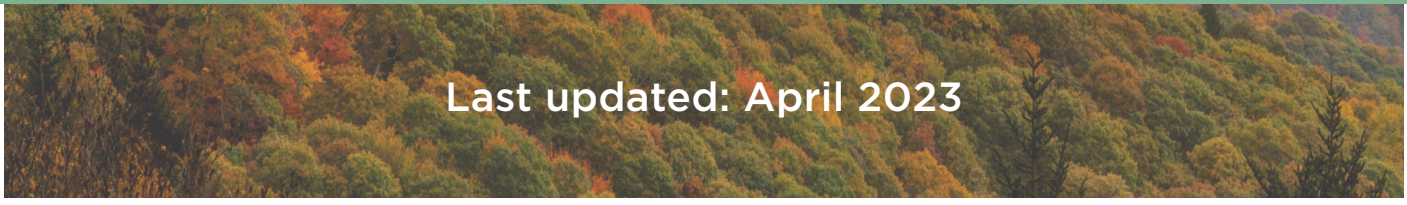
NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Public Health

HARM REDUCTION
to Prevent Overdose: A Primer

WHAT IS IT? WHEN DO WE USE IT? HOW DO WE USE IT?



Last updated: April 2023

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INTRODUCTION

This document was developed by the North Carolina Division of Public Health Injury & Violence Prevention Branch.

It is intended to provide introductory information about harm reduction for those working in overdose prevention in North Carolina and highlight useful resources developed by harm reduction organizations in North Carolina and nationally. The information in this Primer may be useful to diverse audiences including, but not limited to:

- Syringe services program (SSP) staff,
- Volunteers,
- Peer support specialists,
- Overdose prevention community educators,
- First responders,
- Law enforcement officers,
- Counselors, and
- Other health providers.

The North Carolina Division of Public Health Injury and Violence Prevention Branch provides training on harm reduction and has additional resources.

To learn more, contact beinjuryfreenc@dhhs.nc.gov

If you use any of these...

...You practice harm reduction!

WHAT IS HARM REDUCTION?

Harm reduction is the framework for reducing the negative consequences of drug use and other criminalized behaviors such as sex work.

Harm reduction promotes the health and dignity of people who use drugs (PWUD) or otherwise engage in risky or criminalized behavior. This is done through **"meeting people where they are,"** as opposed to making judgments about where they "should" be, related to their health and lifestyle. A harm reduction approach **acknowledges the humanity of PWUD and emphasizes the importance of treating them as people deserving of care.**

Implementing a harm reduction approach entails giving PWUD the resources necessary to make informed decisions to reduce health risks associated with drug use. Harm reduction-based programs **provide information and tools that empower people to make decisions and apply risk-reducing strategies.** These approaches also include PWUD as equal partners in the planning and implementation process of programs. Harm reduction programs **do not have abstinence requirements, nor do they use abstinence as a measure of success for people's recovery.** Rather, programs operating with a harm reduction framework allow individuals to define success for themselves.

Effective harm reductionists recognize the effects of unequal access to resources on health outcomes. Social determinants of health such as lack of access to health care, insecure housing, involvement with the criminal justice system, and inadequate employment exacerbate risk factors for harm, including drug use. Therefore, harm reduction work often **includes activities to address social determinants of health and mitigate harms associated with unmet needs.**

Harm reduction work cannot be done effectively and sustainably without addressing areas of health, wellness, and justice; because of this, harm reduction work is seen as a part of the social justice movement.

Why Do We Use a Harm Reduction Approach?

A harm reduction approach is an effective way to prevent unintended consequences of substance use, such as infectious disease transmission and fatal overdoses.

Harm reduction strategies such as syringe services programs (SSPs) delay HIV and hepatitis C transmission and increase the likelihood of participants entering substance use treatment. **People who use SSPs are three times more likely to stop injecting drugs (1) and are more likely to enter substance use treatment than those who do not use these services (2), (3).**

Many SSPs in NC have started offering low-barrier medications for opioid use disorder (MOUD) within their program. Moreover, having SSPs has also been shown to result in fewer syringes in public spaces. When two similar cities were compared, the one with an SSP had 86% fewer syringes in places like parks and sidewalks (1).

