Chapter 10
Harm Reduction: Tipping the Balance Toward Treatment and Recovery

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Abstract Opioid use has risen dramatically over the past 40 years. In response, federal programs and policies aimed at decreasing supply of prescription opioids have stabilized excessive prescribing. Unintended consequences of limiting the quantity of prescription opioids in the population has resulted in increased use of illicit drugs and opened a pathway of transition from misuse of pills to injection of heroin and use of potent formulations of cheap, synthetic opioids such as fentanyl. Harm reduction interventions function at the community level to provide health benefits and avoidance of harm to persons engaging in illicit and injection drug use. The Consolidated Appropriations Act of 2016 gives states, local, tribal, and territorial health departments the opportunity to use federal money to support a comprehensive set of harm reduction services. Critics of harm reduction strategies argue that formalizing and legalizing certain activities creates the perception that communities and local authorities are sanctioning or encouraging illicit/illegal drug use. Syringe services programs that provide clean needles and syringes so people who inject drugs are not forced to share or reuse injection equipment, are often at the heart of such controversy. This story addresses tensions that exist in communities grappling with harm reduction approaches to opioid and injection drug use.

Disclaimer: *This paper is presented for instructional purposes only, the story that follows does not depict an actual event and all people, places, and dialogue are fictional. The ideas and opinions expressed are the authors' own. The paper is not meant to reflect the official position, views, or policies of the editors, the editors' host institutions or the authors' host institution.*

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Public Health Ethics Issue

Health and safety are essential for human survival and prosperity. From the time of Hippocrates, doing good and avoiding harm have been central to medicine and medical ethics. Harm reduction interventions and policies function at the community level to provide health benefits and avoidance of harm to persons engaging in injection drug use. Interventions protect persons who engage in illegal and potentially fatal activities by lowering the risk of such activities. Over time, they can open a window to treatment, counselling, and recovery. The goals of harm reduction, then, align with public health's core ethical responsibilities "to prevent, minimize, and mitigate health harms and to promote and protect public safety, health, and well-being" (American Public Health Association 2019, 5).

Society criminalizes some high-risk activities, such as injection drug use, that harm reduction interventions target. Moreover, society often stigmatizes people who engage in high-risk activities, people who are already more likely to be vulnerable by virtue of belonging to a marginalized subculture or population group. All community members, including people who inject drugs, are entitled to be treated with dignity and respect. Health officials at all levels of government have an obligation to promote and protect the health and safety of the entire population – not just some or most of the population. In addition, public health authorities have a special obligation to engage and protect vulnerable populations and eliminate disparities in health status. Protecting the health of those most vulnerable protects the health of the community and upholds the right to health for all.

Background Information

Opioid Crisis of the Early Twenty-First Century

Over the past 40 years, opioid use has risen dramatically. In the 1980s the opioid propoxyphene was the second-most dispensed drug in the United States for acute pain (Dasgupta et al. 2018, 182). During the 1990s, the volume of opioids prescribed to patients for chronic pain also began to grow (Dasgupta et al. 2018, 182; Levy et al. 2015, 411; Centers for Disease Control and Prevention (CDC) 2011,

1488–1489). By the early 2000s, treating the high prevalence of chronic pain had become an increasingly large proportion of the business of pharmaceutical companies (Dasgupta et al. 2018, 182; CDC 2011, 1488–1489). The high prevalence of chronic pain was attributable to increased survival after injury and cancer, musculoskeletal problems of an aging population, obesity, and more complex surgeries. A decade later, rates of opioid use disorder and overdose spiked resulting in concomitant increases in heroin use, synthetic opioid use, and overdose deaths (CDC 2014, 852; Compton et al. 2016, 155). In October 2017, the U.S. Department of Health and Human Services (DHHS) declared opioid use disorder (OUD) a federal public health emergency (Government Accountability Office 2018). Opioid overdose had become an epidemic in the United States and by early 2020 an estimated 128 people were dying each day from prescription and illicit opioid use (CDC 2020).

