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Principles of Harm Reduction for Young People Who Use Drugs

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Abstract

In summarizing the proceedings of a longitudinal meeting of experts on substance use disorders among adolescents and young adults, we review 2 principles of care related to harm reduction for young adults with substance use disorders. The first is that harm reduction services are critical to keeping young adults alive and healthy and can offer opportunities for future engagement in treatment. Such services therefore should be offered at every opportunity, regardless of an individual's interest or ability to minimize use of substances. The second is that all evidence-based harm reduction strategies available to older adults should be available to young adults and that whenever possible, harm reduction programs should be tailored to young adults and be developmentally appropriate.

Harm reduction is defined as a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use.^{1,2} It is also a movement for social and health justice built on a belief in, and a respect for, the rights of people who use drugs.³ Harm reduction programs for young adults are focused on minimizing the negative effects of

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substance use on young people, their families, and peers without mandating reductions in, or abstinence from, substance use to access services or receive medical treatments.⁴

In the United States, formal harm reduction programs were initially established to reduce risk for infectious diseases, such as HIV, hepatitis C, and bacterial infections transmitted through nonsterile injection practices. Amid the HIV crisis in the 1980s and 1990s, syringe service programs provided sterile injection equipment and risk reduction counseling to people who inject drugs in high-prevalence areas. As the risk for opioid overdose increased among people who used drugs throughout the early 2000s, overdose education and naloxone distribution (OEND) programs also emerged, often but not always in tandem with syringe service programs.⁵ Condom distribution and HIV pre- and postexposure prophylaxis, which are aimed at reducing HIV transmission risk without specifically attempting to reduce either sexual or injection behaviors, represent other harm reduction interventions. Additional emerging harm reduction interventions include distribution of fentanyl test strips, which are used to detect fentanyl in drug samples and have been shown to be feasible and acceptable among young adults at high risk for fentanyl overdose.⁶ Outside of the United States, harm reduction efforts also include supervised consumption facilities, where people use drugs in a supervised setting.

Decades of evidence have revealed that many harm reduction strategies are highly effective in decreasing the transmission of infectious diseases, preventing overdose, and reducing other sources of morbidity and mortality among people who use substances, including young people who use illicit drugs.⁷⁻¹¹ Harm reduction programs can also serve as a critical access points for additional resources, health care, and treatment.^{12,13} However, despite a compelling body of scientific evidence, the uptake and dissemination of harm reduction programs for young people who use drugs continues to be limited in the United States.^{4,14} Youth-focused harm reduction programs face substantial social, political, and structural barriers to their implementation in jurisdictions throughout the country.

In this article, we describe 2 key principles related to harm reduction for young adults that were discerned by a workgroup of experts as part of a longitudinal meeting on substance use disorders (SUDs) in young adults convened by Boston Medical Center's Grayken Center for Addiction. The recommendations in this article are not American Academy of Pediatrics policy, and publication herein does not imply endorsement. We present evidence in support of these principles (Table 1) and summarize practice considerations. We describe opportunities for expansion of harm reduction interventions focused on young adults and for incorporating harm reduction approaches into clinical programs to maximize public health impact. Additionally, we highlight obstacles to successful implementation and expansion and strategies to overcome these challenges.

PRINCIPLES OF CARE

Principle 1: Harm Reduction Services Are Critical to Keeping Young Adults Alive and Healthy and Can Offer Opportunities for Future Engagement in Treatment

Guidance—The workgroup recommended that the harms of substance use be reduced at every opportunity, regardless of an individual's interest or ability to minimize use of

substances. Young adults who use substances or who meet criteria for an SUD have a right to the same care as those who do not, care that is nonjudgmental, dignified, and optimizes their ability to reach their own goals. Harm reduction programs are designed to be facilitative and incremental, meaning that they should address an individual's needs by facilitating any positive change, regardless of how small or incremental that change may be. The workgroup concluded that the evidence was clear that rather than enabling or increasing substance use, harm reduction services are safe, pragmatic, evidence-based interventions that reduce the harms from substance use.^{2,15} Such programs should therefore be offered to adolescents and young adults with SUDs.

Evidence—Robust evidence (Table 1) supports both the efficacy and effectiveness of harm reduction interventions to improve the health of people who use drugs. As mentioned, myriad harm reduction strategies exist; we limit our discussion to strategies directly linked to safer drug use practices.

