

Harm Reduction

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Harm reduction (or more commonly known as harm minimisation) refers to a range of public health policies designed to reduce the harmful consequences associated with recreational drug use and other high risk activities. Harm reduction is put forward as a useful perspective alongside the more conventional approaches of demand and supply reduction.

Many advocates argue that prohibitionist laws criminalize people for suffering from a disease and cause harm, for example by obliging drug addicts to obtain drugs of unknown purity from unreliable criminal sources at high prices, increasing the risk of overdose and death. Its critics are concerned that tolerating risky or illegal behaviour sends a message to the community that these behaviours are acceptable.

Drugs

Heroin maintenance programs

Providing a medical prescription for pharmaceutical heroin (diamorphine) to heroin addicts has been seen in some countries as a way of solving the 'heroin problem' with potential benefits to the individual addict and to society. The treatment greatly improves the social and health situation of patients, while reducing costs incurred by delinquency, criminal trials, incarceration and health interventions.

In Switzerland, heroin assisted treatment is fully a part of the national health program. There are several dozen centers throughout the country at which heroin-dependent people can receive heroin in a controlled environment. The Swiss heroin maintenance program is generally regarded as a successful and valuable component of the country's overall approach to minimizing the harms caused by drug use. In a 2008 national referendum a majority of 68% voted in favor of continuing the program.

The Netherlands has studied medically supervised heroin maintenance. A German study of long-term heroin addicts demonstrated that diamorphine was significantly more effective than methadone in keeping patients in treatment and in improving their health and social situation. Many participants were able to find employment, some even started a family after years of homelessness and delinquency. Since then, treatment had continued in the cities that participated in the pilot study, until heroin maintenance was permanently included into the national health system in May, 2009.

The British have had a system of heroin maintenance since the 1920s. Drug addiction was in the so called British system seen as an individual health problem, drug addiction to opiates was rare in the 1920s and mostly limited to middle class person that had easy access to opiates in their profession or persons who had become drug addicts as a side effect of medical treatment. In the 1950s and 1960's contributed a small number of doctors, through legal prescribing of excessive

quantities of addictive drugs, to the alarming increase of drug addicts in the U.K. This gave the method a bad reputation and the U.K. switched to a more restrictive drug law. However, in recent years the British are again moving toward heroin as a legitimate component of their National Health Service. This is because evidence is clear that methadone maintenance is not the answer for all opioid addicts and that heroin is a viable maintenance drug which has shown equal or better rates of success in terms of assisting long-term users establish stable, crime-free lives.

The first, and only, North American heroin maintenance project is being run in Vancouver, B.C. and Montreal, Quebec. Currently some 80+ long-term heroin addicts who have not been helped by available treatment options are taking part in the North American Opiate Medication Initiative (NAOMI) trials. However, critics have alleged that the control group gets unsustainably low doses of methadone, making them prone to fail and thus rigging the results in favor of heroin maintenance.

Critics of heroin maintenance programs object to the high costs of providing heroin to users. The British heroin study cost the British government £15,000 per participant per year, roughly equivalent to average heroin user's expense of £15,600 per year. Drug Free Australia contrast these ongoing maintenance costs with Sweden's investment in, and commitment to, a drug free society where a policy of compulsory rehabilitation of drug addicts is integral, which has yielded the lowest illicit drug use levels in the developed world, a model in which rehabilitated users present no further maintenance costs to their community, as well as reduced ongoing health care costs.

A substantial part of the money for buying heroin is obtained through criminal activities, such as robbery or drug dealing. King's Health Partners notes that the cost of providing free heroin for a year is about one-third of the cost of placing the user in prison for a year, making it cost-effective even without perfect outcomes.

Needle exchange program

The use of some illicit drugs can involve hypodermic needles. In some areas (notably in many parts of the US), these are available solely by prescription. Where availability is limited, users of heroin and other drugs frequently share the syringes and use them more than once. As a result infections such as HIV or hepatitis C can spread from user to users through the reuse of syringes contaminated with infected blood. The principles of harm reduction propose that syringes should be easily available or at least available through a needle and syringe programmes (NSP). Where syringes are provided in sufficient quantities, rates of HIV are much lower than in places where supply is restricted. In many countries users are supplied equipment free of charge, others require payment or an exchange of dirty needles for clean ones, hence the name.

