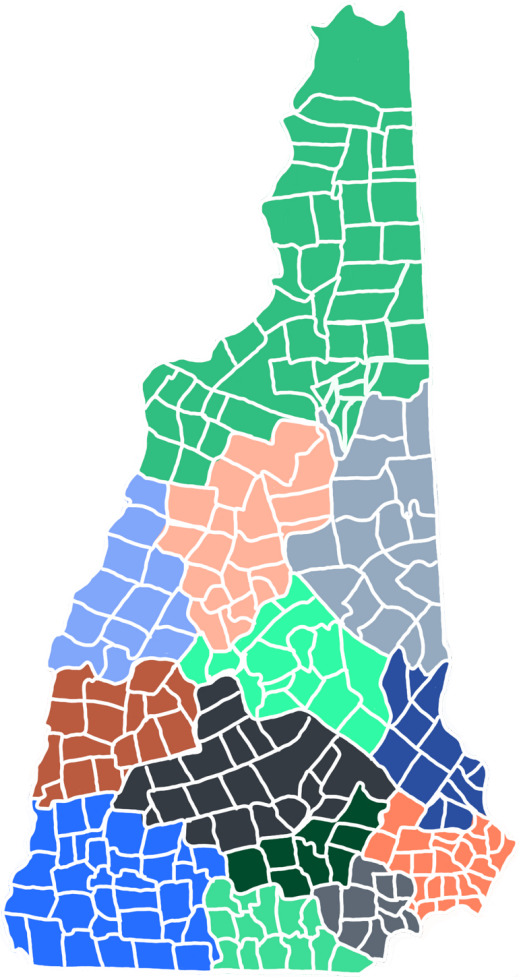

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