Distribution of sterile syringes and injecting equipment reduces HIV transmission and soft tissue infections.^{8,10,16} In fact, the volume of syringes distributed and made available is directly linked to proportionally lower rates of subsequent HIV infections.¹⁷ Hepatitis C infections can also be dramatically decreased when distribution of sterile syringes is paired with ready access to medication to treat opioid use disorder.¹⁸ When syringe service programs close or are not scaled up in the setting of outbreaks, behaviors associated with increased risk for HIV and subsequent HIV infections increase.^{19,20} Additionally, community-based programs that distribute naloxone dramatically reduce fatal opioid overdose.⁵ A strong body of evidence from outside the United States reveals that supervised consumption facilities are acceptable to marginalized and structurally vulnerable individuals, promote safer injection practices, reduce overdose mortality and public injecting, and increase access to treatment without increasing overall drug use or crime in a neighborhood.^{13,15,21,22} Growing evidence suggests that drug checking, in which the contents of a drug is confirmed before consuming, may promote harm reduction behaviors.²³ Although most harm reduction programs are located outside the hospital setting, emerging evidence suggests many of these interventions, including syringe distribution²⁴ and hospital-based supervised consumption, are of interest to people who use drugs and can be integrated into traditional clinical settings, including clinics and hospitals.²⁵

Abstinence-only approaches and stigma associated with drug use drive individuals at high risk for drug-related complications away from services and care.²⁶⁻³¹ Nearly half of individuals who died of opioid overdose in Massachusetts in 2014 did not have an encounter in the health care system related to opioid use disorder.³² Harm reduction programs and approaches offer an opportunity to engage these individuals and, if and when they are able, ultimately offer subsequent opportunities for treatment and services. Additionally, harm reduction programs can provide valuable infrastructure for broader public health interventions, such as HIV and hepatitis C testing and immunizations.³³

Practice Considerations—Harm reduction programs and approaches are needed to reduce the negative consequences from substance use for all young people. Existing interventions with strong evidence need expansion to better reach young adults who use

drugs, and additional studies are needed to evaluate novel harm reduction interventions for these populations. However, harm reduction programs require additional financial and human resource investments. Additionally, in many states, syringe distribution is illegal³⁴; as of late 2019, the country still does not have a legally sanctioned supervised consumption facility.³⁵

Past experiences with stigma, pain, trauma, and restrictions in the traditional health care and addiction treatment system often prevent individuals from seeking care.^{28,29,31} Harm reduction programs offer important opportunities to engage these individuals who may not otherwise seek care. Integrating clinical services to address the needs of individuals who access service in syringe service programs may be desirable in some facilities. For example, some syringe service programs would benefit from integrating primary care and infectious disease care (eg, pre- and postexposure prophylaxis, abscess care, HIV and hepatitis C virus [HCV] treatment), as well as low barrier buprenorphine prescribing, into these settings. Clinicians should be mindful that such integration of clinical services should be driven by syringe service program staff and participants, who have expertise about their programs and service needs, respectively.³⁶ New funding streams may be needed to support the expansion of these clinical services.

Additionally, clinicians should integrate harm reduction principles into their routine clinical work in every setting, especially for young adults who use drugs. The adoption of harm reduction approaches may counter the fear of medical care and addiction treatment and begin to confront the stigma that keeps many people who use drugs from accessing needed clinical care.^{28,37} Clinicians must develop the skills, approaches, and referral capacity to successfully engage and treat people who use drugs to improve their overall health. Clinicians and clinical programs should learn to provide harm reduction–centered, pragmatic, humanistic care without abstinence as a precondition for engagement. Additional trainings may be necessary not only to teach about harm reduction principles but also to increase capacity to counsel directly with patients about injection practices and overdose risk.

Principle 2: All Evidence-Based Harm Reduction Strategies Available to Older Adults Should Be Available to Young Adults

Guidance—The workgroup recommended that whenever possible, harm reduction programs should be tailored to young adults and developmentally appropriate. The group identified several developmental issues that make engaging young adults in harm reduction services especially challenging: problematic relationships with authority, reluctance to engage in adult-led interventions, high degree of selfreliance, protection of autonomy, cynicism toward personnel in helper roles, and distrust of all but close peers. Efforts are needed to address these challenges and ensure that interventions are youth-friendly. The summit workgroup advised that young people who use drugs be meaningfully involved in all aspects of harm reduction program design, implementation, service delivery, and evaluation. Although youth participation in the design and implementation of harm reduction programs is rare,³⁸ successful models of youth-driven (and entirely youth-led) harm reduction interventions exist. Young people who use drugs have been engaged as peer educators,

mentors, program designers, and evaluators, all of which increase relevance of the intervention for the target population, foster prosocial relationships with peers, and may improve program outcomes. The workgroup concluded that this involvement can also promote harm reduction programs offering services and resources in locations where youth congregate and through accessible media that are most relevant to young people.

