Harm Reduction Strategies Through the Lens of Selective and Indicated Prevention
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The use of affirming language inspires hope. **Language Matters.**

Words have power. **People First.**

The PTTC Network uses affirming language to promote the application of evidence-based and culturally informed practices.
Christopher O’Connell, Deputy Director

SAMHSA Center for Substance Abuse Prevention (CSAP)
PTTC Purpose

Improve implementation and delivery of effective substance use prevention interventions

Provide training and technical assistance services to the substance use prevention field
  • Tailored to meet the needs of recipients and the prevention field
  • Based in prevention science and use evidence-based and promising practices
  • Leverage the expertise and resources available through the alliances formed within and across the HHS regions and the PTTC Network.
Highlight of PTTC Major Projects

Prevention Ethics for Certification

Support for SAPST

Prevention Onboarding and Road Map
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 does not require abstinence from any risky behaviors.
Harm Reduction (HR) is Additive to Prevention Work

- Harm Reduction is a wide-reaching concept that seeks to enhance the wellbeing of individuals and communities.
- It addresses many facets of life including housing, employment, recovery relapse prevention and substance use at any level.
Continuum of Care and Restorative Health

HR is all along the way of the continuum of care
Putting the pieces of the continuum of care puzzle together

Harm reduction is grounded in the ideas of self-determination, person-centered care, and enhancing quality of life for individuals and their communities.
Survey Results
On a scale of 1 - 5: How would you rate your knowledge of Harm Reduction?

12 responses

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On a scale of 1 - 5: How comfortable do you feel managing Harm Reduction grant programs?
12 responses

- 1 (25%)
- 2 (8.3%)
- 3 (25%)
- 4 (33.3%)
- 5 (8.3%)
What is your experience working either directly or indirectly with Harm Reduction programs?

12 responses

- None: 25%
- Minimal: 33.3%
- Moderate: 41.7%
- Extensive: 0%
On a scale of 1-5: How enthusiastic are you to learn about how Harm Reduction could benefit your work?

12 responses

- 0 (0%)
- 1 (8.3%)
- 1 (8.3%)
- 1 (8.3%)
- 9 (75%)
From your perspective, what percentage of overlap does Prevention share with Harm Reduction?
12 responses

- 41.7%: 0%
- 33.3%: 1-25%
- 25%: 26-50%
- 51-75%
- 76-100%
How the PTTCs can be helpful

- Facilitate learning sessions: i.e., webinars, learning community, or online course
- Support: host dialogue sessions with subject matter experts (a modified Project ECHO model)
- Connect: make connections with, national, regional and state stakeholders
More Information

Slides and Resources available at pttcnetwork.org

Contact us at networkoffice@pttcnetwork.org
Keep in touch!

- 5 PTTCs have regular e-publications
- PTTC Network Office publishes the PTTC POST monthly
  - Please Subscribe: https://pttcnetwork.org/centers/global-pttc/pttc-subscription-page

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@PreventionTTCnetwork
Harm Reduction: expanding our approach to prevention

MONIQUE TULA, EXECUTIVE DIRECTOR
NATIONAL HARM REDUCTION COALITION
**Personal Autonomy**

Recovery is a process of change through which people improve their health and wellness, live a self-directed life, and strive to reach their full potential.

SAMHSA working definition of recovery

**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.

Definition of Harm Reduction

**Practical Strategies**
Sometimes we speak about harm reduction, prevention and recovery as separate things. In actuality, each are part of a continuum of increasing safety, self-efficacy, and autonomy.
PRINCIPLES OF HARM REDUCTION

- Health and Dignity
- Participant Centered Services
- Participant Autonomy
- Pragmatism and Realism
- Culturally Informed
- Participant Involvement

GUIDING PRINCIPLES OF RECOVERY

- Person-Driven
- Many Pathways
- Holistic
- Peer Support
- Relational
- Culture
- Addresses Trauma
- Strengths/Responsibility
- Respect
- Hope
California Harm Reduction Initiative, or CHRI, funded 37 Syringe Services Programs (SSPs) across 21 California counties beginning in August 2020 to expand the range, reach, and quality of harm reduction services in California. CHRI was allocated in the Budget Act of 2019 and is led by National Harm Reduction Coalition and funded by the CDPH Office of AIDS.

In February 2021, CHRI funded Syringe Services Programs conducted 491 unique interviews with participants. National Harm Reduction Coalition included Point in Time surveys as a core part of evaluation, to specifically measure how SSPs are including people who use drugs more meaningfully in planning, executing, and evaluating services. The interviews offer key insights to the reality for people who engage with SSPs statewide. Participants shared their experiences with overdoses, drug use, gaps in services and resources needed to support them.