Over the past decade, local, state, and federal responses to the opioid crisis have produced mixed results. A variety of programs and policies aimed at decreasing the supply of prescription opioids in the population have been implemented. The measures include prescription drug monitoring programs, education of health professionals and the public about the dangers of opioid use, and regulatory and law enforcement initiatives to deter inappropriate prescribing (Burris 2018, 29–31; Compton et al. 2016, 154). While prescribing stabilized, unintended consequences of limiting the quantity of prescription opioids in the population has resulted in increased use of illicit drugs (CDC 2017, 701, 2019, 29; Compton et al. 2016, 154–155). Increased use of illicit drugs has opened a pathway of transition for those suffering from OUD from misuse of pills to injection of heroin and use of potent formulations of cheap, synthetic opioids such as fentanyl (National Academies of Sciences, Engineering, and Medicine (NASEM) 2020, S1). Adulteration of heroin with illegally produced fentanyl began around 2013 and has complicated the opioid overdose epidemic by increasing the risk of unintentional lethal overdose (Ciccarone 2017, 109; Compton et al. 2016, 154, 161). While government measures may have lessened the risk of misuse of prescribed opioids, for those already experiencing OUD the effect has been to shift the problem from one target drug to other, more dangerous drugs.

OUD and infectious disease have been veritably interwoven for health professionals since it was determined that HIV could be transmitted through injection drug use. Today, OUD has become associated not only with HIV, but also hepatitis A, hepatitis B, and hepatitis C virus transmission, and with bacterial and fungal infections (NASEM 2020, S-1). Outbreaks of HIV and viral hepatitis occur among people infected through injection drug use or through high-risk sexual behavior associated with drug use. Public health interventions targeting OUD, therefore, need to focus on preventing both overdoses and serious bloodborne infections (NASEM 2020, S1–2).

In contrast, traditional models of care for all substance use disorders (SUDs) have generally occurred in standalone settings outside of medical and public health programs. That segregation tends to align with traditional substance abuse care models that focus on terminating drug use prior to engagement in targeted counseling, treatment, or intervention. Historically, 12-step programs, substance abuse

counseling, addiction recovery centers, and inpatient rehabilitation centers have been the main providers of substance abuse care. However, these approaches are impracticable for people who inject drugs (PWID), or persons with OUD or other SUDs who continue to use drugs. Public health officials need to develop effective messaging and comprehensive evidence-based harm reduction interventions specifically for persons currently experiencing OUD or other SUDs. With a targeted approach, infectious disease transmission, outbreaks, and lethal overdoses, will be prevented and reduced.

Approach to the Narrative

This story addresses tensions that exist in communities grappling with harm reduction approaches to OUD and other SUDs. Interventions to reduce potentially severe adverse consequences of drug use do not, unfortunately, translate directly into reductions in the rate of addiction or drug overdose. Critics of harm reduction strategies argue that formalizing and legalizing certain activities creates the perception that the community and local authorities are sanctioning or encouraging illicit/illegal drug use. Syringe services programs (SSPs) that provide PWID with clean needles and syringes so they are not forced to share or reuse injection equipment, are often at the heart of such controversy. After a prolonged outbreak of HIV infections among PWID from 2011 to 2015, in Scott County, Indiana, the 1988 Congressional ban on use of federal funds for SSPs was lifted.

The Consolidated Appropriations Act of 2016 (DHHS 2016, 1) gives states, local, tribal, and territorial health departments experiencing or at risk for significant increases in hepatitis C or HIV incidence, the opportunity to use federal money to support a comprehensive set of harm reduction services. With a determination of need from the CDC, federal dollars can be used for personnel; injection supplies other than needles and syringes; testing/diagnostic kits for hepatitis C and HIV; biosafety sharps disposal containers; navigation services for linkage to care for hepatitis C and HIV prevention and treatment, including direct acting anti-viral (DAA) therapy for hepatitis C, and antiretroviral therapy (ART) for HIV, pre-exposure prophylaxis (PrEP), post exposure prophylaxis (PEP), hepatitis A and hepatitis B vaccination services; SUD treatment; recovery support services; medical and mental health services; naloxone for opioid overdose; comprehensive education materials; condoms to reduce the risk of sexual transmission of HIV, viral hepatitis, and other STDs; communication and outreach activities, and planning and evaluation activities.