HARM REDUCTION APPROACHES ARE ALL AROUND US

Harm reduction approaches are integrated into many aspects of daily living. Any time people engage in behaviors with a risk of harm, yet take precautions to reduce that risk, they are engaging in harm reduction. Examples include fastening a seatbelt while driving, using sunscreen while at the beach, or wearing an orange vest while hunting. Harm reduction approaches are also seen in provider-patient interactions when they work together to identify a behavior change. Patients are encouraged to make small incremental changes, because providers recognize big, sudden changes are likely unsustainable. Harm reductionists take a similar approach with PWUD and support them in setting small, achievable goals.

Principles of Harm Reduction

There are eight principles of harm reduction, presented below as outlined by the National Harm Reduction Coalition (NHRC). NHRC is a national advocacy and capacity-building organization that promotes the health and dignity of individuals and communities impacted by drug use (4). To learn more about NHRC's activities, click here.

NATIONAL HARM REDUCTION COALITION PRINCIPLES (5):

1. Accepts, for better or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.

2. Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe use to total abstinence and acknowledges that some ways of using drugs are clearly safer than others.

3. Establishes quality of individual and community life and well-being — not necessarily cessation of all drug use — as the criteria for successful interventions and policies.

4. Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live to assist them in reducing attendant harm.

5. Ensures that people who use drugs and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.

6. Affirms people who use drugs themselves as the primary agents of reducing the harms of their drug use and seeks to empower people who use drugs to share information and support each other in strategies that meet their actual conditions of use.

7. Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.

8. Does not attempt to minimize or ignore the real and tragic harm and danger that can be associated with illicit drug use.

Communicating About Harm Reduction

Discussing harm reduction with partners who might not be familiar with the concept or don't understand the evidence base behind this approach can be challenging. It is common for advocates of harm reduction to face resistance. In communicating with people about harm reduction practices and principles, it is important to get an understanding of who your audience is and where they are coming from.

In that way, you can meet your partners where they are, as well as find effective messaging to communicate the importance of this work. Different arguments work better for different people. For some people, humanizing stories of people helped by harm reduction may resonate; others may be more swayed by facts and figures.

EXAMPLE: TALKING ABOUT HARM REDUCTION WITH A FISCALLY MINDED AUDIENCE.

Sharing information about the money saved due to harm reduction programs like SSPs may be key. In this case, one may compare the cost of supplies for safer drug use with the cost of hospital care and hospital stays that are prevented with safer use.

Facts that may capture your audience's attention include:

- Sterile syringes cost 6-10 cents each, while the average lifetime cost of care for someone who is HIV-positive is $350,000-$750,000;
- The cost to cure hepatitis C is $70,000-$100,000; or the cost of a heart valve replacement due to endocarditis is $250,000, plus the cost of a 4–8-week hospital stay.

The Importance of Intersectionality

Intersectionality is a theoretical framework for explaining the "interconnected nature of social categorizations such as race, class, and gender, regarded as creating overlapping and interdependent systems of discrimination or disadvantage" (6).

In 1989, Dr. Kimberle Crenshaw introduced the theory of intersectionality in a paper titled "Demarginalizing the Intersection of Race and Sex." The paper describes legal cases involving Black women and their experiences with discrimination rooted in both sexism and racism. Dr. Crenshaw argues that because Black women are women and Black, their experiences of discrimination are different from the experiences of White women and Black men and should be viewed as such (7).

The concept of intersectionality presents a way to name and understand complicated human experiences with power, privilege, and access to information and services (8). Because individuals can have multiple identities and be members of several groups, their experiences are a summation of how they are treated as members of those groups simultaneously.

Recognizing intersectional identities is important when doing harm reduction work, because participants may be members of several historically marginalized populations.

Participants may have experienced violence, discrimination, or neglect because of their racial, ethnic, sexual, gender, class, or other identities. In North Carolina, overdose rates show a greater impact on historically marginalized populations—especially on American Indian/Indigenous populations (9).

Data also shows that fatal overdose rates are increasing faster in Black and American Indian/Indigenous populations compared to other groups. From 2019 - 2020, overdose rates increased by 93% in American Indian/Indigenous populations and 66% in Black/African American populations compared to 32% in White populations (9).