### DEMOGRAPHIC DATA

- **Median Age**: 41.5 years old
- **Gender**
  - Male: 64.8%
  - Female: 30.1%
  - Transgender: 1.8%
  - Two-spirit: 0.8%
  - GNC: 1.0%
  - No response: 1.4%
- **Sexual Orientation**
  - Straight: 74.3%
  - Bisexual: 9.6%
  - Lesbian: 1.6%
  - No response: 4.3%
- **Race / Ethnicity**
  - White: 56.6%
  - Black: 14.3%
  - American Indian: 4.5%
  - Alaska Native: 4.5%
  - Other: 13.4%
  - Asian: 0.6%
  - More than one race: 7.5%
  - No response: 2.6%
  - Identified as Hispanic or Latinx: 24%

### DRUG USE DATA

- **Used at least one stimulant in the past 6 months**: 83.9%
- **Used at least one opioid in the past 6 months**: 74.5%

### ACCESS & BARRIERS TO MOUD

Commented that they wanted Medications for Opioid Use Disorder (MOUD) services at SSPs, such as treatment on-site, case management and linkage services.

Participants reported that they wanted MOUD offered by people who treated them non judgmentally.

*"Yes, I was prescribed for 5 years ago, started it, it didn’t solve my problems, I had to go to treatment. I started using again - I worked when I did use it."

*"I used to take Suboxone and I was clean for a long time and I failed a single drug test and was cut off of it by my provider."

### ACCESS & BARRIERS TO MOUD

- **29%** reported transportation as a top barrier to MOUD access.

Other barriers to accessing MOUD:

- **32%** clinic barriers when discussing methadone (long waits, waiting lists, or difficult hours, security presence)
- **28%** clinic barriers when discussing buprenorphine (long waits, limited or difficult hours, security presence)
- **15%** needing an ID
- **8%** not covered by insurance
- **13%** requiring abstinence
- **12%** can’t get an apt

Participants specifically noted that having to go to a methadone clinic every day was a barrier to continuing treatment.

*I have done it a few times. But I start to get tired of the trip each day and stop going at first once, or twice a week. But I finally just say screw it, and stop all together." (methadone specific)

*"Had it before for almost a year, never got any take homes -- makes a huge difference to get take homes. (methadone specific)"

The majority of participants did report they know of a provider that offered buprenorphine, some had either been on buprenorphine recently or were currently on it.

- **Nearly 10%** reported they did not know what buprenorphine was.

There is an opportunity here for SSPs who have reported generally high knowledge about buprenorphine to provide more information directly to participants and build their knowledge.

### HIGHLIGHTS

- **75.4%** identified as unstably housed* in the past six months

Higher rate for BIPOC participants:

- **100%** Asian
- **78.8%** Latinx
- **86.4%** Black
- **72.3%** White

*“We defined "unstably housed" as living in a single room occupancy hotel or shelter in place hotel, a house or apartment of a family member, a house or apartment of a friend, a garage, or other place not meant for human habitation, a mobile home (RV), a van, a car, a shelter, navigation center, transitional housing, or in a homeless encampment.

- **75.8%** reported methamphetamine use, the most common drug used
- **83.9%** reported some stimulant use
- **87%** reported smoking drugs, the most common method of use

Syringe Services Programs (SSPs) do much more than offer sterile syringes or injection equipment and this is important data to make sure people who smoke drugs are receiving safe smoking supplies and the best resources possible.

- **46%** nearly half reported they get extra supplies for someone unable to obtain supplies themselves

This could be for a number of reasons: Stigma, fear of harassment, legal concerns, travel distances — but it shows the importance of providing ample access to participants.

- **62%** witnessed an overdose in the last six months
- **48.5%** used Naloxone on someone in the last six months

SSP participants are witnessing higher rates of overdose in their communities and they are the ones saving each other’s lives.

It is important to invest in the infrastructure of SSPs that already exists rather than creating new infrastructure.
# Opportunities for Harm Reduction Approaches

## Evidence-Based Practices that Reduce Harm

- Enumeration of root causes of substance use disorder related to housing, employment, access to healthcare, punitive criminal legal initiatives, food access, transportation, and social and community support

- Community-based participatory research and other restorative justice approaches to engage the community and counter the systemic disempowerment of people who use drugs and communities of color caused by the War on Drugs

- Addressing SDOH as an intergenerational protective factor for **primary prevention**
- Non-punitive programs that do not require abstinence for participation as **secondary prevention**
- Reducing stigma and growing community support for evidence-based programs as **tertiary prevention**

- Overdose education and naloxone distribution
- Health and wellness sites to prevent overdose
- Deploy non-punitive treatment models
- Revise policies that impose barriers to social determinants for people with substance use disorder
- Syringe service programs
- Alternative crisis/overdose response models

