

Upstream Opportunities for Reducing the Harm of Alcohol and Drug Use



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Overview

The use of alcohol and other drugs can lead to untold health and social problems that are largely preventable. Tragic deaths, injuries, and disability could be minimized if communities expand the use of harm reduction approaches and explore development of new strategies. Communities could adopt a full-range of harm reduction approaches as part of their strategy to engage people with unhealthy alcohol and drug use, including those who are not in treatment, in positive behavior change. Harm reduction is not an alternative to treatment but rather is a support to people who use alcohol and other drugs to improve health and functioning through safer practices.

The authors propose a definition of harm reduction which is inclusive—a philosophical approach, as well as specific policies, practices, and interventions intended to reduce harm from the use of an array of drugs (including alcohol). This philosophical approach recognizes that people unable or unwilling to abstain from drug use can make positive choices to protect their health and well-being, and the well-being of their communities. Harm reduction includes a range of evidence-based practices, approaches, and policies; it can include medical services, public health interventions, expanded access to treatment, and public safety initiatives that do not stigmatize the drug user. Community coalitions of diverse stakeholders can work together to replace and reform practices and policies in the health and criminal justice sectors that yield adverse consequences to people using drugs, such as prosecution and incarceration of low-risk, nonviolent individuals who possess drugs.

This White Paper focuses on harm reduction as a social investment in personal, family, and community health, particularly the health of population groups and neighborhoods most severely affected by adverse consequences of drug use. The paper explores opportunities and model programs to redirect expenditures from punitive or stigmatizing approaches that are often unproductive to “upstream investments” (i.e., prevention) that can be developed by collaborations (coalitions) of community-based organizations, health entities, law enforcement, and criminal justice programs working together on common goals related to improving health outcomes and public safety, and preventing avoidable negative consequences, associated with some current practices and policies.

Suggestions are made to evaluate system-wide changes in order to promote accountability and to wisely invest in what is working. Evaluation also helps identify what is not working so corrective action or system improvement is possible.

The White Paper also suggests that communities turn to alternative and diverse sources of financing, including financing approaches that permit redirection of current funds, in order to maximize harm reduction approaches. Therefore, communities that wish to adopt and expand harm reduction approaches should advocate for inclusion of these prevention and personal health services in health care proposals, and should advocate that all infrastructure improvements and reforms of health systems and criminal justice systems include harm reduction components as preventative services.

Synopsis

This White Paper advocates that communities adopt and expand upon a range of approaches that can improve upon personal, family, and community health outcomes by reducing the harm of alcohol and drug use. Twin external changes, the transformation of health care entities in association with the Affordable Care Act, and the increasing financial pressure on states to downsize the low-risk, non-violent population that is incarcerated, create opportunity for community innovations. These approaches can be carried out in three general sectors and include:

Strategies for personal health care settings:

- Build new expectations and infrastructure for preventative initiatives
- Enhance integration of behavioral health services in primary care
- Focus on alternative ways to manage patients' chronic pain
- Adopt screening and brief intervention in primary healthcare settings and in alternative health settings as well

Strategies for addiction systems of care:

- Recognize the potential of patient-centered, psychosocial treatment approaches that foster harm reduction
- Use positive rewards (incentives) to retain people with active drug use into services
- Adopt low-threshold approaches for bring people who use drugs into services
- Create an integrated network with seamless access to support services for positive change

Strategies for community coalitions of stakeholders with interests in public health, public safety, social policy, and harm reduction:

- Change media representation of harm reduction and people who actively use drugs
- Make health reform work for harm reduction
- Invest in the community's capacity to operate the full spectrum of prevention activities
- Distribute naloxone and train good Samaritans to prevent opioid overdose
- Adopt and expand needle and syringe exchange programs
- Develop and collaborate on harm reduction training for law enforcement personnel
- Create a data-driven criminal justice approach for the low-risk, non-violent drug users who are being prosecuted
- Build pre-booking diversion programs through collaborations of grass roots harm reduction programs and law enforcement
- Use community policing practices that reduce crime, not simply increase arrests
- Integrate use of state prescription drug monitoring programs into community-based prevention efforts
- Enable access to legal services in communities disproportionately affected by drug offenses
- Work collaboratively to reform sentencing policies
- Create opportunity for economic empowerment of drug users

