FY 2016 Houston EMA/HSDA Ryan White Part A Service Definition **Substance Abuse Services - Outpatient** (Revision Date: 03/03/14)	
HRSA Service Category Title: **RWGA Only**	Substance Abuse Services Outpatient
Local Service Category Title:	Substance Abuse Treatment/Counseling
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Minimum group session length is 2 hours
HRSA Service Category Definition: **RWGA Only**	***Substance abuse services outpatient*** is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.
Local Service Category Definition:	Treatment and/or counseling HIV-infected individuals with substance abuse disorders delivered in accordance with State licensing guidelines.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV-infected individuals with substance abuse disorders, residing in the Houston Eligible Metropolitan Area (EMA/HSDA).
Services to be Provided:	Services for all eligible HIV/AIDS patients with substance abuse disorders. Services provided must be integrated with HIV-related issues that trigger relapse. All services must be provided in accordance with the Texas Department of Health Services/Substance Abuse Services (TDSHS/SAS) Chemical Dependency Treatment Facility Licensure Standards. Service provision must comply with the applicable treatment standards.
Service Unit Definition(s): **RWGA Only**	**Individual Counseling:** One unit of service = one individual counseling session of at least 45 minutes in length with one (1) eligible client. **A single session lasting longer than 45 minutes qualifies as only a single unit** – no fractional units are allowed. Two (2) units are allowed for initial assessment/orientation session. **Group Counseling:** One unit of service = 60 minutes of group treatment for one eligible client. A single session must last a minimum of 2 hours. Support Groups are defined as professionally led groups that are comprised of HIV-positive individuals, family members, or significant others for the purpose of providing Substance Abuse therapy.

Financial Eligibility:	Refer to the RWPC's approved *FY 2016 Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	HIV-infected individuals with substance abuse co-morbidities/disorders.
Agency Requirements:	Agency must be appropriately licensed by the State. All services must be provided in accordance with applicable Texas Department of State Health Services/Substance Abuse Services (TDSHS/SAS) Chemical Dependency Treatment Facility Licensure Standards. Client must not be eligible for services from other programs or providers (i.e. MHMRA of Harris County) or any other reimbursement source (i.e. Medicaid, Medicare, Private Insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. All services must be provided in accordance with the TDSHS/SAS Chemical Dependency Treatment Facility Licensure Standards. Specifically, regarding service provision, services must comply with the most current version of the applicable Rules for Licensed Chemical Dependency Treatment. Services provided must be integrated with HIV-related issues that trigger relapse. Provider must provide a written plan no later than 3/30/16 documenting coordination with local TDSHS/SAS HIV Early Intervention funded programs if such programs are currently funded in the Houston EMA.
Staff Requirements:	Must meet all applicable State licensing requirements and Houston EMA/HSDA Part A/B Standards of Care.
Special Requirements: **RWGA Only**	Not Applicable.

FY 2017 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/09/2016**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/02/2016**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/19/2016**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup**	Date: **04/26/2016**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

HIV and Substance Use

A strong link between HIV and substance abuse.

Substance abuse has been associated with HIV/AIDS since the beginning of the pandemic. It is well known that sharing injection equipment is a leading cause of HIV transmission among those who inject drugs. But drug and alcohol use also put people at higher HIV risk by disinhibiting them and making it more likely they will engage in unprotected sex.

The National Institute on Drug Abuse (NIDA) reports that from 2005 to 2009, 64 percent of HIV+ people in the U.S. had used an illicit drug, but not intravenously; only 19 percent had never used an illicit drug. A 2009 study found one in four of those living with HIV reported alcohol or drug use at a level warranting treatment. Besides injection drugs, other substances associated with HIV risk include cocaine ("coke, crack"), amphetamines ("speed"), alcohol, inhaled nitrates ("poppers"), and "party" or "club" drugs, such as crystal methamphetamine (meth) or MDMA ("ecstasy").

NIDA further reports that drug abuse and addiction can worsen the progression of HIV and its consequences, especially in the brain. Animal studies have shown that stimulants can increase HIV viral replication. A human study found HIV caused greater neuronal injury and cognitive impairment in drug users than non-users.

How does substance abuse complicate HIV treatment?

Concurrent (or dual) diagnoses of HIV, substance use, and mental health disorders may affect one another, complicating the course of HIV infection. Problematic drug and alcohol use can undermine both prevention and treatment adherence. A substance-using patient is less likely to adhere to antiretroviral medications, increasing the risk for viral resistance.

Needle-exchange programs and information about cleaning injection equipment has reduced new HIV infections among injection drug users. But injection drug users, often with limited access to care, don't tend to seek medical care for HIV until the disease has progressed, complicating treatment.

Drugs such as heroin, cocaine, and alcohol can suppress the immune system. Drugs can also interfere with HIV medications, and vice versa. Amphetamines, ketamine ("Special K") and heroin can interact with specific antiretrovirals, while Ritonavir can increase the potency of MDMA to a fatal degree.

HIV+ patients who are injection drug users are more likely to have comorbid psychiatric conditions. Studies have found that between 70-90% had a psychiatric condition before being diagnosed with HIV. These patients also have high rates of prior suicidal behavior. The multifaceted symptoms of psychiatric conditions can sometimes mask the signs of substance abuse, and vice versa. When there is a comorbid psychiatric disorder, the treating physician should carefully prescribe medications, particularly those that tend to be habit-forming.

Medical complications are also a serious concern when treating an HIV+ patient who has a substance use disorder. A treating clinician must be aware of the risk of severe bacterial infections including tuberculosis, hepatitis C and sexually transmitted diseases.

How is substance abuse treated?

Effective treatment for substance abuse improves the quality of life for HIV+ patients, and reduces the spread of HIV infection. Substance abuse treatment can also make it more likely that patients will adhere to their HIV treatment.

Clincians need to screen all HIV+ patients for ongoing or recurrent drug and alcohol use and abuse. There are a variety of screening tools that can be used to identify these problems. Most important to a good history is for the clinician to use a nonjudgmental attitude in asking questions.

The main goal of substance abuse treatment is to reduce or stop drug use, followed by a sustained reduction of high-risk behaviors. A longer-term goal is to develop the ability to quickly control relapse or relapse behaviors, and to maintain the positive behaviors learned in treatment.

The ideal treatment setting for an HIV+ person with a substance use disorder treats both diseases in an integrated fashion. Even when this is not possible, treating physicians and other health care professionals must communicate with one another to ensure a successful outcome.

Outpatient substance abuse treatment is the most common method, and can be quite effective. If the outpatient method is unable to help an individual stay off drugs, residential treatment should be considered. Twelve-step programs can be helpful in the recovery process, especially meetings where discussion of HIV is welcome or accepted.