- When communicating findings, initiatives should not underestimate the value of contextualizing findings and humanizing approaches
- Building and maintaining community support for harm reduction requires a sustained commitment to reducing stigma

## Step 1: Assessment
- Assess problems and related behaviors
- Prioritize problems (criteria: magnitude, time trend, severity, comparability)
- Assess risk and protective factors
- Consider that context, not the drug itself, may confer risk
- Develop questions and interpret data alongside people who use drugs
- Assess structural factors

## Step 2: Capacity
- Engage community stakeholders
- Develop and strengthen a prevention team
- Raise community awareness
- Engage people with lived experience
- Ensure people who use drugs are part of the decision-making process
- Expand capacity of peer-based advocacy

## Step 3: Planning
- Prioritize risk and protective factors (criteria: importance, changeability)
- Select interventions (criteria: effectiveness, conceptual fit, practical fit)
- Develop a comprehensive plan that aligns with the logic model
- Prioritize structural factors and address the social determinants of health
- Develop questions and interpret data alongside people who use drugs
- Elevate harm reduction principles as primary and secondary prevention

## Step 4: Implementation
- Deliver programs and practices
- Balance fidelity with planned adaptations
- Retain core components
- Establish implementation supports and monitor
- Consider that context, not the drug itself, may confer risk
- Develop questions and interpret data alongside people who use drugs
- Address social determinants of health

## Step 5: Evaluation
- Conduct process evaluation
- Conduct outcome evaluation
- Recommend improvements and make mid-course corrections
- Share and report evaluation results
- Ensure programs work for ALL in target population, (e.g., people of color)
- Gain input from people w/ lived experience at the beginning, middle, and end of evaluation
- Combine data and stories to humanize the issues and reduce stigma
Rationale for **Federal Support**

- Federal resources can alleviate the sustainability treadmill for unfunded/underfunded harm reduction programs
- A federal strategy can guide regional metrics and consistent application and practice
- False narrative about promoting drug use and crime hinders bringing harm reduction to scale in all 10 SAMHSA’s regions
- Training, technical assistance, and grant-making through the ‘center’ model can deepen CSAP’s impact
Thank you!

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The Intersections of Infectious Disease, Drug Use, and Incorporating a Drug User Health Framework

Amanda Muller Manager, Drug User Health
NASTAD
About NASTAD

● **WHO:** A non-profit, non-partisan national association founded in 1992 that represents public health officials who administer HIV and hepatitis programs funded by state and federal governments.

● **WHERE:** All 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, seven local jurisdictions receiving direct funding from the Centers for Disease Control and Prevention (CDC), and the U.S. Pacific Island jurisdictions.

● **MISSION:** NASTAD’s mission is to end the intersecting epidemics of HIV, viral hepatitis, and related conditions by strengthening domestic and global governmental public health through advocacy, capacity building, and social justice.

● **VISION:** NASTAD’s vision is a world free of HIV and viral hepatitis.
Goals and Objectives

Goal

To increase participants knowledge of infectious disease and harm reduction, comprehensive care for PWUDs, and building meaningful support for harm reduction programs.

Objectives

• Improve understanding of how to build support for harm reduction programs
• Identify a range of services necessary to meet the need of people who use drugs
• Increase knowledge coordinated services for PWUDs and systems of comprehensive care
National HIV & Hepatitis Overview

Injection Drug Use accounts for ~9% of new HIV cases ¹
Over 65% of HCV cases ²

Among people who inject drugs
60%-90% have HCV after 5 years
Median time to HCV transmission is ~3 years
And each year ~ 20-30% of PWID acquire HCV ³

Comorbidity
Among PWID and have HIV, 75% also have HCV
Among PLWHIV w/o IDU, 25% have HCV ⁴

Life time cost of each HIV infection is over $480,000 ⁵

Accumulated costs of HCV care over the next 20 years on this trajectory over $78 billion ⁶

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⁶ National Academies of Sciences, Engineering, and Medicine, 2017. [https://www.nap.edu/read/24731/chapter/8](https://www.nap.edu/read/24731/chapter/8)
Hepatitis C is the leading cause of death among all infectious diseases.\(^1\)

The CDC estimates 41,200 acute HCV cases in the US in 2016.\(^1\)

Estimated 2.4 million people have HCV in the US (~1% of US pop.).\(^2\)

85% of HCV infection leads to progresses to chronic infection.\(^1\)

IDU is currently the most common risk factor for HCV in developed countries (60-80% worldwide).\(^3\)

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**Diseases Associated with Injection Drug Use**

- **Viral infections (bloodborne)**
  - Hepatitis C Virus (HCV)
  - Hepatitis B Virus (HBV)
  - Hepatitis A Virus (HAV)
  - HIV