Martindale, West Virginia, the setting for this story, is a fictional town, but the state of West Virginia ranked as the state with the highest rate of new hepatitis B and hepatitis C diagnoses in 2017, the last year for which surveillance data were available (West Virginia Office of Epidemiology & Prevention Services 2018). The story that follows does not depict an actual event, but it was inspired by an amazing woman and poet. She attended a workshop convened by the Board on Population

Health and Public Health Practice of the National Academies of Sciences, Engineering, and Medicine (NASEM) that explored the integration of infectious disease considerations with response to the opioid crisis. The opening session of the workshop focused on the scope of the opioid misuse problem: a subsequent panel discussion addressed the perspectives of patients and providers. That panel discussion included the personal experiences and shared journey of the poet in recovery from SUD from age 11 to age 63.

Narrative

Dr. Mikala, executive director of the Martindale Harm Reduction Center (MHRC), had just submitted her clinic funding proposal for the next fiscal year when she received a call from Lisa Ewing, the mayor. It had only been a week, and upon hearing Lisa's voice she had a sudden feeling of trepidation that it wasn't good news, "Hello Mikala, how are you?"

Mikala responded, "Relieved to have finished the MHRC grant proposal for next year, and how are you Mayor Ewing?"

"I'm well – thanks for asking. Unfortunately, I'm calling about the funding proposal – we need to determine next steps," Lisa responded.

The mayor's words caught Mikala off guard, and she began racking her brain for what might have gone wrong. She knew federal dollars couldn't be used directly to buy needles or syringes. But a big HIV outbreak in Indiana had gotten the feds to lift the ban on using federal funds for other services provided by SSPs. After that, an act of the federal government had authorized health departments to use federal money to support comprehensive services in jurisdictions experiencing, or at risk of experiencing, major increases in hepatitis C or HIV – and theirs certainly was. She had already requested and received a determination of need from the CDC.

Doctor Mike, as Mikala was called by most MHRC program participants and the community at large, went through the budget allocation checklist for services provided through the Center – it was fresh in her mind, what could be the problem?

"Next steps to address what specific problem?" responded Dr. Mike to the mayor.

Lisa Ewing cut right to the chase, "There seems to be some local opposition to the use of federal funds to support the MHRC. As you know, decisions about use of SSPs to support the health and engagement of PWID are made at the local level and the Martindale city council has decided we should have other priorities."

Given that the opioid crisis had been raging in West Virginia for years, Dr. Mike could not believe what she was hearing. "Lisa, I honestly can't believe that local government in the state with the distinction of having the highest rates of new hepatitis B and hepatitis C diagnoses over the last few years would conclude we don't need harm reduction services in our community, I am simply astounded. Can we talk some sense into them?"

"I am so glad to hear you say that," replied Lisa. "I was thinking we might host a town hall with the city council to find out where this is coming from – is it the

council members or their constituents; who exactly wants to shut down the MHRC? And why? I was thinking you could speak with them."

Dr. Mike considered the mayor's strategy, "I may have a better idea, let's ask Ellie to lead the discussion – everyone in town knows and loves Miss Ellie and her children."

Two weeks prior to the town hall, notifications about the meeting had been posted on the city government website, the local paper, and in gathering places around town. It seemed that significant controversy about the need for MHRC services had emerged from a vocal group within the local community. The group wanted to see federal dollars used primarily to fund contracts for privately run abstinence-focused recovery programs rather than services for people who continue to use drugs. Word had spread that some people wanted MHRC shut down and Dr. Mike wasn't certain who exactly might attend the town hall to argue that.

On the scheduled day, community members came into the meeting room of Martindale City Hall in orderly fashion starting at just about 5:45 PM where the city council members were already settled into the upper dais seats. Seated in the lower dais close to the speaker podium were Mayor Ewing, executive director Dr. Mike, and MHRC's senior prevention specialist, Ellie Phipps.

