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Harm Reduction Information

Resource's and References:

- **Harm Reduction Coalition – www.harmreduction.org**
- **Chasing the Scream and Lost Connections by Johann Hari - http://chasingthescream.com/**
- **Harm Reduction Therapy - https://harmreductiontherapy.org/**
- **Medication Assisted Treatment - https://www.samhsa.gov/medication-assisted-treatment**
- **Robert Whitaker – www.robertwhitaker.org**
- **The Stanton Peele Addiction Website – www.peele.net**
- **Motivational Interviewing - www.motivationalinterview.org/**
- **Drug Policy Alliance Network- www.drugpolicy.org/**
- **Rational recovery - https://rational.org**
- **SMART Recovery - http://www.smartrecovery.org/**
- **Moderation management - http://moderation.org/**
- **Housing first and rapid re-housing: http://www.freedom-center.org/section/resources**
- **The Icarus Project - https://theicarusproject.net/resources/publications/harm-reduction-guide-to-coming-off-psychiatric-drugs-and-withdrawal/**
- **The Inner Compass.org - https://withdrawal.theinnercompass.org/help-hub/how-do-people-come-multiple-psychiatric-drugs**
- **Vietnam Heroin Research: https://europepmc.org/article/MED/27650054**
- **Safe Injection Sites - https://www.npr.org/sections/health-shots/2018/09/07/645609248/whats-the-evidence-that-supervised-drug-injection-sites-save-lives**
- **Portugal Experiment - https://time.com/longform/portugal-drug-use-decriminalization/**
- **Drug War Facts - https://www.drugwarfacts.org/**
- **History Channel - https://www.history.com/topics/crime/the-war-on-drugs**
- **Cato Institute - https://www.cato.org/publications/policy-analysis/four-decades-counting-continued-failure-war-drugs**
- **HuffPost - https://www.huffpost.com/entry/war-on-drugs-prisons-infographic_n_4914884**
- **PolitiFact - https://www.politifact.com/factchecks/2016/jul/10/cory-booker/how-war-drugs-affected-incarceration-rates/**

Drug War Statistics

- Amount spent annually in the U.S. on the war on drugs: **More than $51,000,000,000**
- Number of people arrested in 2013 in the U.S. on nonviolent drug charges: **1.5 million**
  Number of people arrested for a marijuana law violation in 2013: **693,482**
- Number of those charged with marijuana law violations who were arrested for possession only: **609,423** (**88 percent**)
- Number of Americans incarcerated in 2013 in federal, state and local prisons and jails: **2,220,300** or 1 in every 110 adults, the highest incarceration rate in the world
  Proportion of people incarcerated for a drug offense in state prison who are black or Latino, although these groups use and sell drugs at similar rates as whites: **57 percent**
- Number of states that allow the medical use of marijuana: **23 + District of Columbia**
  Number of states that have approved legally taxing and regulating marijuana: **4 (Alaska, Colorado, Oregon and Washington)** Estimated annual revenue that California would raise if it taxed and regulated the sale of marijuana: **$1,400,000,000**
  Number of people killed in Mexico's drug war since 2006: **100,000+**
- Number of students who have lost federal financial aid eligibility because of a drug conviction: **200,000+**
  Number of people in the U.S. who died from a drug overdose in 2013: **43,982**

Tax revenue that drug legalization would yield annually, if currently-illegal drugs were taxed at rates comparable to those on alcohol and tobacco: **$46.7 billion**
- The Centers for Disease Control and Prevention found that syringe access programs lower HIV incidence among people who inject drugs by: **80 percent**
- One-third of all AIDS cases in the U.S. have been caused by syringe sharing: **354,000 people**
- U.S. federal government support for syringe access programs: **$0.00**, thanks to a federal ban reinstated by Congress in 2011 that prohibits any federal assistance for them
    - See more at: http://www.drugpolicy.org/drug-war-statistics#sthash.tqYsucTn.dpuf

War on Drugs a "Total Failure" And Statistics to Prove It
By Hao Li on June 17 2011 9:53 AM ED

Former President Jimmy Carter, writing in a NY Times op-ed, agreed with a Global Commission on Drug Policy that showed the current global War on Drugs to be a "total failure, especially in the US.
Statistics more than back up this accusation.