The pharmacological treatments that are a standard part of substance abuse rehabilitation (e.g. disulfiram, naltrexone, acamprosate, buprenorphine, and methodone) can be administered to HIV+ patients as long as care is taken to monitor

reactions to the medications. Long-term Methodone Maintenance Therapy (MMT) is recommended for severe addicts. Drug-drug interactions should be carefully monitored for those on methodone. A number of medications used to treat HIV and related conditions may raise or lower the levels of methodone in a patient's bloodstream. Naltrexone may not be the right treatment for patients who require pain management with opiods.

References

Chaffee, Barbara, *Screening and Ongoing Assessment for Substance Abuse in HIV: Guideline for Care* (April 5, 2011): http://www.medscape.com/viewarticle/739855.

National Institute on Drug Abuse (http://www.drugabuse.gov/related-topics/hivaids)

About this Fact Sheet

This fact sheet was revised by John-Manuel Andriote, based on an earlier version by Kerry Flynn Roy in collaboration with the APA Commission on AIDS. For more information contact American Psychiatric Association, Office of HIV Psychiatry, 1000 Wilson Blvd., Suite 1825, Arlington, VA 22209; phone: 703.907.8668; fax: 703.907.1089; or e-mail AIDS@psych.org. Visit our web site at www.psychiatry.org/AIDS.

Healthline News

Why HIV Patients Must Stop Smoking

Written by David Heitz | Published on August 9, 2014

Smokers with HIV lose more years of life to cigarettes than to the disease itself, a new study shows.

Today, people who have HIV in the western world can live just as long as those who don't, so it's easy to forget the hazards of the chronic illness.

Lighting up a cigarette, especially if it's something you've always done, may not seem like a very big deal. But it is. Studies show that if you have HIV, the harmful effects of smoking are greatly magnified, even when the disease appears to be under control with medication.

Anti-smoking advocates wonder, with HIV now very manageable with antiretroviral drugs, why would anyone jeopardize their health by smoking? Why not just kick the smoking habit for good?

It's easier said than done, especially since smoking is so entrenched in many niche communities of people with HIV. That's why the U.S. Centers for Disease Control and Prevention (CDC) are urging people with HIV to quit, using the story of an HIV-positive man named "Brian" to get their message across.

Hit By a Stroke After Rebounding from HIV

Brian is one of many real people used in the CDC's "Tips from Former Smokers" campaign. HIV was recently added to agency's list of chronic conditions to target with anti-smoking messages, including asthma, cancer, COPD, and cardiovascular disease. Pregnant women are also included in the social media push.

Brian, 43, wound up in the hospital after being diagnosed with HIV. But soon, doctors had his disease under control. He rebounded, went back to work, and began to feel "invincible." Quitting his three decade smoking habit was hardly a priority.

Then Brian had a stroke and nearly lost his life.

"We know from a large surveillance project running here that the prevalence of smoking among people with HIV in care is about 42 percent," said Dr. John T. Brooks, an HIV specialist with the CDC.

That is twice the national average of 21 percent, Brooks told Healthline. "Smoking does impair CD4 cells in a way that can be bad for you," he said. "It increases the risk of certain pneumonias, for example."

CD4 T-cells, or "helper cells," help the body fight infections like pneumonia. Pneumonia remains a leading cause of death among people who

progress from HIV to AIDS. The level of CD4 cells in a person's body is a good indicator of whether their HIV is under control.

Recent studies also point to the role of inflammation in people with HIV. “Just having an HIV infection produces a chronic state of inflammation,” Brooks said.

Inflammation is already linked to other conditions that affect smokers, such as heart disease, lung disease, certain cancers, and low bone density and fragility fractures. “If you have HIV and smoke, you’re getting hit from both directions with this inflammatory problem,” Brooks said.

Just How Dangerous Is Smoking If You’re HIV-Positive?

It’s well established that smoking can cause an early death, and HIV can too. But combine the two, and the deadly punch is much more powerful.

In fact, in a Danish study in which patients got top-of-the-line HIV care including free antiretroviral medication, HIV-positive smokers lost more years of life from smoking than from HIV.

In the study, a person with HIV lost five years of life to the disease. A smoker without HIV lost almost four years of life to smoking. But a person with HIV who also smoked lost a total of 12 years of life, not nine, as one might think.

"If a person's HIV is under control, the risk of smoking remains and becomes a greater and often leading preventable risk for illness and death," Brooks said.

Why Do So Many People with HIV Smoke?

People with HIV are often part of demographic groups that have especially high rates of smoking, namely gay men and African-Americans.

People with HIV in the U.S. also tend to have less formal education and to come from poorer family backgrounds, Brooks said. They may also have issues related

to substance abuse or mental illness. These factors are also linked to higher rates of smoking.

The smoking rate among gays and bisexuals in the U.S. last year was 27.7 percent, according to the CDC. That is compared to 17.3 percent among heterosexuals.

This can partly be blamed on aggressive marketing by the tobacco industry. In fact, when the pioneering HIV advocacy group ACT-UP boycotted Philip Morris in 1990, the tobacco giant won gay customers back by pledging large sums of money to fight AIDS.

HIV Patients Want to Quit

Surveys have shown that two-thirds of people with HIV who smoke want to quit, according to AIDS.gov. But it is a difficult habit for anyone to kick.

Brooks said doctors can help by initiating conversations with their patients about quitting. The problem is that HIV specialists usually are not trained to provide that kind of care.

> **"If a person's HIV is under control, the risk of smoking remains and becomes a greater and often leading preventable risk for illness and death." — Dr. John Brooks**

There is currently a shift, however, toward people with HIV getting care from doctors in family and general practice. While the move toward primary care providers has some HIV experts concerned about the care patients will receive, in some ways it could be beneficial.

“Smoking cessation is a cornerstone of their training,” Brooks said of primary care doctors. “Now they can be in a care setting where providers pay a lot more attention with the other things in your life.”

Care from a primary care physician always can be “backed up by a specialist when things get tough,” Brooks added.

Brooks hopes more doctors who treat people with HIV will start to provide smoking cessation counseling. He encouraged them to look into levels of reimbursement for these services.

The Affordable Care Act requires insurance providers who sell plans on state and federal exchange websites to offer smoking cessation counseling without any out-of-pocket co-payment from the patient.

CDC Program Drives Smokers to Quit

The good news is that the CDC's "Tips from Former Smokers" campaign is working.

A paper published last year in The Lancet found that after only 12 weeks of the campaign, an estimated 1.64 million Americans had tried to quit, with an estimated 100,000 presumed successful. About 6 million non-smokers also talked to friends and family about the dangers of smoking.

Calls to the CDC's 1-800-QUIT-NOW hotline rose by 75 percent during the 2013 "Tips" campaign, and visits to the website increased 38-fold.

Brooks said that with few exceptions, most smoking cessation medications do not interact with antiretroviral therapy. He concedes that people with HIV are under a lot of stress, which makes quitting smoking even more difficult.