At precisely 6 PM, the chair of the city council called the meeting to order and asked the board secretary to read a brief summary of the issue slated for discussion on the agenda:

City council secretary Derek Sanders read the following statement from a letter addressed to the council:

> The city council plays a critical role in determining how the city will spend money. It has come to the attention of a group of concerned citizens that federal dollars were spent in 2019 and are being spent in 2020 to fund the Martindale Harm Reduction Center (MHRC), and that the MHRC provides services to enable people who inject and abuse drugs. We are opposed for three reasons: 1) because federal funding contradicts law enforcement efforts in the "war on drugs" by signaling tacit governmental approval of illegal drug use, 2) federal funding of MHRC services and availability of clean syringes could cause a rise in injection drug abuse and weaken public health, and 3) the appearance of federal approval of MHRC services and removal of an obstacle to unsafe drug use could have a corrupting influence on children in our community.

City council president, John Smith, asked if Mayor Ewing or executive director Dr. Mikala Johnson wanted to speak to these concerns.

Dr. Mike got up and moved to the speaker's podium,

> Thank you all for coming and good evening – we are going to do our best to answer your questions and address your concerns about operating the MHRC. In 2018, Department of Public Health surveillancePublic health surveillance data for hepatitis BHepatitis B and hepatitis CHepatitis C were trending upward at an alarming rate. In response, we requested an assessment and then received permission from the federal Department of Health and Human Services to reprogram some federal dollars to syringe services programs. Not only do these programs prevent transmission of disease but they also provide opportunities to help and support persons experiencing opioid and other substance use disorderSubstance use disorder (SUD). These programs are critical to individual well-being and the long-term health of the community …

"But giving people new syringes just encourages their illegal behavior!" a man in the first row of chairs blurted out. "And it looks like the community condones it!"

At that moment, Ellie Phipps, a local church elder beloved in her community and well-respected by everyone who worked with or had contact with MHRC, stepped to the podium. Everyone in the room either knew Ellie personally, knew her children – one of which was a legal aid attorney in a neighboring town – or knew someone who swore up and down Ellie had saved their life at some point over the past 15 years since she had come on the scene.

"I'd like to tell you about a client, it wasn't someone from my work with MHRC – MHRC didn't exist at the time – but this client was born in 1955 in the tenements on the southeast side of Martindale. She was sexually abused as a child, began using drugs and alcohol at the age of 11 and was snorting heroin by age 15. This girl, Sissy, had been exchanging sex for drugs in 1994 when she was diagnosed with HIV at the age of 39. On multiple occasions before and after her HIV diagnosis, she was seen in the hospital Emergency Department for various medical problems related to her drug use. She spent hours sick and in pain, waiting to be seen and suffering, only to be treated clinically and discharged as soon as possible. There was never a plan for follow up to address the root cause of her medical problems, her underlying substance use disorder. For years before her HIV diagnosis, and afterward while receiving care for HIV, Sissy was never offered counseling or treatment for her drug use. She would leave the hospital, carrying the burden of her drug issues and struggling with how to overcome it alone unassisted. All the while, she was terrified of living with HIV because she didn't know exactly what it meant."

Another community member stood up and asked Miss Ellie (as she was known around town), "But what does your client Sissy have to do with any of the MHRC funding concerns?"

Miss Ellie responded, "That's a good question – so let me explain. Some years after her HIV diagnosis, Sissy had a drug dealer living with her and her children when she had to go to the hospital ED. That was the day her life was set on a different course, the day she met the Martindale Hospital's new infectious disease doctor, Mikala Johnson."

Dr. Mike sat lost in thought, it had been almost 20 years but she still remembered receiving a call from the triage nurse about a repeat patient in the emergency department…this was their first encounter even though the patient had been treated on previous occasions. "Do you use drugs?" She could tell the patient wanted to say no, to give the socially desirable response, however, to Mike's surprise, she didn't, "Yea, I use drugs."

Mike responded, "Today is Tuesday, if I could get you a bed would you start the short-term in-patient treatment program today?" And the patient responded, "Yea". Dr. Mike looked down at the notes from the patient's last visit and replied, "What about your children?" And Sissy had said, "Well, they take care of me. I think they'd be okay while I go in treatment, I think they do fine."

Dr. Mike reflected that she had left the room to call the treatment center but as she came back into the room she said, "I can't get you anything until Friday, but if

you make it back here on Friday, I'll make sure you get up to Crestview to start treatment." She thought the chance Sissy would return was maybe 50/50.