- The Global Commission on Drug Policy reported that between 1998 and 2008, global use of opiates increased 34.5 percent, cocaine 27 percent, and cannabis 8.5 percent.
- Carter said when he left the presidential office in 1980, 500,000 people were incarcerated in America. At the end of 2009, the number jumped to 2.3 million. If the number of people on probation and parole are included, the figure totals 7.2 million people, or more than 3 percent of all US adults.
- In 2011, 50.8 percent of Federal inmates are incarcerated for drug offenses. This compares to just 4.2 percent for robbery, 2.7 percent for homicide/assault/kidnapping, and 4.7 percent for sex offenses.
- In fact, since the mid-1990s, violent crimes (murder, rape and sexual assault, robbery, and assault) and burglary have steadily declined. What has skyrocketed is arrests for drug offenses.
- In the last decade, due almost solely to the surge in drug-related arrests, US prisons are massively overcrowded and underfunded. The rehabilitation aspect of incarceration is slim to nil.

Today more than ever, Carter's fear in 1977 that penalties for drugs are doing more damage than drugs themselves rings true.

Carter put forth the following recommendations to address the abysmal failure of the War on Drugs policies:
1. Decriminalized the possession of less than one ounce of marijuana and add a full program to treat addicts.
2. Remove mandatory minimum sentencing and "three strikes you're out" laws.
3. Don't rely on controlling drug imports from foreign countries. It doesn't work and is responsible for "a terrible escalation in drug-related violence, corruption and gross violations of human rights in a growing number of Latin American countries."
4. Experiment with legal regulation of drugs and thus takeaway the power of organized crime.

http://www.ibtimes.com/war-drugs-total-failure-statistics-prove-it-291447

36 General Cocaine Harm Reduction Strategies

Reducing Nasal Damage

- Make sure to insert the straw high up into the nasal passage before snorting. This reduces the amount of cocaine that gets trapped by nose hairs. Cocaine left in the nostril can lead to irritation and a damaged septum – and ultimately to a perforated septum.

- Alternate snorting sessions between both nostrils and after snorting, rinse out your nostrils to clean off any cocaine adhering to your septum. Try water or saline in a spray bottle for this.
- Make sure to chop up into a very fine powder.

Reducing Injection Risks

If you don't already inject, don't start. If you already inject, switch to safer modes of administration, like smoking.

- Cocaine injection is riskier than opioid injection since cocaine users inject more frequently (due to cocaine's shorter high) because cocaine acts as a tissue damaging anesthetic and because since it's an anesthetic, you can't always feel the damage you do. If you choose to inject, to avoid re-using syringes and damaging veins, make sure you have enough injection equipment on hand. If getting from a harm reduction center or needle exchange, tell them you inject cocaine and therefore need a larger supply.
- Take care of your veins and maintain good injection practices to reduce infection risks. Read our harm reduction guide to heroin injection for a more complete list of safe injection tips.
- Switch from injecting to smoking or snorting - or at least avoid injecting in very risky sites, like the groin or neck. If you get to the point where you need to rely on very dangerous sites, *it's time to stop injecting.*
- Avoid skin popping. Cocaine isn't easily absorbed into tissue and can lead to constricted blood flow and tissue damage. Under-skin tissue damage can lead to discoloration at the injection site.[1]

Reducing Smoking Harms

- Don't share pipes. Sharing pipes or stems can lead to the transmission of HIV, herpes, hepatitis and other diseases.
- To prevent cuts and burns, wrap stem ends with tape or rubber.
- To avoid hand burns, buy a good lighter. A burner type, rather than a flame type, may be preferable, since you'll avoid inhaling the heat from a close flame.
- Treat lip cuts and burns with a water-based lip balm.
- Don't smoke from drink bottles or cans. This can lead to lung damage through the inhalation of ash, paint and toxic dust (a glass pipe is a much safer alternative).
- Use a wire screen in your pipe to prevent the inhalation of hot particles.
- Let the pipe cool down between hits.
- If chasing, use real tinfoil and not foil from packaged foods like candy bars. This type of foil can have harmful contaminants.[2]
- Get medical attention at the first signs of lung damage (don't wait until it's too late). See a doctor if your breathing is wheezy or painful after a session. Because of crack's anesthetic properties, you often can't feel lung pain until after the drugs wear off.