Evidence—Just as young adults are less likely to receive evidence-based medications for treatment of opioid use disorder,³⁹⁻⁴² they are less likely to use evidence-based harm reduction interventions than older adults.^{14,16,43-45} Existing harm reduction services were largely developed, studied, and funded to focus on older individuals who use drugs. Thus, many of these services are likely to need significant adaptation to reach young adults. Youth access harm reduction resources less frequently than older people who use drugs, despite riskier injection practices, including reuse or sharing of syringes and higher rates of concurrent sexual risk factors. As a result, young people bear disproportionate risk for HIV and HCV infection compared with older people who use drugs.⁴⁶⁻⁴⁸ Rather than access existing community services, young people often employ harm reduction approaches within their social networks. For example, youth may attempt to minimize risk by using with other people around or using intranasally rather than by injection to reduce risk for harm.^{49,50} Barriers to engaging with existing services include distance from services, desire to avoid neighborhoods where an individual may have previous substance-related experiences, and homelessness.⁴⁹ As a result, the youth who do use harm reduction services are particularly vulnerable. For example, they are more likely to experience homelessness, incarceration, and psychological distress than older participants.⁵¹ Fear of law enforcement, presence of older people who use drugs, and age restriction are other identified barriers.⁵² Youth also frequently report that programs focus too narrowly on the harm from drug use rather than on their broader social and psychological needs.⁴⁹ Notably, girls and young women may be even less likely to be engaged in harm reduction services and more concerned about having their substance use exposed and having their service use tied to male partners.⁵² Finally, youth may lack information or may believe that services are not needed, despite higher overdose risk, or may prefer to access services from friends or pharmacies.^{51,52}

Several youth-centered harm reduction models have emerged to address disparities and ensure that youth have access to resources that can improve their health. Peer-led naloxone trainings improve attitudes, altruism, and perceptions of programming among youth at risk for overdose.⁵³ In addition to ensuring that peers are involved, establishing harm reduction programming in locations and venues that are easily and safely accessed by young adults can also improve treatment acceptance. For example, including harm reduction services in community pharmacies, in mobile units, and at venues where young people are likely to use drugs (eg, festivals, universities, and colleges) may improve service uptake.⁵⁴ Incorporating harm reduction education into health curriculum and services in schools has also been attempted and requires further study.⁵⁵

Although young adults use social networking sites at high rates, and social media venues have been used effectively to recruit study participants, further studies are needed to understand whether these sites can serve as effective mediums for engaging young people who use drugs in harm reduction education and services.⁵⁶⁻⁵⁸ Internet-based sexual health

and risk reduction education has been used effectively to reach diverse young populations.⁵⁹ The Internet and social media may provide an opportunity to deliver overdose prevention and safe injection practice education to a broader group of young people who use drugs.

Despite barriers and obstacles, when harm reduction services are available and youth focused, young adults will access them.¹⁴ In one study, high-risk youth who lived or spent time near a supervised consumption facility were more likely to use the services than young people using drugs who lived farther away.⁶⁰ Additionally, in other studies, young adults accessed naloxone⁵³ and fentanyl test strips if they were available at sites they used.⁶ In addition to reducing harm from drug use, these programs also engage young people with the highest risk of drug-related harms.⁶¹

To ensure that programs for youth achieve the greatest public health impact, young people who use drugs must be involved at every level of harm reduction programming, including in planning, staffing, implementation, and evaluation, in all harm reduction programs designed for young adults.⁶²

Practice Considerations—To ensure equitable access to harm reduction interventions for young adults, new harm reduction models, designs, and implementation are needed. Although existing harm reduction programs may make changes to improve access for young people, the evidence suggests that targeted programming will also be necessary. To achieve these goals, young adults will need to be trained as harm reduction peers and will need to develop the capacity to engage at every level of programming, including evaluation and dissemination. Additionally, there may be opportunities to integrate harm reduction-oriented peers into existing clinical settings, with the goal of improving clinical engagement. To effectively care for young adults who use drugs, clinicians will also need to establish relationships with community programs.