Evaluation. It is important to evaluate system-wide changes in order to promote accountability and to wisely invest in what is working. Evaluation also helps identify what is not working so corrective action or system improvement is possible. This focus on evaluation is particularly important in the new health delivery context. There are numerous communities exploring accountable care organizations and other innovative reforms to their health care delivery systems. Many states, counties and municipalities are evaluating to redirect spending to more effective prevention initiatives. The Affordable Care Act of 2010, and financing strategies increasingly adopted by local foundations and all levels of government, also

requires that organizations and coalitions evaluate their effectiveness. This White Paper reviews a logic model for community harm reduction systems and proposes one framework, RE-AIM, for assessing system outcomes. RE-AIM is comprised of five evaluative dimensions that add up to the long-term impact of an initiative: its Reach, Efficacy, Adoption, Implementation, and Maintenance.

Financing Approaches. Unless communities turn to alternative and diverse sources of financing, it will be difficult to maximize harm reduction approaches. Therefore, communities that wish to adopt and expand harm reduction approaches should advocate for inclusion of both these prevention and personal health services in funding proposals, and should advocate that all infrastructure improvements to reform health systems and criminal justice systems include harm reduction services. The Affordable Care Act will bring health insurance coverage to most drug users and their families, provide reimbursement for preventive services, and integrated services in patient-centered programs. Non-profit organizations can expand activities directed at their mission by attracting new private and public investments including, use of Hospital Community Benefit funds, Community Reinvestment Act funds from local banks, public prevention Trust Funds, and traditional federal grant programs. A new source of funding and practices is emerging that involved more social enterprise among non-profits and governments. Related to this, local governments are encouraged to repurpose funding to community harm reduction activities and to experiment with pay-for-success approaches.

1. THE CASE FOR HARM REDUCTION

The use of alcohol and other drugs can lead to untold health and social problems that are largely preventable. Nevertheless, nearly all U.S. communities can identify countless missed opportunities to avoid harms to personal health or community wellbeing from alcohol and drug use problems that in many cases are going untreated. The Open Society Foundations recently completed a demonstration project in nine communities that was premised on the idea that *Addiction is a disease – let’s treat it that way*. The nine communities developed innovative solutions to *close the addiction treatment gap*.¹ Despite the success of these demonstrations, including additional local and government investments to expand addiction treatment resources, the vast majority of individuals who develop problems from their chronic use of alcohol and other drugs remain out-of-treatment.²

Harm reduction strategies are worthy social investments in the United States because:

- The vast majority of individuals with addiction and unhealthy alcohol and other drug use are not in treatment; treatment remains inaccessible or unaffordable in most communities or not salient to the stage of change to many people with unhealthy use of alcohol and other drugs.
- Persons with untreated alcohol and drug use problems are disproportionately incarcerated in local jails and state prisons. The U.S. reliance on incarceration for populations in need of addiction treatment is costly and ineffective at reducing social problems that stem from unhealthy alcohol and drug use.
- Cost-effective preventive strategies exist to reduce the harm associated with alcohol and drug use which will help reduce health care costs in the U.S. and reduce health disparities.

Harm to personal and family health. Tragic deaths of adolescents and young adults from prescription drug overdose; overdoses among middle-aged women; low birth-weight babies born to women using alcohol, tobacco, and other drugs; and spread of disabling infections from HIV or Hepatitis C could all be minimized with full-scale adoption of existing harm reduction approaches. The harms to personal health from use of alcohol and other drugs include premature deaths, increased illness and chronic disease, and high rates of disability or reduction in functioning. Each year in the U.S. there are more than 80,000 annual alcohol-attributable deaths,³ and over 38,000 deaths from drug overdose, a dramatic increase since 1999 (16,849 deaths). Similarly, in 2010 there were more than 16,000 overdose deaths involving opioid analgesics such as oxycodone, hydrocodone, and methadone, a four-fold increase since 1999 (4,030).⁴ As the preponderance of deaths is among young adults, these early deaths rob family members and communities of many productive years of life. Many years of illness and disability could be prevented, through early medical or public health interventions, even for individuals unable or unwilling to abstain from use.

Some of this harm to personal health could be reduced or minimized by rethinking the response to individuals who chronically use alcohol and other drugs. While direct harm results from hazardous practices (i.e., sharing needles, driving under the influence), this White Paper challenges the reader to consider *how much this harm could be reduced by expanded adoption of an effective public health response and preventive health measures*. For example, consider how the stigma attached to drug use among some parts of medical system may lead to negative consequences from a lack of medical attention to disease and illness among some people who use drugs.