Avoiding Infection

- Don't share snorting straws. Minute (invisible) flecks of blood are often present and these can confer HIV or hepatitis C between users.
- It's not just the syringe, you can't safely share any injection gear; use your own cooker, cotton, tie and water too.
- Don't use a rolled-up bill to snort with. These bills are far from sterile and can transfer many common infections when inserted against the mucous membranes of your nasal cavity.
- Carry and use condoms. Cocaine can increase sexual desire and reduce inhibitions, so plan in advance and stay safe.
- Get a hepatitis B vaccine or booster.

Avoiding Social and Psychological Harm

You know you won't feel great so plan an easy recovery day after a session or binge. After using, try to get plenty of sleep and make sure to drink lots of water and or juice. Think about how to ease the discomfort of the crash. Know that the worst part of the crash only lasts for 45 minutes to an hour. Try relaxation techniques to calm down during the crash. Some people find eating after a binge can help get you feeling better. Avoid using alcohol during the crash. If your binges tend to get out of control, limit your access to funds before you begin a session so you won't end-up with nothing to pay the rent. You might try asking a loved-one to hold onto your money for a while or leaving with only a set amount of money and no ATM card.

Avoiding General Physical Harm

One way to reduce your use is to set rules for yourself, such as never using before a certain time of day. Eat a good meal before you start using (since it may be a while before eating well again.) Mixing cocaine with alcohol and other drugs increases the risks significantly. People who use alcohol and cocaine together are at significantly elevated risk of heart attack (alcohol and cocaine combine in the body to form toxic cocaethylene). If you skin-pick when high, make sure to have something else to keep in your hands to play with, or if you chew on your lips or grind your teeth, try chewing gum instead. Cocaine is riskier for people with age-related cardiovascular disease, so get checked for cardiovascular heath, and if you have any degree of disease, strongly consider ceasing or at least reducing your cocaine use.[3]

Avoiding Overdose and Death

- Cocaine kills more people than heroin, in fact, it's second only to prescription drugs as America's leading O.D. killer, so if you choose to use cocaine, you NEED to take precautions to stay alive.[4]
- Get a physical and be upfront with your doctor about your cocaine habits (if you don't feel comfortable revealing the truth to your doctor, it's time to get a new doctor!) As a cocaine user you need to take care of your cardiovascular health, so ask your doctor to test your blood pressure, circulation and whatever else she recommends. Again, if you have early warning signs of heart damage or cardiovascular disease, you should strongly consider stopping or at least reducing your cocaine use. Studies show that seemingly healthy young adult recreational cocaine users often display multiple cardiovascular risk factors, such as higher blood pressure, aortic thickening and heart scarring.[5]
- Cocaine overdose is not always dose-dependent; sometimes a small amount can cause dangerous symptoms. Variables which increase your likelihood of experiencing an overdose include your state of mind (feeling anxious), your state of sleep deprivation, your state of food deprivation or dehydration and/or using other substances with cocaine.
- When using new cocaine, always try a small amount first as a potency tester, especially if injecting.
- Avoid mixing cocaine with opiates for a speedball. Mixing cocaine with alcohol or other sedatives also increases fatal overdose risks.
- Cocaine overdose is often cardiovascular in nature (heart attack, stroke or serious arrhythmia). Naloxone injection will not reverse cocaine overdose so emergency medical attention is required. To avoid fatal overdose, you should avoid using cocaine alone, so you have someone on hand to call 911, if needed.
- Do not wait before calling 911. If you wait until the situation becomes critical, it may be too late.

Signs of Overdose

Anyone who uses cocaine or loves a cocaine user should know the warning signs of overdose:
Signs of cocaine overdose include:

- Nausea and throwing up.
- Passing out.
- An elevated body temperature and heavy sweating.
- Racing heart beat.
- Any signs of heart attack, such as chest pain (tightening in the chest).
- Intense headache.