Two 2010 reviews of reviews, which examined systematic reviews and meta-analyses on the topic,

concluded that there is insufficient evidence that NSP prevents transmission of the hepatitis C virus, tentative evidence that it prevents transmission of HIV and sufficient evidence that it reduces self-reported injecting risk behaviour. However, Drug Free Australia has criticized this review, claiming that its 'tentative' conclusion regarding HIV transmission is based on significant errors replicated from the World Health Organisation 2004 review, which when corrected, would alter the finding to 'inconclusive'. It has been shown in the many evaluations of needle-exchange programs that in areas where clean syringes are more available, illegal drug use is no higher than in other areas.

Safe injection sites

A clandestine kit containing materials to inject illicit drugs (or legitimate ones illegitimately). Note that it is quite common for an injector to use a single needle repeatedly or share with other users. It is also quite uncommon for a sterilizing agent to be used.

Compare this legitimate injection kit obtained from a needle-exchange program to the user-compiled one above.

Safe injection sites (SIS), or Drug consumption rooms (DCR), are legally sanctioned, medically supervised facilities designed to address public nuisance associated with drug use and provide a hygienic and stress-free environment for drug consumers.

The facilities provide sterile injection equipment, information about drugs and basic health care, treatment referrals, and access to medical staff. Some offer counseling, hygienic and other services of use to itinerant and impoverished individuals. Most programs prohibit the sale or purchase of illegal drugs. Many require identification cards. Some restrict access to local residents and apply other admission criteria, such as they have to be injection drug users, but generally in Europe they don't exclude addicts who consume by other means.

The Netherlands had the first staffed injection room, although they did not operate under explicit legal support until 1996. Instead, the first center where it was legal to inject drug was in Berne, Switzerland, opened 1986. In 1994, Germany opened its first site. Although, as in the Netherlands they operated in a "gray area", supported by the local authorities and with consent from the police until the Bundestag provided a legal exemption in 2000.

In Europe, Luxembourg, Spain and Norway have opened facilities after year 2000. As did the two existing facilities outside Europe, with Sydney's Medically Supervised Injecting Center (MSIC) established in May 2001 as a trial and Vancouver's Insite, opened in September 2003. In 2010, after a nine-year trial, the Sydney site was confirmed as a permanent public health facility. As of late 2009 there were a total of 92 professionally supervised injection facilities in 61 cities.

The European Monitoring Centre for Drugs and Drug Addiction's latest systematic review from

April 2010 did not find any evidence to support concerns that DCR might "encourage drug use, delay treatment entry or aggravate problems of local drug markets." Jürgen Rehm and Benedikt Fischer explained that while evidence show that DCR are successful, that "interpretation is limited by the weak designs applied in many evaluations, often represented by the lack of adequate control groups." Concluding that this "leaves the door open for alternative interpretations of data produced and subsequent ideological debate."

The EMCDDA review noted that research into the effects of the facilities "faces methodological challenges in taking account of the effects of broader local policy or ecological changes", still they concluded "that the facilities reach their target population and provide immediate improvements through better hygiene and safety conditions for injectors." Further that the facilitates "does not increase levels of drug use or risky patterns of consumption, nor does it result in higher rates of local drug acquisition crime." While its usage is "associated with self-reported reductions in injecting risk behaviour such as syringe sharing, and in public drug use" and "with increased uptake of detoxification and treatment services." However, "a lack of studies, as well as methodological problems such as isolating the effect from other interventions or low coverage of the risk population, evidence regarding DCRs -- while encouraging -- is insufficient for drawing conclusions with regard to their effectiveness in reducing HIV or hepatitis C virus (HCV) incidence." Concluding with that "there is suggestive evidence from modelling studies that they may contribute to reducing drug-related deaths at a city level where coverage is adequate, the review-level evidence of this effect is still insufficient."

Critics of this intervention, such as drug prevention advocacy organizations, Drug Free Australia and Real Women of Canada point to the most rigorous evaluations, those of Sydney and Vancouver. Two of the centers, in Sydney, Australia and Vancouver, Canada cost \$2.7 million and \$3 million per annum to operate respectively, yet Canadian mathematical modeling, where there was caution about validity, indicated just one life saved from fatal overdose per annum for Vancouver, while the Drug Free Australia analysis demonstrates the Sydney facility statistically takes more than a year to save one life. The Expert Advisory Committee of the Canadian Government studied claims by journal studies for reduced HIV transmission by Insite but "were not convinced that these assumptions were entirely valid." The Sydney facility showed no improvement in public injecting and discarded needles beyond improvements caused by a coinciding heroin drought, while the Vancouver facility had an observable impact. Drug dealing and loitering around the facilities were evident in the Sydney evaluation, but not evident for the Vancouver facility.