Harm to community well-being. The harms to community from the high rates of untreated alcohol and drug problems include social externalities to the loved ones, including high rates of partner and family violence and disrupted homes and child neglect when parents cannot function or support their children because of their drug use. Incarceration generates profound social costs not obvious to the public. An analyst for the Vera Institute

¹See Closing the Addiction Treatment Gap, <http://www.opensocietyfoundations.org/publications/closing-addiction-treatment-gap-early-accomplishments-three-year-initiative>

² See the 2013 National Drug Control Strategy, <http://www.whitehouse.gov/ondcp/2013-national-drug-control-strategy>

³ http://apps.nccd.cdc.gov/DACH_ARDI/default/default.aspx

⁴ http://www.cdc.gov/media/releases/2013/p0220_drug_overdose_deaths.html

estimated that, net the possible benefits from averted crime, the costs of incarceration of a parent for a drug offense are shouldered primarily by the inmate's family (44 percent), then the inmate's own economic loss (32 percent) and third the public's share (24 percent).¹ Over 8.3 million children (11.9 percent) live with at least one parent who abuses alcohol or illicit drugs.² Children of parents with substance use disorders are more likely to experience abuse (physical, sexual, or emotional) or neglect and are more likely to be placed in foster care and to remain there longer than maltreated children without substance use problems.³

There are also social externalities in the work place, including unproductive days at work, days absent, and lost jobs. The majority of individuals who misuse alcohol and other drugs are employed, even though the rate of problems is higher among those unemployed or disabled. Further, alcohol and drug use contributes to major disruptions in healthy community life due to street crime. Some have observed that this community harm disproportionately affects poor inner city communities of color, where drug sales and drug crimes occur in public spaces, even though substance use disorders occur among individuals living in all neighborhoods at similar rates. Community harm also results from misallocated social resources, in part reflective of the current reliance on downstream strategies – we pay for repeated emergency department visits and complex medical treatments for chronic illness rather than pay to prevent harm from substance use or teach how to reduce the risk from substance use. One estimate is \$8.95 billion in 2011 federal spending on treatments of alcohol and drug-related medical illnesses, expenditures that have not reduced the problem.⁴

1.1 Purpose of This White Paper

The authors of this paper argue that all communities can use harm reduction activities to reduce personal, family, and community harm from drug use, as well as conceive of harm reduction activities as a gateway to reduced drug use, safer drug use practices, improved opportunity to engage drug users with treatment providers and specialized health care.

This White Paper:

- Presents an expanded definition of harm reduction and outlines common harm reduction principles
- Presents target populations and possible target outcomes
- Identifies a comprehensive list of strategies, as well as successful model programs and the evidence for them
- Discusses why evaluation is important for future funding and describes one policy framework for evaluation
- Describes certain innovative financing strategies that explicitly acknowledge the perceived value of evidence-based prevention (i.e., harm reduction activities) as a worthy social investment.

Given the current evidence, reducing the harm from drug use is a moral, economic, and policy imperative. There is a need to experiment with novel mechanisms for new private and government investment in adoption and implementation of community-based harm reduction solutions.

The intended audiences of the White Paper are policy and program experts, health and social service providers, addiction services systems, harm reduction organizations, and coalitions of community-based organizations working with government agencies. This paper is intended to provide a foundation, common language, and summary of evidence-based initiatives to encourage conversations and collaborations across treatment, harm reduction, and policy silos.

If this White Paper is successful, stakeholders will advocate for upstream investment in additional harm reduction activities as a high priority for their own communities, organizations, and clients. Further, avenues for

¹ From Marilyn Brown, blog, Vera Institute, <http://www.vera.org/blog/incarceration%E2%80%99s-corrosive-effects-families>

² <http://www.samhsa.gov/data/2k9/SAParents/SAParents.htm>

³ Child Welfare Information Gateway, U.S. Department of Health & Human Services (DHHS) (2009). Parental Substance Use and the Child Welfare System, Bulletins for Professionals.

<https://www.childwelfare.gov/pubs/factsheets/parentalsubabuse.cfm> Accessed July 9, 2013

⁴ <http://www.whitehouse.gov/ondcp/the-national-drug-control-budget-fy-2013-funding-highlights>

dissemination of this paper will be clearly identified in order to influence how communities, organizations, and stakeholders think about and allocate their resources.