- Muscle cramps.
- Being unable to urinate.
- Feeling short of breath or breathing irregularly.
- Experiencing tremors or convulsions or signs of seizure, like drooling or frothing or limb spasms or rigidity.
- Grinding teeth.
- Signs of stroke, such as: a sudden inability to talk coherently or understand what other people are saying, sudden weakness or loss of feeling in the face, arms or legs (usually on one side of the body), sudden loss of balance or coordination and or sudden vision difficulties.

Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis

Sam Tsemberis, PhD, Leyla Gulcur, PhD, and Maria Nakae, BA

Abstract

Objectives. We examined the longitudinal effects of a Housing First program for homeless, mentally ill individuals' on those individuals' consumer choice, housing stability, substance use, treatment utilization, and psychiatric symptoms.

Methods. Two hundred twenty-five participants were randomly assigned to receive housing contingent on treatment and sobriety (control) or to receive immediate housing without treatment prerequisites (experimental). Interviews were conducted every 6 months for 24 months.

Results. The experimental group obtained housing earlier, remained stably housed, and reported higher perceived choice. Utilization of substance abuse treatment was significantly higher for the control group, but no differences were found in substance use or psychiatric symptoms.

Conclusions. Participants in the Housing First program were able to obtain and maintain independent housing without compromising psychiatric or substance abuse symptoms.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448313/

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Housing First and Rapid Re-Housing

Housing First is an approach to ending homelessness that centers on providing people experiencing homelessness with housing as quickly as possible – and then providing services as needed. This approach has the benefit of being consistent with what most people experiencing homelessness want and seek help to achieve.

Housing First programs share critical elements:

A focus on helping individuals and family's access and sustain permanent rental housing as quickly as possible without time limits; A variety of services delivered to promote housing stability and individual well-being on an as-needed basis; and A standard lease agreement to housing – as opposed to mandated therapy or services compliance.

While all Housing First programs share these critical elements, program models vary significantly depending upon the population served. For people who have experienced chronic homelessness, there is an expectation that intensive (and often specialized) services will be needed indefinitely.

For most people experiencing homelessness, however, such intensive services are not necessary. The vast majority of homeless individuals and families fall into homelessness after a housing or personal crisis that led them to seek help from the homeless assistance system. For these families and individuals, the Housing First approach is ideal, as it provides them with assistance to find permanent housing quickly and without conditions. In turn, such clients of the homeless assistance networks need surprisingly little support or assistance to achieve independence, saving the system considerable costs.

Core Components of Rapid Re-Housing

This document was developed in collaboration with, and endorsed by, the United States Interagency Council on Homelessness (USICH), the Department of Housing and Urban Development (HUD), and the Department of Veterans Affairs (VA).

Rapid re-housing is an intervention designed to help individuals and families to quickly exit homelessness and return to permanent housing. Rapid re-housing assistance is offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the unique needs of the household. The core components of a rapid re-housing program are below. While a rapid re-housing program must have all three core components available, it is not required that a single entity provide all three services nor that a household utilize them all.

Housing Identification

Recruit landlords to provide housing opportunities for individuals and families experiencing homelessness. Address potential barriers to landlord participation such as concern about short term nature of rental assistance and tenant qualifications. Assist households to find and secure appropriate rental housing.

Rent and Move-In Assistance (Financial)

Provide assistance to cover move-in costs, deposits, and the rental and/or utility assistance (typically six months or less) necessary to allow individuals and families to move immediately out of homelessness and to stabilize in permanent housing.

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Rapid Re-housing Case Management and Services

Help individuals and families experiencing homelessness identify and select among various permanent housing options based on their unique needs, preferences, and financial resources.

Help individuals and families experiencing homelessness address issues that may impede access to housing (such as credit history, arrears, and legal issues).

Help individuals and families negotiate manageable and appropriate lease agreements with landlords.

Make appropriate and time-limited services and supports available to families and individuals to allow them to stabilize quickly in permanent housing.

Monitor participants' housing stability and be available to resolve crises, at a minimum during the time rapid re-housing assistance is provided.

Provide or assist the household with connections to resources that help them improve their safety and well-being and achieve their long-term goals. This includes providing or ensuring that the household has access to resources related to benefits, employment and community-based services (if needed/appropriate) so that they can sustain rent payments independently when rental assistance ends.