Miss Ellie continued in a soothing tone to all those gathered in the room, "Dr. Mike made certain that Sissy had access to support services – 34 years of sustained drug use but she finally entered treatment for opioid and other substance use disorder. What made that transformation possible from drug user to patient in treatment and then recovery was outreach by Dr. Mike and her continued support. But maybe this could have happened sooner if only there had been somewhere for Sissy to go for care other than the hospital. The emergency department is intended for and focused on emergency care, maybe it didn't have to take decades – the provision of care, support, and counseling to those suffering from opioid and substance use disorder is not circumventing law enforcement – it's protecting our citizens and community" Ellie stated firmly.

Another community member moved to the microphone that had been set up between the aisles of seats, "I'm Shanice, born and raised in Martindale, and I just know that handing out needles is going to result in more people shooting up – make it easy for them, lord forbid, make it safer, and we are going to have more people doing it and kids are going to see that and you know how kids are, they'll be doing it too!"

Dr. Mike flipped the switch on her microphone to address the crowd, "Last year, West Virginia had higher rates of new hepatitis B and hepatitis C diagnoses than any other state in the nation. However, since implementation of comprehensive harm reduction services at MHRC last October, our county has flattened those epidemiological curves and we are on track to see a significant reduction in incidence for 2020 compared to last year."

Miss Ellie continued in her matter of fact way, "In accordance with public health goals, study findings indicate that the availability and use of evidence-based harm reduction programs, such as those we offer at MHRC, lead to a net reduction in opioid and other substance use over time. Such programs should not be viewed as sanctioning bad behavior but as effective interventions by which to respectfully meet people suffering addiction where they are, and provide them with care and services that reasonably offset the potential harms and losses that drug use imposes on individuals and communities."

"Our data and trend analysis thus far, appear to bear that out" Dr. Mike said as she stood up and moved to the podium next to Ellie.

Ellie turned to look at Dr. Mike, "That client, 'Sissy', that I was telling you all about – she didn't have an easy time of it. While she was waiting even that few days to go to rehab, her disability check came. She needed to return a loan to one of her neighbors but she knew if she went to the bank to get cash she would get more than she needed to repay the loan, would buy more drugs and then the cycle would begin again and she wouldn't go back to the hospital on Friday…".

"See, that Sissy woman was on welfare – using her welfare money for drugs" Mr. Butler of the local grocery piped up loudly and with resentment in his tone.

"But she didn't receive welfare because she had substance use disorder, she received disability because she was HIV positive" Miss Ellie quickly explained,

"She made it into the short term treatment program and then, with God working, after her discharge she was referred to an eight month aftercare program. After 1 year in the 8-month program, she was "put out," as she likes to say, with instructions to attend 90 support group meetings in 90 days."

"Is she still on welfare, are my taxpayer dollars still supporting her, Miss Ellie?" Mr. Butler wanted to know.

Ellie shifted her weight from one foot to the other as she tucked a stand of grey hair behind her ear, "You will be happy to know, she is not – Sissy went to 200 or 300 support group meetings in 90 days and then a few years later, she went to community college, and then applied the credits from her 2-year associates degree to a 4-year course of study to complete her bachelor's degree. After graduating she reluctantly accepted a volunteer position and then once she had some experience, Sissy was hired as a paid peer mentor – that was 14 or 15 years ago – she is still employed today in a different community health position and is also a published author."

Dr. Mike leaned forward toward the microphone, "She would tell you that things might have been different had she received a different type of care in the ED or had somewhere else to go – that maybe the existence of an intervention, even just a counselor who could have sat and talked to her, might have resulted in access to treatment and cessation of her drug use years earlier, perhaps before she contracted HIV – that there were many missed opportunities."

"MHRC should focus on recovery and make certain people stop using drugs before they help them," Shanice argued, popping out of her chair to get back to the microphone. "It's not right to help them keep using by giving them medical care and testing and treatment for STDs".

"Well," responded Ellie, "we might consider how Sissy's experience shows how opioid and substance use are intertwined with infectious disease transmission. It highlights the way in which harm reduction programs can overcome some of the barriers to patient-centered care and treatment faced by people who use drugs. A user who's been treated for a disease and educated about safer sex or drug use behavior is less likely to get infected or to infect someone who does not use – your brother, your sister, your son or daughter. People take drugs to self-medicate; substance use disorder is a brain disease that requires long-term treatment and linkage to healthcare services. Some addicts never get to that place, but many take a long time before they are ready to quit."