But he remains hopeful. "They may say, 'This is the only way I can release my stress, it's my last bad habit,'" Brooks said. "But it's not an argument that's hard to win when you remind them of the damage smoking is doing to them."

HARM REDUCTION

Daniel Wolfe & Joanne Csete

OPEN SOCIETY FOUNDATIONS

As member states of the United Nations take stock of the drug control system, a number of debates have emerged among governments about how to balance international drug laws with human rights, public health, alternatives to incarceration, and experimentation with regulation.

This series intends to provide a primer on why governments must not turn a blind eye to pressing human rights and public health impacts of current drug policies.

WHAT IS HARM REDUCTION?

Harm reduction is based on the idea that people have the right to be safe and supported even if they are not ready or willing to abstain from illicit drug use. A harm reduction approach involves giving people who use drugs choices that can help them protect their health.

An example of a harm reduction approach is providing people who inject drugs with access to sterile injection equipment, which reduces the risk of HIV and hepatitis C transmission. Treatment with the oral medications methadone and buprenorphine, given under medical supervision, reduces overdose and injection of heroin and other opiates. While harm reduction often focuses on addressing health harms, the term is also used to describe measures that reduce the adverse consequences of drug law enforcement, such as training of police to increase diversion of people who use drugs to health services.

Harm reduction approaches are important for addressing many public health and social problems. To combat driving under the influence of alcohol, for example, societies do not ban driving or prohibit drinking. They may institute harm reduction measures such as encouraging social groups to designate non-drinking drivers, or providing free or subsidized transportation for people who have been drinking.

"While harm reduction approaches often serve as a bridge to drug dependence treatment or cessation of drug use, these outcomes are not preconditions or the only goals."

Drug-related harm reduction takes a similar approach, emphasizing measures to reduce risk rather than demanding total abstinence. While harm reduction approaches often serve as a bridge to drug dependence treatment or cessation of drug use, these outcomes are not preconditions or the only goals. Harm reduction programs may include measures such as drug consumption rooms where people can consume drugs under medical supervision; heroin prescription and supervised administration; and distribution of the medicine naloxone to people who use opioids and their families, police, and emergency medical teams for use in reversing fatal overdose. Some municipal housing programs also take a harm reduction approach, for example, offering shelter without requiring residents to cease use of crack or other illicit substances in order to mitigate the high risk of chronic homelessness and its concomitant health-related and social harms.

WHAT DOES THE UNITED NATIONS SAY ABOUT HARM REDUCTION?

Harm reduction emerged as a guiding principle for health programs after two of the UN drug conventions—those of 1961 and 1971—were written and came into force. The 1988 convention, while mentioning the importance of improving health, does not mention harm reduction. Nonetheless, the UN has affirmed harm reduction in multiple settings and declarations.

The unanimous **2001 Declaration of Commitment on HIV/AIDS** was the first major statement of all United Nations member states on drug-related harm reduction. In the declaration, member states committed themselves to ensuring implementation of a "wide range of [HIV] prevention programmes," notably "expanded access to essential commodities, including…sterile injecting equipment [and] harm-reduction efforts related to drug use…".[1] The commitment of UN member states to harm reduction as a mainstay of HIV prevention was reiterated in the 2006 General Assembly Political Declaration on HIV/AIDS.[2]

"The UN has affirmed harm reduction in multiple settings and declarations."

Several documents published by the Joint United Nations Programme on HIV/AIDS (UNAIDS) have since reiterated the importance of harm reduction in national and global HIV responses. As noted in the 2014 UNAIDS publication *Harm Reduction Works*:

> **Abundant evidence shows that harm reduction programs can significantly reduce HIV**

1 United Nations General Assembly. Declaration of commitment on HIV/AIDS . UN doc. no. A/RES/S-26/2, 2 August 2001. At: http://www.un.org/ga/aids/docs/aress262.pdf

2 United Nations General Assembly. Political declaration on HIV/AIDS. UN. doc. no. A/RES/60/262, 15 June 2006.

> **transmission among people who inject drugs…. Countries should not wait, but should start immediately to scale up harm reduction responses that are public health-based and human rights informed.**[3]

In 2004, the **World Health Organization (WHO), the UN Office on Drugs and Crime (UNODC), and UNAIDS** issued a position paper asserting the importance of medically assisted treatment of opioid dependence using methadone or buprenorphine.[4] As stated in this paper:

> **As with other health conditions such as hypertension, diabetes and heart disease, people with opioid dependence can stabilize their condition by developing and incorporating behavioral changes and by appropriate use of medicines….The ultimate achievement of a drug-free state…is unfortunately not feasible for all individuals with opioid dependence, especially in the short term. An exclusive focus on achieving a drug-free state for all patients may jeopardize the achievement of other important objectives, such as HIV prevention.**[5]

The 2006 International Guidelines on HIV/AIDS and Human Rights published by UNAIDS and the Office of the High Commissioner for Human Rights underscored the importance of an enabling legal environment for harm reduction measures. It enjoined countries, for example, to review their criminal law with an eye to ensuring that the law does not impede "authorization…and promotion of needle and syringe programmes" and especially does not criminalize "the possession, distribution and dispensing of needles and syringes."[6] The Guidelines underscore the human rights responsibility of governments to take necessary measures to ensure HIV services for people who use drugs and other populations that "already suffer from a lack of human rights protection and from discrimination and/or are marginalized by their legal status."[7]

3 UNAIDS. *Harm reduction works*. Geneva, 2014. At: http://www.unaids.org/sites/default/files/media_asset/JC2613_HarmReduction_en_0.pdf

4 World Health Organization, UN Office on Drugs and Crime, Joint United Nations Programme on HIV/AIDS (UNAIDS). *Position paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*. Geneva, 2004. At: http://www.unodc.org/documents/hiv-aids/Position%20Paper%20sub.%20maint.%20therapy.pdf

5 Ibid. p 8.

6 Office of the UN High Commissioner for Human Rights and UNAIDS. International Guidelines on HIV/AIDS and human rights (2006 consolidated version). Geneva, 2006, p 30. At: http://www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf

7 Ibid. p 78.

UN legal experts on the drug conventions have concluded that needle and syringe programs, methadone and buprenorphine treatment, and supervised drug consumption rooms are consistent with the spirit of the conventions. With respect to supervised drug consumption rooms, for example, the UN's in-house legal experts noted that the intent of these facilities is not to induce drug use but rather "to provide healthier conditions" for people who inject drugs, "reducing their risk of infection with grave transmittable diseases and, at least in some cases, reaching out to them with counseling and other therapeutic options."[8]

"An exclusive focus on achieving a drug-free state for all patients may jeopardize the achievement of other important objectives, such as HIV prevention."