Researchers looking at Black and Indigenous populations found inequalities in access to treatment and services for people of these backgrounds. They identified that racial stereotypes negatively influenced clinician behaviors and resulted in Indigenous and Black people being dismissed, having delays in care, or not being able to receive care (10).

These same groups face significantly higher rates of criminalization for their substance use. It is critical that we look at these intersecting forms of discrimination to start addressing the root causes of overdose.

Edith Springer & Mona Bennett: Worker Stances for Harm Reductionists

Harm reduction work can be challenging. It requires service providers to be transparent, compassionate, and authentic. Harm reduction work calls for volunteers and staff to engage in deep self-reflection and to see the humanity and autonomy of their clients.

To offer guidance on how to best interact with clients, Edith Springer, one of the founders of the National Harm Reduction Coalition, developed the following key tenets—which she called "worker stances"—for harm reductionists to follow (11).

Edith Springer's Worker Stances

1. Show client unconditional regard and caring. Acknowledge her or his intrinsic worth and dignity.
2. Be a real person. Let the client see you as you really are. "Blank screens are for movie theaters."
3. Don't get caught up in the client's urgency; take your time – practice mindfulness.
4. Be non-judgmental toward the behaviors of the client.
5. Be consistent with setting limits: control oneself not the client.
6. Empower the client.
7. Work through one's behavior or enabling: When is it positive? When is it negative?
8. We are not responsible for rescuing the client who is responsible for his or her own life. We are responsible for the intervention process: The client is responsible for the outcome. Trust the client's strength and ability.
9. Never take away defenses until alternatives are developed. Introduce new coping strategies and shore up those used previously.
10. Avoid the expert trap, especially if you aren't one. Use the client as a consultant and collaborator. Act out of a place of humility.
11. Explore one's own values about drugs, people who use drugs [and sex and sex workers, homelessness and people who are homeless…]
12. Be mindful of the stages of change. Set the table. Provide options non-judgmentally and non-coercively. Any reduction in harm is a step in the right direction.
13. Reinforcement is more effective than punishment. Use incentives when available.
14. Use supervision to process emotional responses and attitudes.
15. The agenda for change belongs to the client; the worker facilitates – rather than implements – the agenda.
16. Consider the client's relationship with drugs [and sex…] - the positives and the negatives, rather than judging the use itself. Focus on behaviors.
17. Quality of life and well-being are the criteria for measuring success, not reduction in the consumption of drugs.

Stigma

People Who Use Drugs (PWUD) are stigmatized and discriminated against more than any other group with a health or mental health diagnosis.

In a 2018 poll of 1,054 adults representative of the U.S population, **less than 1 in 5 Americans were willing to closely associate with PWUD as a friend, co-worker, or neighbor (12).** In NC, according to results from a 2021 survey done among the residents of Surry County, only 27% of participants agreed with the statement: "Most people would willingly accept someone who has been treated for substance use as a close friend" (13).

For PWUD, stigma and its effects are experienced at different levels, including the individual, community, and institutional levels. Stigma related to substance use is often rooted in the belief that substance use is a moral failing rather than a health issue. Therefore, suggested solutions arising from stigma tend to criminalize PWUD rather than focus on treatment or harm reduction (14). PWUD experience different types of stigma resulting in a lack of access to substance use care.

Internalized stigma refers to individuals absorbing societal messages about PWUD and believing those to be true about themselves (15). This type of stigma is a barrier to care and increases the risk of an overdose due to discomfort in disclosing substance use.

Another type of stigma is **community stigma,** or the collective negative beliefs and stereotypes held by healthcare providers, employers, neighbors, or others in the community (16). This type of stigma can be seen in the negative language used by community members and in the media to describe PWUD (17). Community stigma can lead to limited support services being available for substance use disorder in a particular community, as well as the reluctance of PWUD to turn to services that do exist (18).

The last type of stigma is **institutionalized stigma.** This is when negative beliefs about PWUD become cultural norms, laws, and institutional policies (17). Institutionalized stigma results in laws that are damaging to PWUD and reduced political support for spending funds to address challenges faced by PWUD. Some argue that laws treating drug use as a criminal rather than a health matter are the result of the stigma against PWUD. For example, North Carolina's Good Samaritan law prioritizes the ability to arrest PWUD over protections for PWUD who attempt to get help for another person in the event of an overdose (19).