1.2 The Current Situation: Why We Care

In the U.S., illicit drug use contributed to an estimated \$193 billion in crime, health, and lost productivity in 2007).¹ Lack of access to treatment for substance use, and particularly services provided using a low-threshold approach, remains a major issue. In the U.S., 20.5 million persons with alcohol and drug disorders are estimated to be out of treatment² and thus would benefit from harm reduction services and increased access to treatment. Injection drugs remain a major focus of harm reduction efforts, and over 1.8 million in the U.S. are estimated to be injection drug users (IDUs).³ Over 300,000 IDUs were living with HIV in the U.S. in 2008.¹¹ Historically, public health and harm reduction funding has focused almost exclusively on reducing harms from injection drug use because of its association with the spread of HIV, viral hepatitis, and tuberculosis.

This section highlights brief epidemiological data related to three drugs less often addressed in harm reduction efforts: alcohol, methamphetamine, and prescription drugs in order to expand the dialogue of improving the health and wellbeing of U.S. communities.

Alcohol is a legal drug, sometimes used concurrently with other drugs, with well-known consequences, including interpersonal violence, sexual assaults, fetal alcohol syndrome, and motor vehicle accidents. The magnitude of harm from alcohol far exceeds the harm associated with all other drugs combined.

- The estimated economic cost of excessive drinking in the U.S. was \$223.5 billion in 2006, with 72% from lost productivity, 11% from health care costs, and 9.4% from criminal justice costs.⁴ This translates to \$746 per capita (2006).¹² Most costs were associated with binge drinking, \$170.7 billion; underage drinking accounted for \$24.6 billion; and drinking during pregnancy \$5.2 billion.¹²
- Most Americans who binge drink are not dependent on alcohol. Binge drinking is a particular problem among adolescents, young adults, college students and military personnel. Binge drinking accounts for over half of the alcohol consumed by adults and 90% of the alcohol consumed by youth.⁵ In 2006, binge drinking was reported by 23% (57 million) people in the U.S.
- Alcohol is a leading cause of death for people under age 21, with approximately 5,000 annual deaths, including 1,500 homicides and 300 suicides.⁶
- About one in ten returning service members from the wars in Iraq and Afghanistan who were seen in at Veterans Administration medical centers have a problem with alcohol or other drugs.⁷
- Excessive alcohol use is associated with unintentional burns, falls, drowning, and other fatal and non-fatal events, and is a frequent factor in physical and sexual assault, unwanted or unintended sexual activity, and suicide attempts and completions.
- Harm to others (externalities) also frequently occurs as a result of alcohol:
 - ▶ Fetal alcohol spectrum disorders affect an estimated 40,000 infants born in the U.S each year.⁸
 - ▶ Half of all persons who die in traffic crashes involving drinking drivers under age 21 are the passengers rather than the drivers.¹

¹ <http://www.justice.gov/archive/ndic/pubs44/44731/44731p.pdf>

² <http://www.samhsa.gov/data/nsduh/2k10nsduh/2k10results.htm>

³ http://www.ihra.net/files/2012/07/24/GlobalState2012_Web.pdf

⁴ Bouchery, E. E., Harwood, H. J., Sacks, J. J., Simon C. J., and Brewer, R. D. (2011) Economic costs of excessive alcohol consumption in the U.S., 2006. *American Journal of Preventive Medicine*, 41(5):516-524

⁵ <http://www.cdc.gov/fact-sheets/binge-drinking.htm>

⁶ <http://report.nih.gov/nihfactsheets/Pdfs/UnderageDrinking%28NIAAA%29.pdf>

⁷ http://www.ptsd.va.gov/public/pages/ptsd_substance_abuse_veterans.asp

⁸ <https://www.childwelfare.gov/pubs/factsheets/parentalsubabuse.pdf>. Accessed July 9, 2013

- ▶ Among college students, 50,000 experience alcohol-related date rape, and 43,000 are injured by another student who has been drinking².