– WHO, UNODC and UNAIDS, 2004

WHO, UNAIDS, and UNODC have repeatedly affirmed the importance of harm reduction, including in prisons.[9] WHO's 2014 guidelines on services for "key populations" affected by HIV emphasize that drug-related harm reduction should be a policy and program priority, and stress the need for programs to be protected from undue police surveillance or other interference.[10] As the former executive director of UNODC noted in 2007: "Harm reduction is often made an unnecessarily controversial issue as if there [were] a contradiction between prevention and treatment on one hand and reducing the adverse health and social consequences of drug use on the other. This is a false dichotomy. They are complementary."[11]

8 International Narcotics Control Board. Flexibility of treaty provisions as regards harm reduction approaches (decision 74/10, prepared by the UN Drug Control Programme Legal Affairs Section). UN doc. no. E/INCB/2002/W.13/SS.5, 30 September 2002.

9 UN Office on Drugs and Crime, International Labour Organization, World Health Organization and UNAIDS. Policy brief: HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions. Vienna, 2013.

10 World Health Organization. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva, 2014 . At: http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1

11 AM Costa, Foreword. In UNODC. *Reducing the adverse health and social consequences of drug use: a comprehensive approach* (Discussion paper). Vienna, 2007. At: http://www.unodc.org/docs/treatment/Reducing_the_Adverse_Health_and_Social_Consequences_of_Abuse.pdf

EVIDENCE FROM RESEARCH AND NATIONAL PRACTICE

UN agencies have also reviewed the scientific evidence of harm reduction measures. An extensive review of needle and syringe programs (NSP) commissioned by WHO, for example, documented the many peer-reviewed studies showing that NSP reduced risk of HIV.[12] It also concluded that there was no evidence that NSP led to new or increased drug use or that NSP contributed to crime. Rather, needle and syringe programs were found not only to reduce HIV transmission but also to contribute to safe disposal of syringes and referrals to treatment and other care for people who inject drugs.[13]

Treatment with buprenorphine or methadone, also called opioid substitution treatment or maintenance therapy for opiate dependence, is endorsed as an important part of HIV national responses by WHO, UNODC, and UNAIDS[14] and has been the subject of scholarly research for decades. Many randomized controlled studies, meta-analyses, and systematic reviews have demonstrated the effectiveness of these medicines both in treating opioid dependence and in reducing the harms of drug injection, including HIV transmission.[15] Treatment with methadone and buprenorphine has also been associated with improved family function and employment, reduced criminal activity, and increased self-efficacy.[16]

Medically supervised facilities where people inject or smoke drugs have also demonstrated positive health impact. Studies of Insite, the supervised injection facility in Vancouver, Canada, have contributed a large body of peer-reviewed research to scholarship in this area. Insite's work has been shown to be associated with, among

12 A Wodak and A Cooney. Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users – Evidence for Action Technical Paper. Geneva: World Health Organization, 2004. At: https://www.unodc.org/documents/hiv-aids/EFA%20effectiveness%20sterile%20needle.pdf

13 Ibid. See also WHO Consolidated guidelines…for key populations, op.cit.

14 WHO, UNODC, UNAIDS, op.cit. (note 4).

15 See, e.g., RP Mattick, C Breen, J Kimber, M Davoli . Buprehnorphine maintenance vs. placebo or methadone maintenance for opioid dependence. *Cochrane Database Systematic Reviews* doi: 10.1002/14651858.CD002207.pub4, Feb. 2014; CA Fullerton, M Kim, CP Thomas et al. Medication-assisted treatment with methadone: assessing the evidence. *Psychiatric Services* 65(2):146-157, 2014; and G MacArthur, S. Minozzi, N Martin et al. Evidence for the effectiveness of opioid substitution treatment in relation to HIV transmission in people who inject drugs: a systematic review and meta-analysis. *British Medical Journal* 345:e5945. doi:10.1136/bmj.e5945, 2012.

16 WHO, UNODC, UNAIDS, op.cit.

other things, reduced HIV transmission, prevention of death from overdose, reduced needle sharing, improved public order and reduced crime in the neighborhood of the facility, reduced injection-related injury and infection, and improved referral to drug dependence treatment and other health services for people who use drugs. These benefits have been achieved without increase in new drug use and with significant cost savings for the public health budget of the city and province.[17] Some of the same effects have been demonstrated in supervised injection facilities in Australia,[18] as well as in several countries in western Europe.[19]

The strong evidence of positive effects of harm reduction measures has informed and inspired drug policy change in a number of countries, including the following:

Switzerland

Faced with a very fast-growing injection-linked HIV epidemic in the late 1980s, the Swiss government instituted low-threshold methadone treatment and NSP in virtually all cities and established supervised drug consumption sites in bigger cities.[20] HIV transmission linked to drug use plummeted and has remained very low.[21] Switzerland coined the term "four pillars" to describe its drug policy, which is based on policing (supply reduction), demand reduction, harm reduction, and prevention of drug use.[22] This framework has been adopted in many countries.

Portugal

In the 1980s and 1990s, Portugal faced rapidly escalating HIV linked to growing drug consumption following its long period as a dictatorship. In 2001, the government instituted many of the same harm reduction and drug dependence treatment measures as in Switzerland but with the additional reform of removing drug consumption and minor possession offenses from its criminal law. Injection-linked HIV and problematic drug use have both declined dramatically.[23]

17 See summary in Urban Health Research Initiative, University of British Columbia. Insight into Insite. Vancouver, undated. At: http://uhri.cfenet.ubc.ca/content/view/57/92/

18 See, e.g., AM Salmon, I van Beek, J Amin et al. The impact of a supervised injecting facility on ambulance call-outs in Sydney, Australia. *Addiction* 105(4):676-83, 2010; and AM Salmon, R Dwyer, M Jancey et al. Injecting-related injury and disease among clients of a supervised injecting facility. *Drug and Alcohol Dependence* 101(1-2):132-136, 2009.

19 D Hedrich, T Kerr, F Dubois-Arber. Drug consumption facilities in Europe and beyond. In European Monitoring Centre for Drugs and Drug Addiction, *Harm reduction: evidence, impacts and challenges* (monograph). Lisbon, 2010. At: http://www.emcdda.europa.eu/publications/monographs/harm-reduction

20 J Csete and PJ Grob. Switzerland, HIV and the power of pragmatism: lessons for drug policy development. *International Journal of Drug Policy* 23:82-86, 2012.

21 Swiss Confederation, Federal Office of Public Health. Fact sheet on HIV/AIDS in Switzerland 2013. Bern, 2014. At: http://www.bag.admin.ch/hiv_aids/05464/12908/12909/12913/index.html?lang=en

22 Csete and Grob, op.cit.

23 A Domoslawski. *Drug policy in Portugal: the benefits of decriminalizing drug use*. Open Society Foundation, 2011. At: http://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf; and CE Hughes and A Stevens. What can we learn from the Portuguese decriminalization of illicit drugs? *British Journal of Criminology* 50:999-1022, 2010.