There are several successful strategies for addressing stigma at different levels. For internalized stigma, therapeutic interventions like Acceptance and Commitment Therapy (ACT) have worked well in reducing negative self-thoughts and shame associated with substance use (20).

With ACT, clients learn skills to stop avoiding or denying emotions and instead accept and understand them as responses to situations. ACT therapy encourages PWUD to process their emotions and begin moving forward with their lives (21). To reduce community stigma, sharing positive stories about PWUD and providing opportunities to interact with PWUD improve attitudes about this population; this demonstrates why centering people with lived experience is critical to overdose prevention work (20).

Another important aspect of reducing community stigma is changing the language used to describe drug use and PWUDs. Using person-first language affirms people's individuality and dignity. The table below offers useful alternative phrases to use to reduce stigma. You can also click here to learn more about person-first language and stigma reduction in NC.

A SIMPLE SHIFT IN LANGUAGE COULD CHANGE SOMEONE'S LIFE.

INSTEAD OF SAYING:	TRY SAYING:
Drug Abuse / Substance Abuse	Substance Use / Substance Use Disorder
Addict / Junkie	A Person with a Substance Use Disorder / A Person Who Uses Drugs
Clean / Dirty	Sterile / Unused / Unsterile / Used

Examples of Harm Reduction Programs

Harm reduction programs are social service and healthcare activities designed to reduce harm resulting from drug use. Below are examples of successful harm reduction programs that offer services to people who use drugs (PWUD) in NC.

SYRINGE SERVICES PROGRAMS

Syringe services programs (SSPs) offer sterile syringes and other injection supplies to prevent blood-borne pathogens, including HIV and hepatitis C infections. SSPs are an evidence-based strategy to reduce overdose deaths by distributing naloxone and fentanyl test strips directly to PWUD (22). SSPs also provide a variety of social and health services for people who use drugs. These services include HIV and hepatitis testing and referrals to mental health and substance use disorder treatment. SSPs are often the primary avenue for PWUD to access basic health services. They offer syringe disposal services to remove hazards from the community and prevent sharing and reuse of syringes and other supplies. Visit the North Carolina Safer Syringe Initiative to learn more about SSPs in NC. For any questions, please contact SyringeExchangeNC@DHHS.nc.gov

POST-OVERDOSE RESPONSE TEAMS

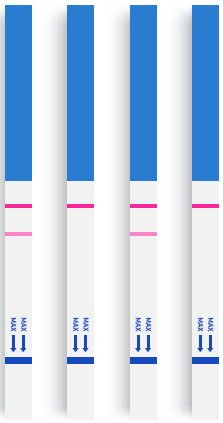
Post-overdose response teams (PORTs) are overdose follow-up programs designed to connect individuals who have recently overdosed—typically within 24-72 hours—to a variety of support services based on the individual's wants and needs (23). These follow-up visits provide connections to harm reduction services, overdose prevention and naloxone access, social determinants of health services, and treatment and recovery supports. PORT programs provide opportunities for overdose prevention programs to build relationships with PWUD. Click here to learn more about PORT programs in NC. For any questions, please contact portnc@dhhs.nc.gov

LOW-BARRIER MEDICATION-ASSISTED TREATMENT (MAT)

For people interested in stopping their drug use, low-barrier access to medication-assisted treatment (MAT) can help initiate and sustain recovery. Buprenorphine and methadone are medications used to treat opioid use disorder. MAT medications normalize brain chemistry, block the euphoric effects of opioids, relieve physiological cravings, and normalize body functions. MAT is the gold standard treatment of opioid use disorder (24). The availability of safe and effective MAT allows PWUD to focus on addressing other needs like housing, employment, and access to mental health support services (25). To learn more about MAT, click here.