Methamphetamine has emerged as a drug compelling more and more women to seek treatment during pregnancy³. Methamphetamine use during pregnancy is associated with many pregnancy complications, including preterm birth, small for gestational age, preeclampsia, and abruption. The long-term effects of prenatal exposure to methamphetamine on children from preschool through adolescence are similar to the effects of cocaine exposure and include behavior problems, attention, language, and cognition.⁴ Methamphetamine research suggests:

- Among pregnant women, admissions for treatment of methamphetamine abuse increased from 8% of federally funded treatment admissions in 1994 to 24% by 2006¹⁹
- Methamphetamine admissions to substance abuse treatment of pregnant women are concentrated in the West (73%), and among white (64%) and unemployed (88%) women¹⁹
- Methamphetamine is increasingly becoming an injection drug of choice among young gay and bisexual men

**What we don't know
(research is needed on synthetic drugs)**

More research is needed on understudied drugs, such as synthetic cathinones and cannabinoids (e.g., "K2," "Spice", and "bath salts"). The NIDA-supported Monitoring the Future Study began collecting data on teen use of synthetic cannabinoids in 2011 and synthetic cathinones in 2012 to help inform prevention efforts.

Prescription drug abuse is recognized as the largest drug problem after alcohol among middle class adults, adolescents, and military members and combat veterans who are at risk because of chronic pain. Most recently, abuse of opioid pain relievers (OPRs) among middle-aged women is of growing concern. The Centers for Disease Control and Prevention (CD) have recently reported that women aged 45-54 years had the highest rate of overdose deaths in 2010, and for every woman who dies of an OPR overdose 30 go to the ED visits for OPR misuse or abuse.⁵ In addition, there is concern is that prescription opioid abusers may switch to heroin which is less expensive than many OPRs. Specifically:

- Prescription drug abuse is the nation's fastest growing drug problem. In a typical month, approximately 5.3 million Americans use a prescription pain reliever for nonmedical reasons. Deaths from opioid pain relievers (OPRs) increased fivefold between 1999 and 2010 for women, while OPR deaths among men increased 3.6 times during the same time period. In 2010, there were 943,365 ED visits by women for drug misuse or abuse.²¹
- The majority (58%) of the 38,329 annual drug overdose deaths in the U.S. in 2010 involved pharmaceuticals. Of prescription drug overdose deaths, 73% were unintentional, and 75.2% involved prescription opioids.⁶
- The rate of prescription drug misuse among U.S. military personnel doubled between 2002 and 2005 (from over 2% to 5%), and almost tripled from 2005 to 2008 (from 5% to 12%).¹

¹ National Highway Traffic Safety Administration (2003). Traffic Safety Facts 2002: Alcohol. DOT HS 809 606. Washington, DC: U.S. Department of Transportation. Cited in <http://www.store.samhsa.gov/shin/content/SMA11-4645/SMA11-4645.pdf> (p 23)

² NIH. (2010). Underage Drinking Fact Sheet. [http://report.nih.gov/NIHfactsheets/Pdfs/UnderageDrinking\(NIAAA\).pdf](http://report.nih.gov/NIHfactsheets/Pdfs/UnderageDrinking(NIAAA).pdf). Accessed July 9, 2013

³ Terplan, M., Smith, E. J., Kozloski, M. J., & Pollack, H. A. (2009). Methamphetamine use among pregnant women. [Research Support, Non-U S Gov't]. *Obstet Gynecol*, 113(6), 1285-1291

⁴ Lester, B. M., & Lagasse, L. L. (2010). Children of addicted women. *J Addict Dis*, 29(2), 259-276.

⁵ Centers for Disease Control and Prevention (2013). Vital Signs: Overdoses of Prescription Opioid Pain Relievers and Other Drugs Among Women – United States, 1999-2010. Morbidity and Mortality Weekly Report, Early Release Volume 62, July 2, 2013. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm62e0702a1.htm?s_cid=mm62e0702a1_e, Accessed July 2, 2013

⁶ Jones, C. M., Mack, K. A., & Paulozzi, L. J. (2013). Pharmaceutical overdose deaths, United States, 2010. *JAMA*, 309(7), 657-659

In sum, harm reduction strategies have a vast potential to reduce the adverse effects of alcohol and other drug use. The Office of National Drug Control Policy (ONDCP) describes the need to complement current national policies intended to discourage use, provide treatment, and reduce the supply of illegal drugs, with additional harm reduction approaches to reach those currently not in treatment. Most individuals who meet criteria for a diagnosis of substance use disorder will change their behavior through use of social support, positive incentives, identifying how their lives will improve from the change, and/or from helpful conversations with professionals or others. In addition, prescription drug monitoring programs can play an important role in reducing misuse of OPRs.