Cannabis

Specific harms associated with cannabis include increased accident-rate while driving under intoxication, dependence, psychosis, detrimental psychosocial outcomes for adolescent users and

respiratory disease. Strategies recommended by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) to deal with those include roadside drug-testing to deter intoxicated driving and education about patterns of use that increases the risk for dependence, mental health and respiratory problems.

The fact that cannabis possession carries prison sentences in most developed countries - although rarely imposed - is also pointed out as a problem by EMCDDA, as the consequences of a conviction for otherwise law abiding users arguably is more harmful than any harm from the drug itself. For example by adversely affecting professional or travel opportunities and straining personal relationships. Due to lack of research on the plant, many of its alleged side effects can still be reasonably disputed. Some people have suggested that organized marijuana legalization would encourage safe use and reveal the factual adverse effects from exposure to this herbs individual chemicals.

The way the laws concerning cannabis are enforced is also very selective - even discriminatory. Statistics show that the socially disadvantaged, immigrants and ethnic minorities have significantly higher arrest rates. Drug decriminalization, such as allowing the possession of small amounts of cannabis and possibly its cultivation for personal use, would alleviate these harms. Where decriminalization has been implemented, such as in several states in Australia and United States, as well as in Portugal and the Netherlands no adverse effects have been shown on population cannabis usage rate. The lack of evidence of increased use indicates that such a policy shift does not have adverse effects on cannabis-related harm while, at the same time, decreasing enforcement costs.

Alcohol

Traditionally, homeless shelters ban alcohol. In 1997, as the result of an inquest into the deaths of two homeless alcoholics two years earlier, Toronto's Seaton House became the first homeless shelter in Canada to operate a "wet shelter" on a "managed alcohol" principle in which clients are served a glass of wine once an hour unless staff determine that they are too inebriated to continue. Previously, homeless alcoholics opted to stay on the streets often seeking alcohol from unsafe sources such as mouthwash, rubbing alcohol or industrial products which, in turn, resulted in frequent use of emergency medical facilities. The program has been duplicated in other Canadian cities and a study of Ottawa's "wet shelter" found that emergency room visit and police encounters by clients were cut by half. The study, published in the Canadian Medical Association Journal in 2006 found that serving chronic street alcoholics controlled doses of alcohol also reduced their overall alcohol consumption. Researchers found that program participants cut their alcohol use from an average of 46 drinks a day when they entered the program to an average of 8 drinks and that their visits to emergency rooms drop to an average of eight a month from 13.5 while encounters with the police fall to an average of 8.8 from 18.1.

Downtown Emergency Service Center(DESC), in Seattle Washington, operates several Housing First, harm reduction model, programs. University of Washington researchers, partnering with DESC, found that providing housing and support services for homeless alcoholics costs tax-payers less than leaving them on the street, where tax-payer money goes towards police and emergency health care. Results of the study funded by the Substance Abuse Policy Research Program (SAPRP) of the Robert Wood Johnson Foundation appeared in the Journal of the American Medical Association April, 2009. This first US controlled assessment of the effectiveness of Housing First specifically targeting chronically homeless alcoholics showed that the program saved tax-payers more than \$4 million over the first year of operation. During the first six-months, even after considering the cost of administering the housing, 95 residents in a Housing First program in downtown Seattle, the study reported an average cost-savings of 53 percent--nearly US \$2,500 per month per person in health and social services, compared to the per month costs of a wait-list control group of 39 homeless people. Further, despite the fact residents are not required to be abstinent or in treatment for alcohol use, stable housing also results in reduced drinking among homeless alcoholics.

Alcohol-related programs

A high amount of media coverage exists informing users of the dangers of driving drunk. Most alcohol users are now aware of these dangers and safe ride techniques like 'designated drivers' and free taxicab programs are reducing the number of drunk-driving accidents. Many cities have free-ride-home programs during holidays involving high alcohol abuse, and some bars and clubs will provide a visibly drunk patron with a free cab ride.

In New South Wales groups of licensees have formed local liquor accords and collectively developed, implemented and promoted a range of harm minimisation programs including the aforementioned 'designated driver' and 'late night patron transport' schemes. Many of the transport schemes are free of charge to patrons, to encourage them to avoid drink-driving and at the same time reduce the impact of noisy patrons loitering around late night venues.

