Harm Reduction: Are we Ready for it?

Lessons from Portugal

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Presentation Objectives

- **Objective 1:** The participant will be able to analyze the main tenets of global Harm Reduction policies.

- **Objective 2:** The participant will inspect the complexity of Portugal’s Harm Reduction policies by investigating treatment of drug addiction as a medical problem rather than a criminal one, focusing on the importance of prevention through psychoeducation, and understanding the impact of reintegration of drug users and dealers into society.

- **Objective 3:** The participant will be able to integrate the presented information into evaluating the implementation of similar policies within the United States.
What is Harm Reduction?

• Often used in the context of global health policy, harm reduction is an approach that attempts to reduce adverse health, social, and economic consequences of drug use while the person is still using.

• Focus is on keeping people safe, and minimizing the negative consequences of higher risk behaviors, such as substance use.

• No universal definition or formula for implementing harm reduction, as it demands the consideration of the needs and unique circumstances of each individual.
Drug-related Harms

- Drugs can cause real harms.
  - Harms are psychological, physical, social, legal, economic
  - Harms are to individual, family, community, society

Harms are not an inevitable consequence of drug use. Harms can be prevented or reduced through a range of strategies
Harm Reduction: Overview

• Harmful consequences of drug use can be placed on a continuum
• Goal: to move along this continuum by taking steps to reduce harm
Harm Reduction Continuum

Substance use and behaviors occur along a continuum from no use to chaotic use.
Harm Reduction: Central Assumptions

• Preference of public health alternatives to moral/criminal and disease models of drug use and addiction
• Recognition of abstinence as an ideal outcome, but acceptance of other alternatives
• Value in partnering with the group to obtain input on programs
Habit is habit and not to be flung out of the window by any man, but coaxed downstairs a step at a time.

(Mark Twain)
Continuum of Excess, Moderation, and Abstinence

—Any steps toward decreased risk are steps in the right direction—
Harm Reduction-Background (cont)

- Keep in mind- Harm Reduction is *not legalization* (Dorn, 1992), on the contrary, it is an attempt to reduce drug related diseases.
- May have an eventual goal of abstinence, but allows counselors to establish more flexible treatment goals (Walch & Prejean, 2001).
- Meets the client where they are at in order to provide a more effective and respectful treatment approach based on their needs.
- The Harm Reduction Approach is composed of five Principals:
  - Pragmatism
  - Humanistic Values
  - Focus on Harm (drug/alcohol-related)
  - Balancing costs versus benefits
  - Importance of immediate goals
Harm Reduction Components

- Harm reduction:
  - is based on the assumption that substance abuse and other potentially risk behavior are better understood in the context of the whole person” (Tatarsky & Kellog, 2010).
  - sees substance use as varying along a continuum of negative consequences and seeks to assist users in modifying their use in the direction of reduced harm.
  - seeks to join with that which motivates the client to seek help, meet the client’s needs and facilitate a positive treatment alliance (Tatarsky, 2003).
- This model keeps a more concrete and molecular focus on discovering the specific harmful aspects of substance use and generating specific goals to address them (Marlatt, Larimer, Baer, & Quigley, 1993).
Harm Reduction Goals

- Reduce the spread of infections such as HIV & Hep C
- Reduce risky drug use
- Prevent drug overdose deaths
- Provide honest drug education
- Increase users' contact with services and treatment
Portugal

Harm reduction in action!
The story of Portugal

• In 1974, Portugal rose up, deposed its dictatorship and embraced democracy. It was a heady time, filled with freedoms bottled up during over 40 years of totalitarian regime.

• At about the same time, with Portugal’s former colonies claiming their independence, shiploads of Portuguese soldiers and bureaucrats were returning home – hundreds of thousands of newly unemployed bringing drugs of far away lands into this potent mix of a moment.

• By the late 1980s, the country had greater freedom of press, of speech and of justice.

• With freedom came...drug use. Heroin was king, with an estimated 100,000 people – almost 1% of the country’s population - addicted.

• Crisis in the 90s lead to Government takeover. People felt safe with Government taking over.
Joao Goulao was a young family practice doctor in Algarve, who found himself with more and more patients with drug addiction problems, and a dilemma about reporting them to the police.

“It seemed everyone at the time had family or a friend with a drug habit. These were not ‘outsiders,’ but part of our communities. These were decent people with problems.”
Director-General of The General-Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD) in Lisbon, Portugal.

• Goulao soon joined a new government task force searching for a way forward.
  • They traveled to other countries with innovative drug policies, studied theoretical models, consulted psychologists and lawyers and social workers. And they came up with a plan.

• The plan, which soon became law, changed the categorization of drug users, from criminals who needed to be punished into sick community members who needed help.

• Thus, Portugal proceeded to take the revolutionary step of decriminalizing all illicit drugs, from marijuana thru heroin; becoming the first such country in the world to do so.
Decriminalization, not legalization!

• Decriminalization does not mean legalizing the use of substances.
• Drug usage is still illegal in Portugal—it’s just not considered a crime.
• Based on the premise that it is possible to rehabilitate drug users outside the criminal system.
• Decriminalization does not increase drug use.
• Even the Catholic church supported Portugal’s progressive developments!
“What was unique was that, for the first time ever, there was a focus on the rights of drug users...That, and a willingness to take a risk even if it was unclear that it would work.”