NALOXONE DISTRIBUTION UPON RELEASE FROM INCARCERATION

Naloxone is an FDA-approved, fast-acting drug used to reverse opioid drug overdoses (26). Naloxone is especially important for justice-involved PWUD, because they are 40 times more likely to overdose compared to the general public (27). Access to naloxone can be initiated through partnerships between jails and local health departments or community-based organizations. People may be educated about naloxone while they are incarcerated, and naloxone can be given to them upon release or to their friends and family members who visit the jail. Some jails in NC are distributing naloxone through vending machines located in their lobbies. To learn more about naloxone, visit this website here. For any questions, please contact naloxonesaves@gmail.com



FENTANYL TEST STRIPS

Fentanyl test strips are an inexpensive drug testing mechanism that can detect the presence of fentanyl. Fentanyl is a synthetic opioid found in injectable drugs, powders, and pills and it is the key contributor to the rise of overdose deaths in the United States (28). The ability to test for the presence of fentanyl, particularly in non-opioid substances such as methamphetamine or cocaine, allows people to make informed decisions and use risk reduction strategies. These strategies include not using the drug, not using it alone, having naloxone present, and using smaller doses at a time (28). In a 2016 study looking at fentanyl test strips as a strategy to prevent opioid overdoses in NC, authors found that 77% of study participants felt safer by using fentanyl test strips (29). Currently, there is an increase in the presence of fentanyl in the drug supply, therefore drug checking is critical to overdose prevention. To learn more about fentanyl test strips, click here.

COMMUNITY-BASED TESTING FOR INFECTIOUS DISEASES

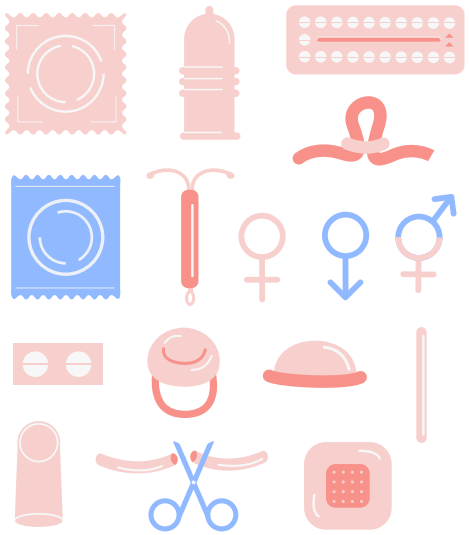
PWUD are disproportionately impacted by HIV and hepatitis B and C. The two main reasons for the disproportionate impact are 1) these bloodborne pathogens are easily spread when sharing injection equipment and 2) people are unaware of their infection status. Only 50 % of people living with hepatitis C and 30% of people living with hepatitis B are aware of their status. Effective care to address the spread of infections includes community-based rapid testing for HIV and hepatitis C, offering sterile injection supplies, and linking individuals to care as needed (30). The Communicable Disease Branch of the Division of Public Health runs a statewide Hepatitis Bridge Counselor Program, through which people who test positive for hepatitis C can be connected to care. Hepatitis Bridge Counselor Program contact: Kayla Ellis; kayla.ellis@dhhs.nc.gov

CONDOM DISTRIBUTION

Condom distribution is an effective way to prevent HIV transmission among high-risk populations (31). When used correctly and consistently, male condoms are 90% effective in reducing HIV transmission, and female condoms can reduce HIV transmission by up to 94% (32). Condoms are also effective in preventing other sexually transmitted infections such as gonorrhea, chlamydia, and syphilis, which are more easily contracted compared to HIV (32). Making condoms available at no cost in easily accessible places, such as local syringe service programs or bars, is an important harm reduction strategy to reduce the transmission of sexually transmitted diseases (31). The Communicable Disease Branch of the Division of Public Health funds agencies to distribute condoms to high-risk populations. Condom Program Distribution Program contact: Marti Eisenberg; marti.eisenberg@dhhs.nc.gov

PRE-EXPOSURE PROPHYLAXIS (PREP)

Pre-exposure Prophylaxis (PrEP) is a medication that, if taken as prescribed, can significantly reduce the risk of HIV transmission. According to the Centers for Disease Control and Prevention, PrEP can reduce the risk of getting HIV from sex by 99% while it reduces the risk of getting HIV from drug injections by 74% (33). Historically, PrEP has not been available for PWUD in NC; however, harm reduction programs are becoming more aware of the need for this medication and are offering PrEP or referring participants to other agencies to obtain it (33). The Communicable Disease Branch of the Division of Public Health (DPH) has a statewide PrEP program in which DPH-funded agencies refer persons to DPH PrEP coordinators. PrEP Program contact: Kristena Clay-James; kristena.clay-james@dhhs.nc.gov