Vietnam

Facing high HIV incidence and prevalence among people who inject drugs, the government of Vietnam in 2006 passed an HIV law that explicitly adopted harm reduction measures—including provision of condoms, sterile needles, and syringes, as well as opiate substitution therapy—as central to the national HIV response.[24] NSP and methadone treatment have expanded significantly in recent years.[25] One program that supported peer-based outreach and provision of injection equipment near the border with China found substantial reductions in needle-sharing, HIV incidence, and HIV prevalence over an eight-year period, representing an enormous saving in cost and disease burden as well as potentially lasting behavior change.[26] As methadone has expanded, Vietnam has also taken steps to reduce its reliance on compulsory drug detention centers, which were created purportedly for rehabilitation but have offered few services beyond physical discipline and forced labor.[27]

"A World Bank study indicated that harm reduction services in Malaysia averted over 13,000 cases of HIV in the period 2005–2013 and projected that over 100,000 infections may be averted by the year 2050."

Iran

Harm reduction measures are protected in Iran by a 2005 order from the head of the national judiciary, which instructed criminal justice and law enforcement agents not to interfere with NSP or methadone-assisted treatment services as these were essential for protection of the population from infectious disease.[28] The order gave explicit protection from criminal prosecution to health workers providing harm reduction services. Iran also established methadone maintenance treatment in prisons, recognizing that many people entered prison or pretrial detention with opiate dependence. From 2004 to 2014, the number of methadone patients went from a few hundred

24 M Jardine, N Crofts, G Monaghan, M Morrow . Harm reduction and law enforcement in Vietnam: influences on street policing. *Harm Reduction Journal* 9:27, 2012, http://www.harmreductionjournal.com/9/1/27

25 L Degenhardt, BM Mathers, AL Wirtz, D Wolfe et al. What has been achieved in HIV prevention, treatment and care for people who inject drugs, 2012-2012? A review of the six highest burden countries. *International Journal of Drug Policy* 25:53-60, 2014.

26 TM Hammett, DC Des Jarlais, R Kling et al. Controlling HIV epidemics among injection drug users: Eight years of cross-border HIV prevention interventions in Vietnam and China. PLoS ONE 7(8): e43141. doi:10.1371/journal.pone.0043141.

27 Ibid.

28 Seyed Mahmood Hashemi Sharoudi, head of the judiciary, Executive Order of 24 January 2005. On file with authors.

to over 41,000 in 164 prisons and detention centers with a concomitant threefold reduction in HIV incidence. Iranian authorities report that, in addition to a significant contribution to HIV control, the methadone program in prisons has resulted in less violence and self-injury, less suicide, fewer abscesses and injection-related injuries, and less trafficking and use of illicit drugs in prison.[29]

Malaysia

Prior to 2005, when needle exchange and methadone treatment were put in place, drug injection was linked to a high percentage of HIV transmission in Malaysia.[30] Malaysia also routinely detained people who use drugs in compulsory drug detention centers with locked facilities, where detainees were subjected to harsh punishment and emotional abuse for around two years.[31] In addition to support for needle exchange and methadone, the Malaysian government began in 2010 to expand treatment in "cure and care" centers, which offer voluntary in- and out patient methadone and other health and counseling services, with the idea of reducing reliance on compulsory detention centers.[32] Evaluators and representatives of the National Antidrugs Agency report that "cure and care" patients experience sharp decreases in drug injection and higher appreciation of services, sharply lowering rates of return to illicit drug use as compared to those in compulsory centers.[33] Voluntary centers also cost the state more than 40 percent less per patient per year.[34] More generally, a World Bank study indicated that harm reduction services in Malaysia averted over 13,000 cases of HIV in the period 2005-2013 and projected that over 100,000 infections may be averted by the year 2050.[35]

China

Tracking HIV through a nationwide sentinel surveillance system, China detected a significant HIV epidemic linked to injection of opiates by the late 1990s.[36] Methadone maintenance therapy was scaled up rapidly from eight facilities in 2004 to over 700 clinics serving over 340,000 patients around the country in 2011.[37] Some 91 needle exchange pilot sites opened in 2003 expanded to over 930 exchange points by 2011.[38] Though the

29 Presentation by Iranian delegation, UNODC Global Consultation on HIV Prevention, Treatment, Care and Support in Prison, Vienna, 16 October 2014.

30 UNAIDS, *Harm reduction works*, op. cit., p 4.

31 D Wolfe and R Saucier. In rehabilitation's name? Ending institutionalised cruelty and degrading treatment of people who use drugs. *International Journal of Drug Policy* 21(3):145-148 DP Wilson, N Fraser, D Wilson. The economics and financing of harm reduction. Presentation to International Harm Reduction Conference, Vilnius, 10 June 2013.

32 MA Ghani, SE Brown, F Khan et al. An exploratory qualitative assessment of self-reported treatment outcomes and satisfaction among patients accessing an innovative voluntary drug treatment centre in Malaysia. *International Journal of Drug Policy* 26(2):175-182, 2015

33 Ghani et al, Ibid. Kaur, S. "Transformation journey of Treatment and Rehabilitation Programs in Malaysia". International AIDS Society Conference on the Twin Epidemics of HIV and Drug Use. Washington DC: July 2012

34 Wilson et al, op.cit (note 31)

35 H Naning, C Kerr, A Kamarulzaman et al . Return on investment and cost-effectiveness of harm reduction programme in Malaysia . Washington, DC: World Bank, University of Malaya, Kirby Institute, 2014 . At: https://openknowledge.worldbank.org/handle/10986/18641

36 L Wang, W Guo, D Li et al . HIV epidemic among drug users in China: 1995-2011. *Addiction* 110 (Supp 1):20-28, 2015.

37 Ibid., p 21.

38 Ibid.

drug injection-related HIV epidemic in China is far from over, national surveys have associated this period of expansion of harm reduction services with declining risk behaviors, including needle sharing, and declining HIV incidence from drug injection.[39] A number of rigorous studies have shown that in addition to their HIV impact, methadone programs in China are also associated with crime reduction in affected communities, higher rates of employment among patients, and greater participation of patients in community and family activities.[40]

REACHING THOSE IN NEED: CONTRAST WITH ABSTINENCE-BASED APPROACHES

WHO/UNODC guidance for treatment of drug dependence emphasizes the need for low-threshold options to maximize the reach of services to people who may fear or be unready for treatment.[41] As depicted in Fig. 1, studies by governments considering inclusion of a harm reduction approach have indicated that without such low-threshold services, including harm reduction services, the large majority of people who inject drugs would simply not be reached.[42]

Good-quality harm reduction services meet people who use drugs "where they are" and work to ensure that they have the capacity to protect themselves from the worst harms of whatever their degree of drug dependence or pattern of use. These lower-threshold services are a gate to drug dependence treatment and other health services for individuals who have remained out of reach of or resistant to higher-threshold approaches. In São Paolo, Brazil, for example, the "Open Arms" (*Braços Abertos*) program offers housing and employment to residents without requiring that they abstain from crack use. Hundreds of formerly homeless, street-involved individuals are now housed and employed.[43] In Vancouver, the supervised injection site serves as a gate to the possibility of seeking other services, including treatment for drug dependence.[44]

39 Ibid.; see also W Luo, Z Wu, K Poundstone et al. Needle and syringe exchange programmes and prevalence of HIV infection among intravenous drug users in China. *Addiction* 110 (Supp 1):61-67, 2015.