Too many people, disproportionately from poor communities and persons of color, are jailed or incarcerated for possession of drugs, or for committing non-violent offenses related to their alcohol or drug use -- yet these domestic law enforcement activities (criminal prosecution, sentencing, and incarceration) have failed to reduce the problem, and high recidivism rates demonstrate this response not only is costly but also ineffective.

Opportunities. There are new opportunities for communities to embrace harm reduction. Communities can redirect (and save) some of the vast resources devoted to downstream, too-late medical treatments and expensive incarceration of low-risk, non-violent persons disabled by alcohol and drug abuse. This White Paper reviews upstream, preventive solutions being implemented in different communities. These strategies tend to be data-driven, involve a network of local systems, and/or coordinate a public health response that is based on harm reduction principles. The authors present a paradigm of harm reduction that focuses on fundamental goals that is intended to bring together providers and systems that historically may have worked at cross purposes.

One catalyst to invigorate a public health paradigm of harm reduction is the opportunities provided by the Affordable Care Act of 2010. A second catalyst is the growing policy interest in data-driven, evidence-based approaches to social problems, and the increased numbers of community-based agencies that are striving to demonstrate they can improve outcomes. These approaches are embodied in an emerging trend towards funding based on social investment strategies and performance-based models.

Communities may find that the time is right to more broadly apply harm reduction strategies that will substantially reduce demands on state budgets. For example, budget pressures have already fuelled in some states the pendulum's swing away from building more prisons towards adopting sentencing reform. We use some examples from the Open Society Foundation's community grantees of the Closing the Addiction Treatment Gap demonstration to illustrate how bold proposals can be developed and adopted when a data-driven community coalition advocates for such change.

Further Reading on the Current Situation

Bouchery, E. E., Harwood, H. J., Sacks, J. J., Simon C. J., and Brewer, R. D. (2011). Economic costs of excessive alcohol consumption in the U.S., 2006. *American Journal of Preventive Medicine*, 41(5):516-524

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Stoicescu, C., Cullen, L., Toska, E., Cook, C., & Abrickaja, L. (2012). *The global state of harm reduction 2012: Towards an integrated response*. London: Harm Reduction International, Public Health, Research and Policy Programme. http://www.ihra.net/files/2012/07/24/GlobalState2012_Web.pdf Accessed August 14, 2012

¹ <http://tricare.mil/tma/dhcape/surveys/coresurveys/surveyhealthrelatedbehaviors/downloads/2008SurveyQ&As.pdf>

2. DEFINITION OF HARM REDUCTION

The authors propose a definition of harm reduction which is an inclusive notion – a philosophical approach, as well as specific policies, practices, and interventions intended to reduce harm when people use drugs, including alcohol and tobacco. Harm reduction comprises a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. It recognizes some harm to people who use drugs is the result of current policies and practices (i.e., arrests and convictions stigmatize and reduce opportunity for full economic participation). It recognizes that people unable or unwilling to abstain from drug use (hereafter, the term drug is inclusive of alcohol) can still make positive choices to protect their health and well-being, and the well-being of their communities. Harm reduction can include medical services, public health interventions, expanded access to treatment, and social services, as well as activities designed to counteract adverse consequences from policies that rely on prosecution and incarceration of drug users.

Harm reduction includes a range of evidence-based approaches that recognize that people unable or unwilling to abstain from harmful drug and alcohol use can still make positive choices to protect their health, and the health of their families and communities.

Given this broad definition, harm reduction activities are consistent with person-centered approaches; it means meeting people where they are at –emotionally, socially, and with respect for their beliefs. It means supporting people to be functional and productive without regard to their current alcohol or drug use. At a societal level, harm reduction aims to empower drug users to reject the stigmatized identity of addiction. Harm reduction practitioners recognize that drug users can be empowered to advocate for their own health.