Jack Hanson, another community member, stepped up to the microphone as Shanice returned to her seat,

> Okay, I'll concede that having MHRC provide comprehensive care and treatment seems to make sense, I can support the use of HHS dollars to fund harm reduction locally – I really like the idea of people having somewhere to go if they are sick, need to talk to someone, or even to exchange needles – and there aren't restrictions based on whether they have health insurance or not. MHRC is certainly cheaper than having people use the emergency department at the hospital, we pay for that with our tax dollars too. I didn't know about the high rates of hepatitis B and hepatitis C in our community – I am glad to hear that MHRC is on top of it and impressed that it's an issue they, and we the community, can tackle. You have my support.

"But what about our children?" Jennifer Parsons was back at the microphone. "Can you assure us that MHRC will not be a corrupting influence on our children?"

Doug and Mary Williams approached the microphone hand in hand, "Our Amanda died last year of bacterial endocarditis – infection in the lining of her heart and heart valves – as a result of injecting with dirty needles. She had been to rehab twice but couldn't stop using… she tried so hard. If only she had access to safe injection equipment, we might have kept her alive long enough for her to get to a place where she could stop. We want MHRC to get the funding they need" declared Mary as tears streamed down her face.

"You all know me as a god fearing woman," asserted Miss Ellie, "so trust me when I tell you that addiction is a long, arduous journey – there is physical pain, psychological pain, a deep sense of shame and feelings of stigma and discrimination – the feeling of being invisible and having nothing left but faith. Sissy wrote a poem describing her despair, I'd like to read it to you:

What Is This All About
What is this all about?
I'm dying but not yet dead,
I refuse to lay down and rest my head,
I come in many colors, races, and religions,
I'm tall, I'm short, I'm thin, I'm stout,
Do you know yet what this is all about?
I can fly just not like a pigeon,
People walk by me like they don't have vision,
No one can hear me screaming out loud,
No one can see that I am proud,
No one knows what I'm feeling, no one can see that I'm not healing,
Up and down, up and down, all through the night, not realizing that I'm headed to the light,
Knowledge, potential, dreams, and power
Turn around now you're heading to the end hours.
Jesus, Jesus help me please, I bow before you on my knees,
Oh God, I pray you can hear me shout,
Do you know yet what this is all about?"[1]

Jack Hanson spoke from his seat, "Sounds like someone who almost died."

"That is exactly what the poem is about," responded Miss Ellie.

"But how would you know?" someone in the back of the room shouted.

Ellie looked out into the crowd of community members who had come to debate the value of harm reduction services and felt a small sense of redemption, "Because the author of that poem is me."

[1] Ms. Veda B. Moore attended and spoke at a 2018 workshop convened by the Board on Population Health and Public Health Practice of the National Academies of Sciences, Engineering, and Medicine (NASEM) exploring the integration of infectious disease considerations with response to the opioid crisis; she wrote the poem, *What Is This All About,* while watching and listening to other speakers and presenters at the workshop and read the poem out loud to conference attendees at the close of the conference.

Questions for Discussion

1. Why or why shouldn't people who are still using drugs have access to health services?
2. How can concerns that harm reduction programs condone or give permission for misuse of opioids or other drugs be balanced with the need to improve the health of people who use drugs?
3. Critics argue that harm reduction programs condone or enable users to misuse drugs, while health professionals tend to see substance use disorder as a disease.
   (a) Are these positions irreconcilable and, if so, which side has the stronger argument, and why?
   (b) Alternatively, is there a way of incorporating personal agency and responsibility within the view that substance use disorder is a disease?
4. What preconceived ideas do you have about people who experience OUD and SUD?
5. How should local, state, and federal health officials/governments work together to address the opioid use crisis?
6. Should the practice of public health require interventions to address behaviors that are illegal?
7. Are there any interventions for people who use drugs that should be beyond the scope of public health responsibility? If yes, which interventions?
8. What approaches should be used to obtain a better understanding of community values and concerns relating to harm reduction interventions?

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