40 HM Sun, XY Li, EP Chow et al . Methadone maintenance treatment programme reduces criminal activity and improves social well-being of drug users in China: a systematic review and meta-analysis. BMJ Open Jan 8;5(1):e005997. doi: 10.1136/bmjopen-2014-005997, 2015.

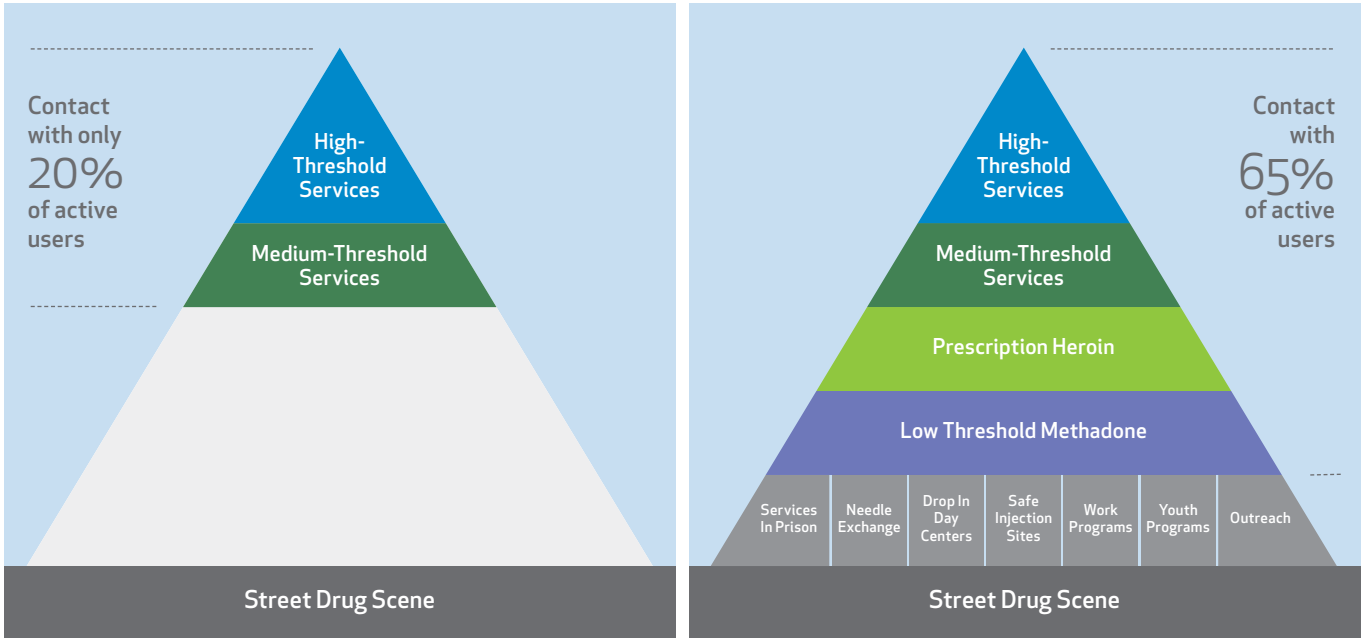
41 UNODC and WHO. Principles of drug dependence treatment: discussion paper. Vienna, 2008.

42 D MacPherson. A framework for action: a four-pillar approach to drug problems in Vancouver. City of Vancouver, 2001. At: http://donaldmacpherson.ca/wp-content/uploads/2010/04/Framework-for-Action-A-Four-Pillars-Approach-to-Drug-Problems-in-Vancouver1.pdf

43 Programa "De Braços Abertos" completa um ano com diminuição do fluxo de usuários e da criminalidade na região," last modified January 16, 2015. http://www.capital.sp.gov.br/portal/noticia/5240#ad-image-0

44 MW Tyndall, T Kerr, R Zhang et cl. Attendance, drug use patterns and referrals made from North America's first supervised injection facility. *Drug and Alcohol Dependence* 3:193-198, 2006.

Fig. 1: Street-level outreach and low-threshold services reach more people than those requiring abstinence as a condition of entry



Source: D MacPherson[45]

45 D MacPherson, op.cit.

FAILURE TO FUND HARM REDUCTION SERVICES

In spite of overwhelming scientific evidence of the success and cost-effectiveness of harm reduction measures in addressing HIV and other negative effects of drug use, harm reduction funding lags far behind need. Of the package of services proven effective in averting HIV transmission among people who use drugs, UNAIDS estimates that only seven percent are funded.[46]

International donors and national governments need to pledge financial commitment or harm reduction services. People who inject drugs in middle-income countries in Eastern Europe and Asia have been particularly hard hit by the Global Fund's reduction of support to these countries.[47] Countries that have been deemed too wealthy for HIV assistance from the Global Fund, such as Romania, have shown how quickly HIV epidemics among people who inject drugs can become resurgent, with infections spiking quickly after cuts to needle and syringe programs.[48] Similarly, where government support for harm reduction is reduced due to budget cutbacks, as in Greece after the recession of 2008-09, HIV infection via contaminated injecting equipment often sharply increases, creating a public health problem many times more costly than harm reduction services (see Fig. 2).

Harm reduction services are cost-effective and affordable. Advocates estimate that only 10 percent of the approximately $100 billion spent annually on drug enforcement around the world would cover HIV prevention services for people who use drugs for four years.[49] A widely cited study by the government of Australia concluded that for every $1 invested in NSP, over $4 would accrue in short-term health-care cost savings, and that this figure would only grow with the cumulative effect of HIV transmission averted.[50]

46 C Cook, J Bridge, S MacLean, M Phelan, D Barrett. The funding crisis for harm reduction: donor retreat, government neglect and the way forward. London: Harm Reduction International, International HIV/AIDS Alliance and International Drug Policy Consortium, 2014. At: http://www.ihra.net/files/2014/07/20/Funding_report_%C6%92_WEB_(2).pdf

47 Ibid.

48 A Botescu, A Abagiu, M Mardarescu, M Ursan. HIV/AIDS among injecting drug users in Romania: Report of a recent outbreak and initial response policies. Lisbon: European Monitoring Centre for Drugs and Drug Abuse, 2012, http://www.emcdda.europa.eu/publications/ad-hoc/2012/romania-hiv-update; see also Government of Romania. Country progress report on AIDS, January-December 2013. Bucharest, 2014. At: http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/ROU_narrative_report_2014.pdf

49 Cook et al, op.cit.

50 Government of Australia, National Centre in HIV Epidemiology and Clinical Research. "Return on investment 2: evaluating the cost-effectiveness of needle and syringe programs in Australia", 2009.