Moderation Management is a program which helps drinkers to cut back on their consumption of alcohol by encouraging safe drinking behavior.

The HAMS Harm Reduction Network is a program which encourages any positive change with regard to the use of alcohol or other mood altering substances. HAMS encourages goals of safer drinking, reduced drinking, moderate drinking, or abstinence. The choice of the goal is up to the individual.

Tobacco

Tobacco harm reduction describes actions taken to lower the health risks associated with using tobacco, especially combustible forms, without abstaining completely from tobacco and nicotine. These measures include:

Smoking safer cigarettes

Switching to Swedish or American smokeless tobacco products

Switching to non-tobacco nicotine delivery systems

It is widely acknowledged that discontinuation of all tobacco products confers the greatest lowering of risk. However, there is a considerable population of inveterate smokers who are unable or unwilling to achieve abstinence. Harm reduction may be of substantial benefit to these individuals.

Sex

Safer sex programs

Many schools now provide safer sex education to teen and pre-teen students, some of whom engage in sexual activity. Given the premise that some adolescents are going to have sex, a harm-reductionist approach supports a sexual education which emphasizes the use of protective devices like condoms and dental dams to protect against unwanted pregnancy and the transmission of STIs. This runs contrary to the ideology of abstinence-only sex education, which holds that telling kids about sex can encourage them to engage in it.

These programs have been found to decrease risky sexual behavior and prevent sexually transmitted diseases. They also reduce rates of unwanted pregnancies. Abstinence only programs however do not appear to effect HIV risks in developed countries with no evidence available for other areas.

Legalized prostitution

Since the 1990s some countries are classifying prostitution as a form of exploitation of women, or violence against women. Laws to this effect have been enacted in Sweden (1999), Norway (2009) and Iceland (2009), where it is illegal to pay for sex, but not to be a prostitute (the client commits a crime, but not the prostitute). Denmark is considering to adopt the "Swedish model".

In contrast, since 1999 other countries have legalized prostitution, such as Germany (2002) and New Zealand (2003).

Those who support the prohibition of the sex trade also say that legalized prostitution does nothing to improve the situation of the prostitutes and leads only to an increase in criminal activities and human trafficking. For example, Netherlands, a country which has legal and regulated prostitution,

has severe problems with human trafficking (it is listed by UNODC as a top destination for victims of human trafficking), and, in response to these problems has decided in 2009, to close 320 prostitution "windows", after having closed numerous other prostitution business during the past years. The mayor of Amsterdam, Job Cohen said about legal prostitution in his city: We've realized this is no longer about small-scale entrepreneurs, but that big crime organizations are involved here in trafficking women, drugs, killings and other criminal activities".

Sex work and HIV

Despite the depth of knowledge of HIV/AIDS, rapid transmission has occurred globally in sex workers. The relationship between these two specific lifestyles greatly increases the risk of transmission among these populations, and also to anyone associated with them, such as their sexual partners, their children, and eventually the population at large.

Many street-level harm-reduction strategies have succeeded in reducing HIV transmission in injecting drug users and sex-workers. HIV education, HIV testing, condom use, and safer-sex negotiation greatly decreases the risk to the disease. Peer education as a harm reduction strategy has especially reduced the risk of HIV infection, such as in Chad, where this method was the most cost-effective per infection prevented.

Decriminalization

The threat of criminal repercussions drives sex-workers and injecting drug users to the margins of society, often resulting in high-risk behavior, increasing the rate of overdose, infectious disease transmission, and violence. Decriminalization as a harm-reduction strategy gives the ability to treat drug abuse solely as a public health issue rather than a criminal activity. This enables other harm-reduction strategies to be employed, which results in a lower incidence of HIV infection.

Self harm

Harm reduction programs work with people who are at risk of self harm (e.g. cutting, burning themselves with cigarettes, etc.) Such programs aim at education and the provision of medical services for wounds and other negative consequences. The hope is that the harmful behavior will be moderated and the people helped to keep safe as they learn new methods of coping.

Psychiatric medications

With the growing concern about psychiatric medication adverse effects and long-term dependency, peer-run mental health groups Freedom Center and The Icarus Project published the Harm

Reduction Guide to Coming Off Psychiatric Drugs. The self-help guide provides patients with information to help assess risks and benefits, and to prepare to come off, reduce, or continue medications when their physicians are unfamiliar with or unable to provide this guidance. The guide is in circulation among mental health consumer groups and has been translated into Spanish and German.

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