The Need for Expanded Access to Harm Reduction

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This past November, New York City opened two overdose prevention centers, also sometimes called supervised injection sites, to help address the overdose epidemic that is ravaging that city just as it is ravaging the nation. In overdose prevention centers, trained staff provide sterile injection equipment to people with opioid addiction and can administer naloxone if necessary. While the evidence base for this approach is still developing and it has yet to be tested in the United States, proponents of harm reduction are hopeful that it could make a difference. In their first two weeks of operation, personnel in the Manhattan facilities reportedly intervened in 43 potentially fatal overdoses and did not need to call 911.[1]

Harm reduction is a pillar of the Overdose Prevention Strategy announced in October by the U.S. Department of Health and Human Services[2], but winning acceptance for this approach has been an uphill battle due to the enormous stigma that still prevails around substance use and addiction. No one chooses to have an addiction to drugs, and once addiction develops, drug use is not "for fun." But failure of many segments of society to understand this, including many policymakers and leaders, has impeded the adoption of approaches whose focus is outside of drug use deterrence.

Syringe services programs (SSPs) are the best known harm reduction modality, with much evidence that they prevent the spread of HIV and link people who inject drugs to treatment.[3] But these facilities are seen by critics as encouraging drug use by giving clean needles to people with addiction. Sluggishness at implementing SSPs has unfortunately contributed to HIV outbreaks, for instance in Indiana.[4] Sometimes offered within SSPs, overdose education and naloxone distribution (OEND) programs are another example of an effective approach that is demonstrably saving lives in a growing number of localities[5,6]; yet these programs face similar resistance from factions who see it as encouraging drug use by removing overdose as a deterrent.

The New York overdose prevention centers are the first of their kind operating in the U.S., so supporting data currently comes from Canada and other countries in which they have been utilized for decades. Those data show that these facilities prevent overdose mortality among clients—no one has ever died in such a facility—and that they also reduce ambulance calls, etc.[7] Importantly, evidence also shows no increases in drug use or drug-related crime in neighborhoods surrounding overdose prevention centers; some evidence suggests they may even reduce crime.[8] Similarly, U.S. data show that SSPs and OEND programs do not increase drug use or crime in localities that implement them.[9,10] The absence of feared collateral harms or side effects of harm reduction may be critical in winning greater acceptance of approaches to the drug crisis that don't focus exclusively on preventing or treating SUD or legally deterring drug use.

Harm reduction services like SSPs are sometimes the only settings where people who use drugs may access healthcare without fearing stigma, where they and their disorder are accepted.[11] Some SSPs employ providers waivered to prescribe buprenorphine. They may also offer wound care and other medical services clients might not otherwise seek out. During the COVID pandemic, many SSPs have offered vaccines and vaccine education.

As the Director of the National Institute on Drug Abuse, Dr. Nora Volkow, has recently argued, our society's approach to the overdose epidemic and the multiple intersecting drug crises (opioids and increasingly stimulants like methamphetamine) must be realistic in its acceptance of drug taking by those with active addiction as well as by people undergoing treatment or seeking recovery.[12] Demanding abstinence as the sole criteria of recovery and sole standard of treatment effectiveness is counterproductive and reinforces both societal stigma and the internalized shame that may even be part of the vicious cycle reinforcing addiction.[13]

We must move past the stigmatizing, judgmental, punitive mindset that has impeded progress in delivering compassionate care to all people with substance use disorders. Expanded investment in harm reduction, including research to evaluate innovative harm-reduction approaches, must be a part of this shift in mindset. Harm reduction research is the focus of a recently released funding opportunity announcement in which NIDA is participating.[14]

Meeting people who use drugs where they are—both in terms of an individual's unique needs as well as geographically—is crucial. Harm-reduction professionals in a recent summit hosted by the White House Office of the National Drug Control Policy and agencies of the Department of Health and Human Services emphasized the need to work with state, local, and tribal partners to make sure harm reduction is available in all communities.[15]

Addiction counselors can play a role in winning support for harm reduction at the community level. Educating the public and policymakers about the effectiveness of such programs and helping bust myths that they merely encourage drug use are crucial to eroding doubts that impede the uptake of these programs. The "not in my backyard" mentality persists in many or most communities, but the successes of measures like SSPs and OENDs may be used to show that harm reduction benefits communities in the long run by reducing overdoses and infectious diseases and even by connecting more people to addiction treatment and other forms of healthcare.

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