- **Bacterial Infections (soft tissue/skin)**\(^4\)
  - Septicemia
  - Bacteremia
  - Cellulitis
  - Abscesses (staph, strep)
  - Endocarditis
  - Necrotizing fasciitis
  - Wound botulism

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Huge Increases in HCV Related to Injection Drug Use

- Among 18- to 29-year-olds, there was a
  - 400 percent increase in acute hepatitis
  - 817 percent increase in admissions for injection of prescription opioids
  - 600 percent increase in admissions for heroin injection

- Among 30- to 39-year-olds, there was a
  - 325 percent increase in acute hepatitis C
  - 169 percent increase in admissions for injection of prescription opioids
  - 77 percent increase in admissions for heroin injection

- There were also sharp increases among whites and among women

Scott County, Indiana

- HIV Outbreak in Austin, Indiana (pop. 4,200) in 2015
- Over 200 cases of HIV were eventually attributed to injection drug use behavior
- Only had 5 reported cases of HIV in the previous decade
- Within this initial outbreak 115 persons were co-infected with HCV and currently 92% are co-infected
HIV/HCV Vulnerable Counties
HARM REDUCTION and Syringe Services Programs

- Most effective way to prevent infectious disease transmission for PWIDs
- Do not increase drug use or crime
- SSP participants are 5 times more likely than nonparticipants to enter treatment

So What Can Be Done?
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Harm Reduction for Substance Use Behaviors: Expanding programs and strategies to reach more individuals, families, and communities

Brenda A. Miller, Ph.D.
Senior Scientist
Pacific Institute for Research and Evaluation, Prevention Research Center
Berkeley, CA
Harm Reduction: “Accessing” Selected and Indicated Populations

• Universal prevention sought to prevent any use and largely focused on children with “prevention of any use” as the goal.

• Selected populations are substance users “at risk” for substance-related problems and can be “reached” with harm reduction programs

• Indicated populations can include users with problems who are not ready to seek treatment, harm reduction programs can offer an intermediary step
Why Embrace Harm Reduction Programs & Strategies?

• Relevant to a continuum of substance users (first time, intermittent, regular, to addicted)
• Opens the door to examining co-occurring unwanted consequences (e.g., aggression, accidents)
• Increases access to strategies that address the entire lifespan.
Using a Harm Reduction Perspective Results in a Broader Scope of Actions

- Reduce social or legal consequences
- Improve physical health and/or longevity
- Address mental, emotional, and/or spiritual needs
- Improve access to treatment
- Inclusive of larger community impacted by substance use
Selected and Indicated Populations--Frequency of drinking in past year

Figure 1: How often people drank alcohol in the past year

- Not at all, 29%
- About 1-11 times per year, 20%
- 1-3 times per month, 21%
- 1-2 times per week, 14%
- 3-6 times per week, 11%
- Every day, 4%
Selected and Indicated populations: Drug Use-Past Year

Inter-American Drug Abuse Control Commission-CICAD, www.cicad.oas.org
Young Adults* at Nightclubs: Example of a Selected Population

*88% between 21-35 years of age
Young Adults at Nightclubs: Prevalence of Aggression

Aggression experienced at a club during past 30 days
Rethinking Outcomes

Rather than a binary outcome (use/no use)—measure the reductions in number of days or amounts used

Consider the context of use—(e.g., alcohol consumption is safer if there is not a drinking driver).

Consider the related harms that are averted (e.g., drug overdoses decreased, less victimization, less aggression).

Identifying harms that are avoided for the community, the family, and other individuals
Engaging Communities—From Punitive to Safety Approaches

• Perception is important! Identifying motives behind our public health efforts.

• Staying safe approach --makes it easier for young people to accept and adopt harm reduction approaches—

• Nightlife Safety Approach—working with naturally occurring groups to reduce harm while at nightclubs—A RCT for harm reduction
Engaging Families in Harm Reduction Approaches

• Families as a resource for prevention—universal, selected and indicated populations

• Reframing from monitoring to guiding difficult real-life scenarios helping youth make safe choices—the Smart Choices for Teens approach—A RCT for teens and parents as a harm reduction approach
Final Thoughts on Harm Reduction Approaches

• Greater than a list of programs or strategies—a change in thinking, measuring, and evaluating success
• De-emphasizes stigmatization and marginalizing people and communities
• Emphasizes building health and resilience in the entire community
• Harm reductions models, beliefs and strategies are not static but constantly evolving
Next Steps: Focusing on Selected and Indicated Populations

• Importance of the 18-34 age range for expanding our services and adopting a harm reduction approach
• Addressing not just the substance use, but the related harms
• Engaging the community and resources available in the community
Questions?
Thank you

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