2.1 Harm Reduction Principles

Harm reduction has key principles or tenets that distinguish it from other interventions and strategies and govern choices in program design and interactions with people to whom services are offered. Defining harm reduction by its principles may garner broad support from many community stakeholders, including those who traditionally identify themselves as ‘abstinence-only’ in philosophy. The Harm Reduction Coalition and the clinical principles of harm reduction psychotherapy state that harm reduction

- *Accepts, for better or worse, that drug use is part of our world, and drugs may be used for adaptive reasons, and chooses to work to minimize the harmful effects of drugs rather than simply ignore or condemn them.*
- *Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and recognizes that drug use falls on a continuum of harmful consequences.*
- *Establishes quality of individual and community life and well-being—not necessarily cessation of all drug use—as the criteria for successful interventions and policies, and recognizes that engagement in harm reduction can be a first step in treatment engagement.*
- *Calls for non-judgmental, non-coercive, low-threshold provision of services and resources to people who use drugs and the communities in which they live, to assist them in reducing attendant harm.*
- *Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them, and a good place to start is meeting the individual or patient where he or she is.*
- *Affirms drug users themselves as the primary agents of reducing the harms of their drug use, recognizes their strengths, and seeks to empower users to share information and support each other in strategies that meet their actual conditions of use and to develop collaborative, empowering relationships with clinicians.*

- *Recognizes that environmental issues (poverty, class, racism, discrimination) affect people's vulnerability to drug-related harm and capacity for effectively dealing with it, and that substance use problems are best understood and addressed in the context of the whole person in her social environment and that goals and strategies emerge from the therapeutic process.*

Many of these individual principles share common attitudes and beliefs central to evidence-based behavior change strategies such as motivational interviewing, person-centric care, and public health prevention.

Thinking beyond Current Paradigms

If personal health care and addiction treatment programs adopted the principles of harm reduction, would...

- More people enter treatment programs?
- Health care and addiction treatment be more patient-centered?
- More lives be saved?
- Communities get behind these efforts and undertake campaigns to promote the dissemination and adoption of harm reduction principles?

Further Reading on Definition and Principles of Harm Reduction

Drug Policy Alliance. Harm Reduction. <http://www.drugpolicy.org/harm-reduction>. Accessed June 15, 2013

Harm Reduction Coalition (2012). Principles of Harm Reduction. <http://harmreduction.org/about-us/principles-of-harm-reduction/> Accessed November 27, 2012

Inciardi, J.A. and Harrison, L. D. (Eds). (2000). *Harm Reduction: National and International Perspectives*. Thousand Oaks: Sage Publications, Inc.

Lenton, S. and Single, E. (1998). The definition of harm reduction. *Drug and Alcohol Review*, 17, 213-220. <http://onlinelibrary.wiley.com/doi/10.1080/09595239800187011/pdf> Accessed June 25, 2013

3. GOALS AND OUTCOMES OF HARM REDUCTION

Increasingly people view harm reduction as a health and community imperative, to prevent unhealthy substance use, associated harm, and crimes against people and property; reduce associated costs; and improve community, family, and individual health and well-being. To be most effective, harm reduction must encompass policy change as well. Such changes can be accomplished by building multi-sector alliances to increase access to harm reduction services and addiction treatment services that use a harm reduction approach. This discussion of outcomes is based on discussions the authors held with expert informants and a literature review. It is organized by three main themes: personal and family care; community health and well-being; and policy change.

3.1 *Improved Personal and Family Health*

For individuals, harm reduction activities aim to support drug users to make positive choices to protect their health. Core principles of harm reduction recognize that adverse consequences can be addressed without drug use abstinence, and engagement can lead to reduced use and positive change. Addressing personal health through harm reduction is a health imperative. Health and substance use treatment providers, harm reduction and other social service providers, and social policies are all implicated in facilitating behavior change to improve personal health.

Desired personal harm-reduction outcomes include, to:

- Prevent or reduce mortality and reduce morbidity directly associated with drug use
 - Overdose and overdose fatalities
 - Transmission of infectious diseases such as HIV, Hepatitis C, viral hepatitis, sexually transmitted disease, and tuberculosis
- Reduce complications of other conditions and diseases that are worsened by drug use
- Prevent and reduce acquaintance and intimate partner violence
- Improve birth outcomes and neonatal health and development
- Prevent and reduce incidence of children removed from parent and placed in foster care
- Prevent and reduce driving under the influence, and driving crashes, injuries, and deaths

3.2 *Improved Community Well-being*

Most of the harms (e.g. incarceration, homelessness) from current U.S. drug and drug enforcement policies are concentrated in poor communities, while most of the benefits (e.g. employment, income) of current US drug and drug enforcement policies are concentrated in communities with higher socioeconomic status. A prior history of convictions from drug use can lead to lifelong unemployment, underemployment, lack of housing, loss of relationships, and loss of civil rights. Addiction treatment, social service, harm reduction, law enforcement, and criminal justice systems can play an important role in bridging service silos, empowering peers, and preventing or minimizing harm from unhealthy drug use. Improving community well-being means improving the quality of life for all community members. Reducing drug-related crime, homelessness, and incarceration of community members for minor drug offenses can improve the quality of life and economic productivity of the whole community. Evidence suggests that harm reduction can reduce the stronger negative impact of drug use and can increase the positive aspects of a healthy community.