-Caitlin Hughes

(Australian National Drug and Alcohol Research Centre)
The mission of SICAD is to promote the reduction of licit and illicit psychoactive substances use, the prevention of addictive behaviors and the decreasing of addictions. To fulfil this mission, among other attributions, SICAD:

- supports the Ministry of Health on the definition of the related national strategy and policies;
- develops, promotes and fosters research in all of these areas;
- keeps updated information systems in order to answer to the information needs of the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) and other national and international agencies;
- ensures the cooperation with national and international bodies in the fields of drugs, alcohol and drug addiction.
Some numbers

- 80% of the costs of treatment are paid by the state.
- 20% of the costs are paid by the individual.
- 3 national facilities and appx. 60 run by NGOs
- 1600 beds available
- Inpatient facilities run by the state
- Outpatient facilities run by NGOs
• The number of Portuguese dying from overdoses plunged more than 85% (rising a bit in the aftermath of the European economic crisis of recent years).

• Portugal’s drug mortality rate is the lowest in Western Europe!
  • 1/10 the rate of Britain or Denmark, 1/50 the latest number for the U.S.

• If the U.S. could achieve Portugal’s death rate from drugs, we would save one life every 10 minutes.
  • Almost as many lives as are now lost to guns and car accidents combined.

• The Health Ministry spends less than $10 per citizen per year on its successful drug policy.
  • U.S. has spent appx. $10,000 per household (more than $1 trillion) over the decades on a failed drug policy that results in more than 1,000 deaths each week.
A Stark Difference: Drug-Related Deaths

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Portugal has the lowest rate of drug-induced death in Western Europe, a small fraction of the American toll.

Deaths per million people ages 15 to 64.

2015 data except: U.S. (2016); Belgium, Britain, Denmark, Ireland, Norway, Poland, Spain (2014);
The case of Casal Ventoso

“Europe’s Drug Supermarket”
Casal Ventoso

• Known as the biggest drugs supermarket in Europe. A shanty town on a hill to which 5,000 users a day would flock to peddle their lethal wares or get their fix.

• People using needles in the street hardly raised an eyebrow.

• Dead bodies lying around on the pavement were a common morning sight.

• Had no water or electricity till the 80s
Highlights of Casal Ventoso Rehab

• $100 million Euros were spent on reconstruction of the shanty town.
• $20 million Euros were set aside for vocational rehabilitation that helped with employability skills and upward mobility.
• “New Opportunities” program offered to residents (GED equivalent).
• Housing first programs for homeless people and drug users (no abstinence requirements to be eligible for program)
“We see them like people, not like criminals”
Mouraria

- NGO created by people living with HIV for people living with HIV.
- Drop-in clinic mainly revolving around Hep C, no fees charged
  - 80-90% of people who are drug users have Hep-C
- Building provided by City Hall
- Nurse, Social worker, Physician, Psychologist, 3 peer mentors and a coordinator
- Peers involved in all aspects and are paid a salary for their work
- Portugal is now an example for Hep-C management as well!
"I think harm reduction is about not giving up on people, I think it is respecting their timings and assuming that even if someone is still using drugs, that person deserves the investment of the state in order to have a better and longer life."

Rachita Sharma PhD, LPC-S, CRC
“The lesson that Portugal offers the world is that while we can’t eradicate heroin, it’s possible to save the lives of drug users — if we’re willing to treat them not as criminals but as sick, suffering human beings who need helping hands, not handcuffs.”

- Nicholas Kristoff (NY Times)
Harm reduction approaches

• There are no specific guidelines for the use of this model. The course and pace of treatment is determined by the patient and counselor’s role to educate on the consequences of the patient’s choices (Tatarsky, 2002).

• It can also be implemented in different treatment setting such as: outpatient settings, residential treatment, homeless programs, traditional drug treatment programs, and any other community outreach programs (Tatarsky, 2002).

• Research has proven that the use of this model can be extremely effective, and it also assists with decreasing usage and rates of relapse.
Harm Reduction Approaches

- **World Health Organization (WHO, 2001):** Prevention of alcohol dependence needs to be seen within the context of the broader goal of preventing & reducing alcohol-related problems at the population level (accidents, injuries, suicide, violence, etc).

- **Moderate Drinking:** (Not recommended for alcohol dependence)
  - Defined as less than *2 drinks per day* for males; *less than 1* for a woman.
  - Logic = Abstinence & heavy drinking associated with increased disease risk; moderation associated with lowest levels of disease risk. Similar relationships seen in cardiovascular health, stroke.
  - Behavioral Self-Control Training (BSCT) reports significantly better at treating problematic drinking than no treatment or alternative moderation oriented treatments.
Criticisms of Harm Reduction Methods

• Though we know it does not mean legalization, it may provide a disguise for pro-legalization efforts. Ex., Legalize underage drinking.

• Secondly, harm reduction may facilitate future, much more harmful behavior by reducing negative consequences associated with use and “encouraging” current substance use.
Any Harm Reduction approach should depend on the client. For example, not appropriate for adolescents, pregnant females, dependent alcohol users, or individuals with medical conditions.

The responsibility of deciding if either a moderation or abstinence goal is most appropriate should be determined with the individual’s needs and goals.

Should begin with education about moderate use.

- For Mexican/Mexican American clients, begin discussion from a health perspective. This removes moral entanglement.

Goal is NOT to encourage drinking, rather decrease the harm experienced by the drinker.
Recommended Harm Reduction Approaches for Mexican Americans

• More closely matches motivation (or lack thereof) of clients in the Precontemplative stage of the transtheoretical model.

• Harm reduction provides easy access to nonstigmatized and flexible treatment options for Mexican/Mexican American clients.
Harm Reduction Acceptance Scale (HRAS-r)

- Used to measure the substance abuse counselors’ acceptance of the harm reduction approach (Goddard et al., 2003).
- The HRAS-R is a 25-item scale that participants are instructed to score based on their personal attitude of each statement.
- Lower scores on the HRAS-R indicate increased acceptance toward harm reduction (Goddard et al., 2003) while higher scores indicate non-acceptance of harm reduction.
References