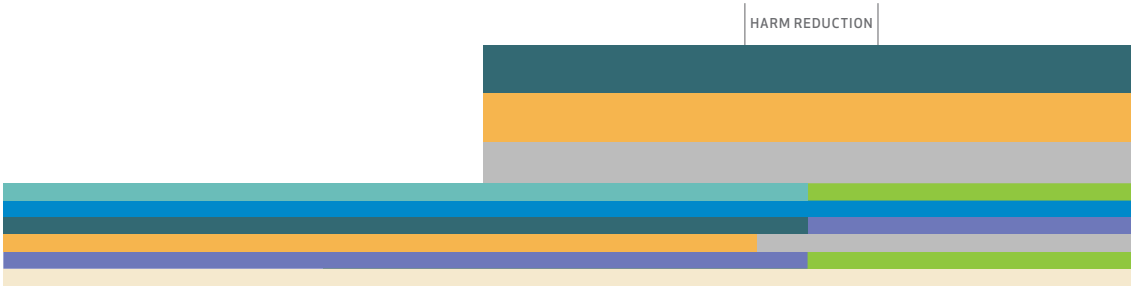
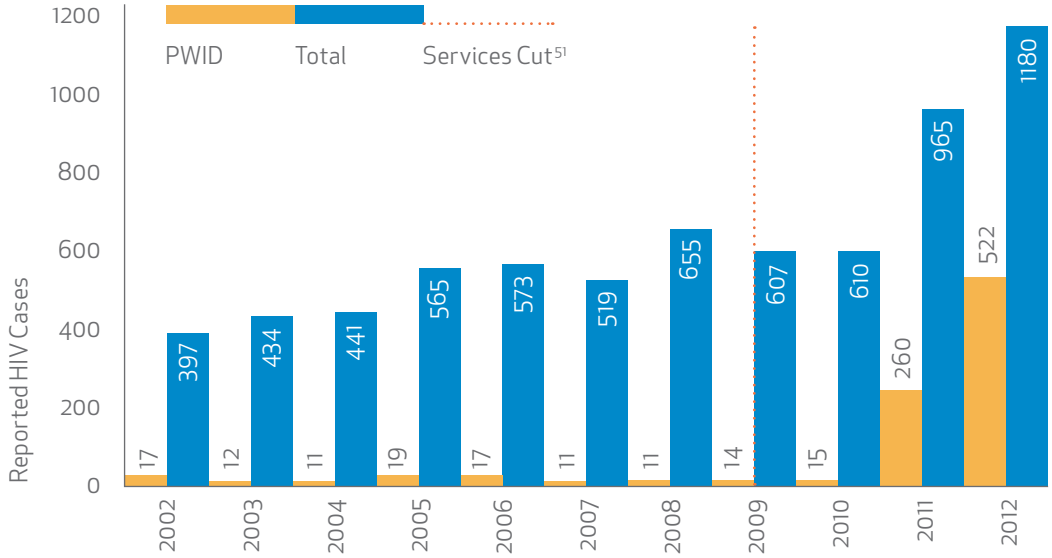


Fig. 2: Surge in HIV transmission among people who inject drugs (PWID) in Greece following cut to harm reduction services during fiscal crisis



Source: Paraskevis et al.[52]

51 Gopal, Anand. "What Austerity Looks Like Inside Greece." *The New Yorker*, March 2015.

52 D Paraskevis, G Nikolopoulos, A Fotiou et al. Economic recession and emergence of an HIV-1 outbreak among drug injectors in Athens metropolitan area: a longitudinal study. PLoS ONE 8(11): e78941. doi:10.1371/journal.pone.0078941

"In the UK, police have been trained not to use possession of syringes as evidence of a crime, and they even may provide sterile injecting equipment to people who have been in police custody."

A mathematical model evaluating naloxone administration by lay witnesses—making what the authors consider to be conservative assumptions about age distribution of overdose, treatment seeking, and relapse—found that one quality-adjusted life year (QALY) resulted from $438 in program costs in the United States and $1,987 in Russia.[53] The authors note that this is equivalent to some of the most cost-effective and accepted health interventions, such as measurement of blood pressure, and that an incremental cost of less than $50,000 per QALY gained is considered cost-effective by health policymakers.[54]

HARM REDUCTION IN LAW ENFORCEMENT

In a number of countries, public health services have worked with law enforcement and justice system to reduce drug-related harms in various ways:

Facilitating access to services

Police in various countries have worked to ensure that harm reduction services operate without interference from law enforcement, and in some countries have facilitated access to harm reduction services. In the UK, police have been trained not to use possession of syringes as evidence of a crime, and they even may provide sterile injecting equipment to people who have been in police custody.[55] In parts of the Netherlands, Australia, Ukraine, and Indonesia, police allow NGO representatives to bring methadone

53 PO Coffin, SD Sullivan. Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal. *Annals of Internal Medicine* 158(1):1-9, 2013; PO Coffin, SD Sullivan. Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal in Russian cities. *Journal of Medical Economics*. 16(8):1061-1060, 2013

54 Coffin and Sullivan, Annals of Internal Medicine, ibid.

55 G Monaghan and D Bewley-Taylor. Police support for harm reduction policies and practices towards people who use drugs. London: International Drug Policy Consortium, 2013.

treatment to patients in police lock-up or pre-trial detention.[56] In several countries, police may allow outreach workers from health services to be present in police stations or otherwise to assist in ensuring that people have access to services to keep themselves safe while they are in custody.[57]

The time and resources of drug police are poorly used if they are focused on people who consume, possess or sell drugs on a small scale, rather than on the most harmful elements of drug markets and drug-related crime.[58] Blanket zero-tolerance approaches or use of arrest quotas to assess police performance is poor practice, and likely to result in filling prisons with minor, non-violent offenders. Police actions themselves can add to or reduce drug-related harms, causing hurried injection and injection in remote places far from services or emergency help, and may even lead people to inject rather than smoke or inhale drugs.[59]

In the U.S., experiments with another approach are underway in Seattle, Washington, and Santa Fe, New Mexico, through a program called Law Enforcement Assisted Diversion (LEAD). In these initiatives, police encountering low-level, non-violent drug offenders can direct them to a range of community services and supports rather than to prosecution and jail.[60] Success in the LEAD program is not judged by drug testing, but by participation and progress in programming as deemed by health and social workers. In Seattle, evaluation of the first five years of the program found that the participants diverted to services had a 58 percent lower chance of subsequent arrest compared to other drug offenders.[61]

Police in some countries themselves provide a harm reduction service by using naloxone, a medicine that reverses

"Police in some countries themselves provide a harm reduction service by using naloxone, a medicine that reverses potentially fatal opioid overdose."