Ensure that services provided are client-directed, respectful of individuals' right to self-determination, and voluntary. Unless basic, program-related case management is required by statute or regulation, participation in services should not be required to receive rapid re-housing assistance.

http://www.endhomelessness.org/pages/housing_first

Harm reduction takes different approach to addiction

May 31, 2010
Evansville Courier and Press

As counselors in the mental health profession we continuously look to advances in treatment approaches involving a variety of mental health-related issues including drug/alcohol abuse, stress, anxiety, depression, and other behavioral difficulties.

Looking for new approaches that can result in better outcomes is always our objective. One such approach is "harm reduction," a treatment intervention particularly useful for patients with high risk behaviors such as alcohol/drug use, gambling, and unprotected sexual activity.

Harm reduction represents a philosophy for engaging at-risk patients with the intent of empowering patients to make better choices and to understand consequences.

A key philosophical shift is the transition of abstinence to a harm reduction model of treatment. The critical piece here is the idea of "starting where the patient is." For example, persons doing cocaine may also be doing pot. The initial objective is to get patients past the cocaine abuse first and then at some point the process of confronting the pot use.

This approach also opens the door for developing a therapeutic alliance that anchors patients in the treatment process. Abstinence may be the best approach for many, but it should not be a pre-requisite or stipulation for treatment.

As "traditionalists" in the field of mental health treatment, we need to lower the threshold keeping in mind that abusers may not be ready for abstinence but may be able to tolerate moderation of risk-taking behaviors.

The old school way of thinking is that persons who are still engaged in risky behaviors are not yet committed to a plan of abstinence. The potential for reaching "non-conforming" persons is increased by staying away from stipulations written in treatment plans that essentially threaten curtailment of services if considered "non-compliant."

Recent evidence-based data within a harm reduction treatment environment shows much better retention rates than with a traditional psychotherapy model.

With alcohol/drug abuse, a harm reduction model of treatment looks at relapse as a stage of change regardless of the addiction. Making mistakes is ok but preferably not the same risky mistakes.

The harm reduction model of treatment can conflict with agency policy regarding abstinence as a condition of providing treatment.

Resilience is an attribute we all have, although at times, it can be severely tested and sometimes overpowered by the urge to engage in risky behaviors.

Harm reduction therapy allows for reinvigorating this attribute by way of emphasizing the ability to adapt; restructuring social outlets that are more healthy which has the potential for helping the patient to begin the process of redefining self; being able to "face the music" with laughter; and, developing new involvements.

Ambivalence, in which the part that wants to change is in conflict with the part that wants to stay high or intoxicated, can be a critical piece in the treatment process. However, this split must be healed. An "I don't care" attitude is the activation of the split.

In harm reduction counseling, ambivalence can be the key to reducing risky behaviors by way of making use of a systematic focus on the pros and cons of using and stopping; even making use of cost/benefit analysis with the patient can be eye-opening.

The core principles of Harm Reduction include:

- Embracing small incremental change.
- Seeking to decrease harmful consequences without requiring abstinence.
- Starting where the patient is.

There are implications however:

- Harm Reduction is an umbrella concept that must be linked with a full range of counseling interventions.
- The onus is on counselors to decide how to reach their patients.
- Treatment goals must be developed between counselor and patient that focus on decreasing risky behaviors.

Counselors must be willing to continually look at shifting long standing treatment paradigms in order to accommodate new attitudes, new styles of adaptation and different ways of making use of patient strengths and vulnerabilities.

Starting where the patient is (even if it means lowering the threshold) stands a better chance of getting the patient engaged in the journey of making changes.

This column was written by Ralph H. Nichols, Director of Mulberry Center, Inc. and Patrick Rhoades, LCSW at Mulberry Center, Inc. Contact the organization at (812) 436-4221 or comments@southwestern.org.

Interventions Cross Walk

Issue/Behavior:

Positives Factors (Honors the Person – The primary reason for the use/behavior)	**Risk Factors/Negative (Concerns/Downsides of use/behavior)**
Suggested Interventions/Options (Education part of the 3 E's):	

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