Young adults who use drugs face a wide array of sociopolitical, organizational, and structural barriers to accessing harm reduction services, including stigma and social condemnation associated with substance use, fear of law enforcement, and, in some settings, policies that restrict access on the basis of age. In a Joint United Nations Programme on HIV and AIDS technical report, it was found that many countries place age restrictions or requirements for parental consent on harm reduction services, which makes them effectively inaccessible for adolescents <18 years of age.³⁸ In addition, many harm reduction interventions are not youth centered and may be perceived as targeting an older population, which increases youth's reluctance to use these services.³⁸

In the United States, federal and state laws prohibiting harm reduction programs and/or restricting access to funding have long impeded the implementation of such interventions, particularly in jurisdictions hardest hit by the opioid crisis. For example, expansion of harm reduction education in school health curriculum, nurse distribution of harm reduction materials, and naloxone access in schools may require changes to local laws. Good Samaritan laws, which encourage individuals to call for help when witnessing an overdose, can encourage help-seeking and engagement by protecting witnesses from drug-related arrests. In locations where syringes are criminalized, fear of arrest may be even more

pronounced, and individuals may avoid seeking out services. Supervised consumption spaces remain criminalized in the United States as well, although legal challenges are underway.⁶³ Many such laws are founded on the unsubstantiated belief that harm reduction programs promote substance use among young people. In these cases, program development must be paired with legal and political efforts to ensure that harm reduction interventions reach young people most at risk, including minors.

CONCLUSIONS

Given the scale and scope of the opioid crisis in the United States, it is past time for policy makers, public health professionals, and clinicians to support harm reduction programs commonplace in other countries, including syringe access, supervised consumption facilities, and drug-checking programs. Moreover, to reach a broader population of young people at risk, expansion of harm reduction approaches into nontraditional venues, such as pharmacies, schools, drop-in centers, clubs, social service agencies (including shelters), and online environments, should be considered.

Such interventions will often require strong community and institutional support and, in some cases, may necessitate changes to local or state laws. Pediatricians, family physicians, addiction medicine providers, and other clinicians who work with young adults will need to join these efforts. As screening and treatment of SUDs are increasingly integrated into medical settings, youth-focused clinicians will inevitably work with young adults who would benefit from harm reduction services. Although physicians are often not taught the principles of harm reduction in traditional medical training, they are nonetheless familiar with the pathophysiologic considerations underlying overdose and transmission of blood-borne diseases. They also routinely counsel young adults on other harm reduction approaches, such as using condoms during sexual intercourse. Thus, they are well poised to integrate harm reduction services for people who use substances into their medical practices. Given their clinical understanding of adolescent and early adult development, clinicians can also support community-based harm reduction programs in designing developmentally appropriate and youth-friendly services.

Ultimately, because young adults are among those most heavily impacted by the national addiction and overdose epidemics, organizers of both established and emerging harm reduction programs should identify ways to ensure that their programming is youth-friendly and, if possible, youth centered. Because youth are active agents in their own health promotion and in the broader community, the meaningful inclusion of young adults who use drugs in harm reduction planning, service delivery, and evaluation is paramount to the effectiveness and success of these programs.

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ABBREVIATIONS

HCV	hepatitis C virus
OEND	overdose education and naloxone distribution
SUD	substance use disorder

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TABLE 1
Selected Summary of Experimental and Quasi-Experimental Evidence About Harm Reduction Interventions