56 Ibid.

57 Ibid.

58 V Felbab-Brown. Focused deterrence, selective targeting, drug trafficking and organised crime: concepts and practicalities. London: International Drug Policy Consortium, 2013.

59 A Stevens. Applying harm reduction principles to the policing of retail drug markets. London: International Drug Policy Consortium, 2013; see also R Jürgens, J Csete, JJ Amon et al. People who use drugs, HIV and human rights. *Lancet* 376(9739):475-485, 2010.

60 K Beckett. Seattle's Law Enforcement Assisted Diversion Program: lessons learned from the first two years. Unpublished report, 2014. At: http://www.seattle.gov/council/Harrell/attachments/process%20evaluation%20final%203-31-14.pdf

61 SE Collins, HS Lonczak, HL Clifasefi. LEAD program evaluation: recidvism report. Seattle: University of Washington, 2015.

"The U.S. states are promoting Good Samaritan laws as part of expanding naloxone capacity."

potentially fatal opioid overdose. Naloxone in injectable and nasal spray forms has been a tool for emergency medical workers in a number of countries for some time, but police are often first on the scene and can save lives. The 2014 U.S. national drug strategy, for example, states that "naloxone…should be in the patrol cars of every law enforcement professional across the nation…."[62] Hand in hand with training and equipping police for overdose interventions in the U.S. is the passage of so-called "Good Samaritan" laws that protect volunteers who provide emergency services such as overdose reversal from prosecution or litigation. These laws have existed for some time in Europe,[63] and U.S. states are promoting Good Samaritan laws as part of expanding naloxone capacity.[64] In 2013, police in Kyrgyzstan launched an initiative to enable officers to administer naloxone for overdose.[65]

Reducing harms of law itself

To keep the police focused on the most damaging crimes, minor infractions should be decriminalized or effectively decriminalized through formal provision of alternatives to arrest and detention. For non-violent minor possession or sale offenses, for example, a number of countries in Europe have defined cut-off amounts of drugs below which there is no arrest but rather a fine or community service sanction.

62 Executive Office of the President of the U.S. *National drug control strategy* 2014. Washington, DC, 2014. At: http://www.whitehouse.gov/sites/default/files/ndcs_2014.pdf

63 JT Pardun. Good Samaritan laws: a global perspective. *Loyola of Los Angeles International and Comparative Law Review* 20:591-613, 1998.

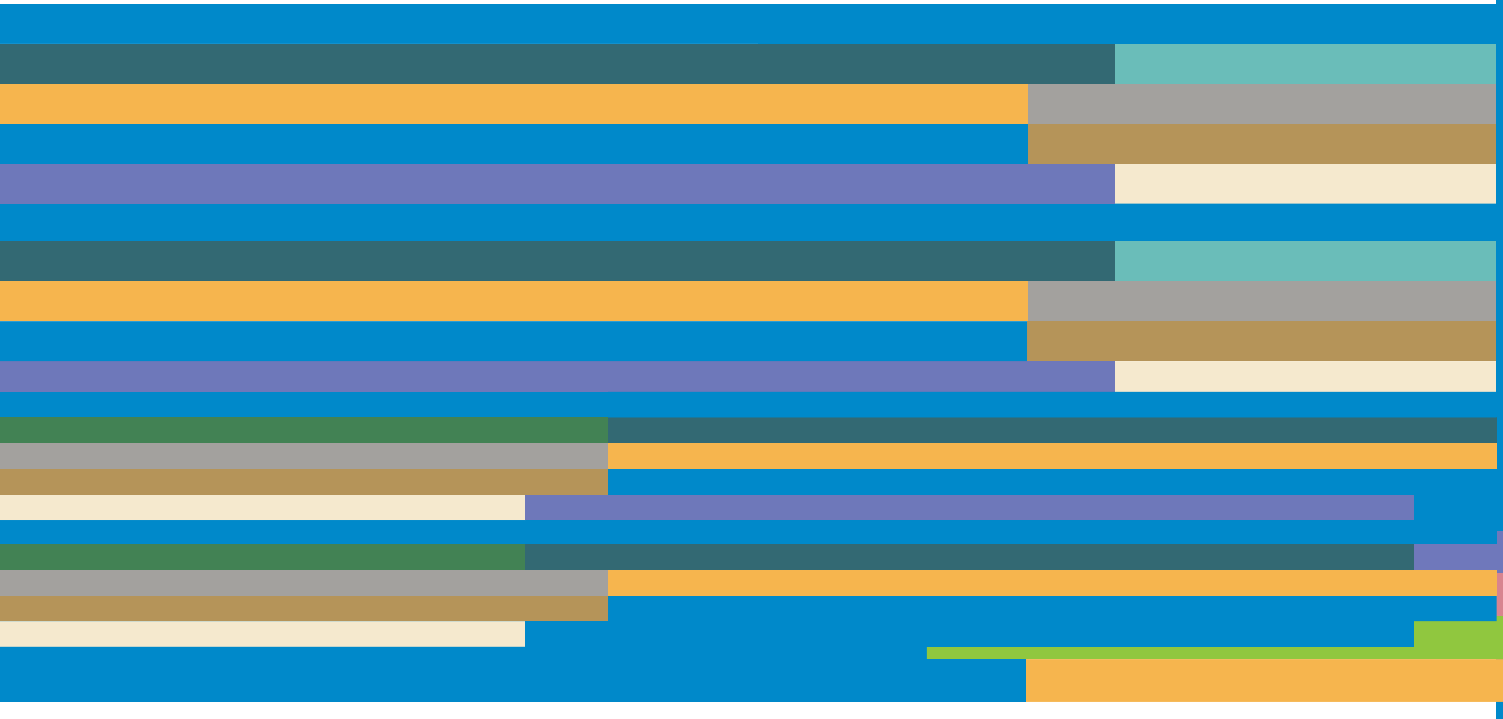
64 Executive Office of the President, op.cit., p 3.

65 Open Society Foundations. *To protect and serve: How police, sex workers and people who use drugs are joining forces to improve health and human rights*. New York, 2014. At: http://www.opensocietyfoundations.org/sites/default/files/protect-serve-20140716.pdf

CONCLUSION

For many people who use drugs, harm reduction services are the most likely entry point into health care and the most likely means of protection from life-threatening conditions. As United Nations agencies have noted, the effectiveness of harm reduction services for HIV prevention and prevention of drug-related mortality is beyond dispute.

The UN General Assembly Special Session on drugs is an opportunity to re-energize the commitment to harm reduction pledged by UN member states at the 2001 UNGASS on HIV/AIDS. Funding for proven and cost-effective harm reduction services that protect not only people who use drugs but entire communities should be a top priority. Harm reduction is a central pillar of effective drug response, critical to reaching people who use drugs with services that can help protect them, their families and their communities.



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Published 2015