SAFER SEX WORK EDUCATION

Sex work is the exchange of consensual sexual services between adults for money or goods. The term "sex work" recognizes sex work as a job and removes the judgments of criminality and immorality often associated with sex work (34). Like substance use, sex work is stigmatized, and people engaging in sex work are marginalized. People involved in sex work have been practicing harm reduction for decades to protect themselves from sexually transmitted infections (STIs) and other risks associated with their work. According to the National Alliance of State & Territorial AIDS Directors (NASTAD), harm reduction programs prioritizing people involved in sex work should focus on the prevention of overdose, violence, and infectious diseases (34). Effective means of addressing these issues include offering free condoms, sterile injection supplies, STI testing, and educational materials. To learn more about how harm reduction programs can center sex worker health in their programs, please visit this resource here.

Technical Assistance Available

Thank you for taking the first step in learning more about harm reduction. The North Carolina Division of Public Health Injury and Violence Prevention Branch provides training on harm reduction and has additional resources.

You can learn more about technical assistance available through the branch here and may contact the Injury and Violence Prevention Branch with any questions at beinjuryfreenc@dhhs.nc.gov

Additional Resources

Below are some additional resources you may want to look at as you're learning more about the basics of harm reduction.

1. What are Syringe Services Programs (SSPs)? - This CDC infographic describes what SSPs are, the benefits of having an SSP, and links to additional CDC resources, including the "Persons Who Inject Drugs (PWID)" CDC webpage. The infographic can be found here.

2. The Spirit of Harm Reduction: A Toolkit for Communities of Faith Facing Overdose - Developed by the National Harm Reduction Coalition, this comprehensive "living" document discusses opioid use disorders, primary prevention methods, and arguments for harm reduction rooted primarily in the Christian faith, including through the use of scripture. This tool can be found here.

3. Pregnancy and Substance Use: A Harm Reduction Toolkit - This resource was developed by the National Harm Reduction Coalition and provides useful information for "pregnant and parenting individuals who use drugs, their loved ones, and their service providers." The tool provides information about the parental rights of people who use drugs, prenatal care, treatment options for substance use while pregnant or parenting, and strategies for navigating the healthcare and legal systems. You can find this resource here.

4. Talking about Drug Use: A Glossary for Elected Officials – The Peer Network of New York, a harm reduction group in New York, created this document to offer guidance on the appropriate language to use when talking about drug use and people who use drugs. The purpose of this tool is to move away from stigmatizing language and speak to—and about—people who use drugs with respect. It can be found here.

5. Anti-stigmatizing language and other resources by Next Distro - Next Distro is an online, mail-based service that distributes harm reduction supplies. Its webpage has several resources related to anti-stigmatizing language, including content related to the media portrayal of different ethnic groups when reporting on drug use.

6. North Carolina Safer Syringe Initiative - This website offers information about syringe services programs in NC and lists resources for healthcare providers and law enforcement agencies. It includes information on the limited immunity provided under the syringe exchange law and information for health departments, community-based organizations, and other agencies interested in starting their exchanges.

7. Centering Sex Workers in Harm Reduction Programming - This resource offers ways to provide holistic "sex worker-centered harm reduction." The tool outlines five core competencies to achieve that: 1) Get informed about the local sex trade and surrounding anti-trafficking, prostitution, and third-party laws; 2) Prioritize non-carceral violence prevention and response; 3) Develop organizational policies to protect participants and staff; 4) Distribute a variety of resources and supplies (along with condoms), and 5) Work through an anti-stigma lens. You can learn more by clicking here.

8. Boston Harm Reduction Toolkit - This comprehensive toolkit is divided into five sections, each addressing an aspect of what makes a strong harm reduction program. It provides information about the following:
   1) principles and practices of harm reduction;
   2) involving the community;
   3) designing harm reduction services;
   4) harm reduction applications and program examples, and
   5) collecting and reporting program evaluation data.

   You can learn more about this toolkit here.

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