Author, y	Sample	Setting	Study Period	Design	Outcome	Main Findings	Contribution to Summit Principles
Fernandes et al., ¹¹ 2017	Studies on effectiveness of NSPs	13 systematic reviews (which cite 133 unique studies from around the world)	Studies published until May 2015	Review of systematic reviews of the association of NSPs and blood-borne infection transmission and IRBs	Summarize the effectiveness of NSPs in reducing blood-borne infection transmission and IRBs among PWID	NSPs were effective in reducing HIV transmission and IRB among PWID, with mixed results around reduction in HCV infection. Full harm reduction interventions provided at the structural level and in multicomponent programs, with high levels of coverage, were more beneficial.	Syringe exchanges reduce HIV transmission and may reduce HCV infection, especially when combined with additional services (referrals, MOUDs).
Gonsalves and Crawford, ¹⁹ 2018	Individuals infected in an opioid-driven HIV outbreak	Scott County, Indiana	October 2014 to November 2015	Mathematical modeling study of harm reduction interventions and HIV infections in an outbreak	Estimated differential HIV infections based on timing of public health intervention	Scale-up to earlier intervention times could have substantially reduced the total number of HIV infections in the Scott County outbreak.	Syringe exchanges and other harm reduction interventions reduce HIV infections in an outbreak.
Guse et al., ⁵⁸ 2012	Studies on the impact of digital media-based interventions targeting adolescents aged 13–24	10 studies	Studies published between January 2000 and May 2011	Systematic review of the impact of digital media interventions targeting adolescents	Intervention impact on sexual health knowledge, attitudes, and/or behaviors	Seven interventions significantly influenced psychosocial outcomes, such as condom self-efficacy and abstinence attitudes. Six studies increased knowledge of HIV, sexually transmitted infections, or pregnancy.	Harm reduction services can be delivered through digital media.
Krieger et al., ⁶ 2018	N = 93 young adults aged 18–35 who reported injecting drugs or using illicit substances in the past 30 d	Rhode Island	May 2017 to September 2017	Nonrandomized pilot study of fentanyl teststrips	Use of rapid fentanyl test strips (binary yes or no). No test strips with positive results	Of 81 participants who returned for follow-up, 77% reported using at least 1 test strip. 98% reported confidence in their ability to use the test strips, and 95% wanted to use them in the future.	Use of rapid fentanyl test strips is feasible and acceptable to young adults.
Platt et al., ¹⁸ 2017	N = ~1817 incident HCV infections	28 studies from around the world	Studies published until November 2015	Systematic review of association of OST and NSPs and HCV infection	Acquisition of HCV among people who inject drugs	OST is associated with a reduction in the risk of HCV acquisition, which is strengthened in studies that assess the combination of OST and NSPs. High NSP coverage was associated with a reduction in the risk of HCV acquisition in studies in Europe.	OST when paired with NSPs reduces the risk of HCV acquisition.
Potier et al., ¹⁵ 2014	Studies on benefits and harms of SIS	75 studies (85% originated from Vancouver, British Columbia, Canada, or Sydney, Australia)	Studies published until January 2014	Systematic review of SIS use benefits and harms	Synthesized evidence for SIS-induced benefits and harms	SIS promoted safer injection conditions, enhanced access to primary health care, and reduced overdose frequency while decreasing public drug injections. SIS were not found to increase drug injecting, drug trafficking, or crime.	SIS reduce multiple harms from injection drug use without increasing injection drug use or crime.
Stockings et al., ⁴ 2016	Studies on effectiveness of various intervention		Studies published	Systematic review of substance reviews of substance	Summarize the evidence for effectiveness of	There is limited available research on interventions for problematic substance use in young people. Interventions that	Interventions have been designed and studied in adults; further efforts

Author, y	Sample	Setting	Study Period	Design	Outcome	Main Findings	Contribution to Summit Principles
Walley et al, ⁵ 2013	Individuals who use opioids at risk for overdose and individuals in their social network	19 communities in Massachusetts with at least 5 fatal opioid overdoses in each of the years 2004–2006, with and without OEND programs	until April 2015 2002–2009	use interventions for young people Interrupted time series analysis comparing overdose in communities with and without OEND programs	prevention, early intervention, harm reduction, and treatment of problem use ARR for annual deaths related to opioid overdose and use of acute care hospitals	are effective with adults should be tested with young people. Community-year strata had significantly reduced ARR's compared with communities with no implementation (ARR 0.73 [95%CI 0.57–0.91] for <100 enrollments per 100 000); ARR 0.54 [95% CI 0.39–0.76 for > 100 enrollments per 100 000]).	are needed to study and tailor interventions for young people. Increased access to naloxone for people who use drugs is associated with reduced overdose death in those communities.

Studies are listed alphabetically. ARR, adjusted rate ratio; CI, confidence interval; IRB, injecting risk behavior; MOUD, medication for opioid use disorder; NSP, needle and syringe program; OST, opioid substitution therapy; PWID, people who inject drugs; SIS, supervised injection services.