Desired community harm reduction outcomes include to:

- Reduce stigma and lost productivity associated with convictions and incarceration for minor offenses and drug possession
- Reduce recidivism and re-incarceration associated with non-violent, low-risk, drug offenses and parole/probation violations
- Improve public safety and public order as a result of reduced criminal behavior and drug-related crime
- Reduce child abuse and neglect, foster care costs, and need of child protective services
- Reduce homelessness and related social and health costs
- Increase employment and economic opportunities for drug users

3.3 Policy Change

Policy change often requires coordinated efforts across sectors – primary health, addiction treatment, criminal justice. Policy change involves gathering and disseminating evidence about what works and what doesn't. When focused on substance abuse, it requires stories that help peers, policymakers, and providers to understand how current policies affect individuals living with substance use and motivate action for change.

Desired harm reduction policy outcomes include:

- Change environments that contribute to problematic drug use and to harm from drug use
- Provide alternatives to arrest and incarceration of non-violent drug users
- Provide services outside of formal addiction treatment aimed at evoking behavior change among individuals using drugs (e.g., supportive housing)
- Modify reimbursement systems and payment schemes to reward outreach, engagement, and success with drug users (a group which typically will have worse than average health outcomes)
- Adopt payment schemes that permit inclusion of a broad range of basic care and social services in order to improve health
- Generate increased data on effectiveness of a broad range of harm reduction activities and strategies
- Bridge gaps between systems and providers that will achieve better outcomes through coordination of care for drug users

Further Reading on Goals and Outcomes of Harm Reduction

Office of National Drug Control Policy. (2013). National Drug Control Strategy. Washington DC: The White House. (<http://www.whitehouse.gov/ondcp/drugpolicyreform>)

Rhodes, T., & Hedrich, D. (2010). Harm Reduction: Evidence, Impacts and Challenges. EMCDDA Monograph 10. Lisbon: European Monitoring Centre for Drugs and Drug Addiction. <http://www.emcdda.europa.eu/publications/monographs/harm-reduction> Accessed August 23, 2012.

4. A PUBLIC HEALTH FRAMEWORK OF HARM REDUCTION

Harm reduction activities fall along a continuum of public health strategies that encompass individuals, families, communities, service providers, and public agencies. Some harm reduction activities aim to reach population groups--others target the individual client. Some are implemented by former and active drug users and their peers, individuals, and communities, and some by practitioners. Harm reduction principles support interventions based on a philosophy of respect and self-empowerment, and that are patient-centered and respect personal choices as alternatives to mandates and restrictions. These principles support actions that use positive incentives to promote positive change rather than negative incentives (i.e., punishments). Harm reduction activities that are adopted and expanded should have evidence of effectiveness. Psychological theory has been applied to the design of many medical and social service interventions intended to effect and maintain behavior change. This literature has established the greater efficacy of positive incentives (rewards) compared to punishments, including withdrawal of rewards.

The author's propose a public health framework, or continuum of harm reduction activities, that includes activities within Robert Gordon's seminal model of prevention activities (Figure 1). In this model, prevention is comprised of interventions *before* the index problem (drug use harm) is manifested. "Universal" prevention activities are aimed at behavior-oriented strategies applicable to those with average risk of harm from drug use; "selective" prevention actions are aimed at groups of individuals with elevated risk of developing harm from drug use; and "indicated" actions are aimed *at the individual* with elevated risk.

In addition to these behavioral approaches, this public health framework includes "environmental prevention", approaches that involve making structural changes that influence everybody and address social, formal, and cultural norms. Lastly, this framework includes medical services and treatment services at the most intensive end of the continuum as tertiary prevention, i.e., increasing safer drug use through low-threshold treatment services.

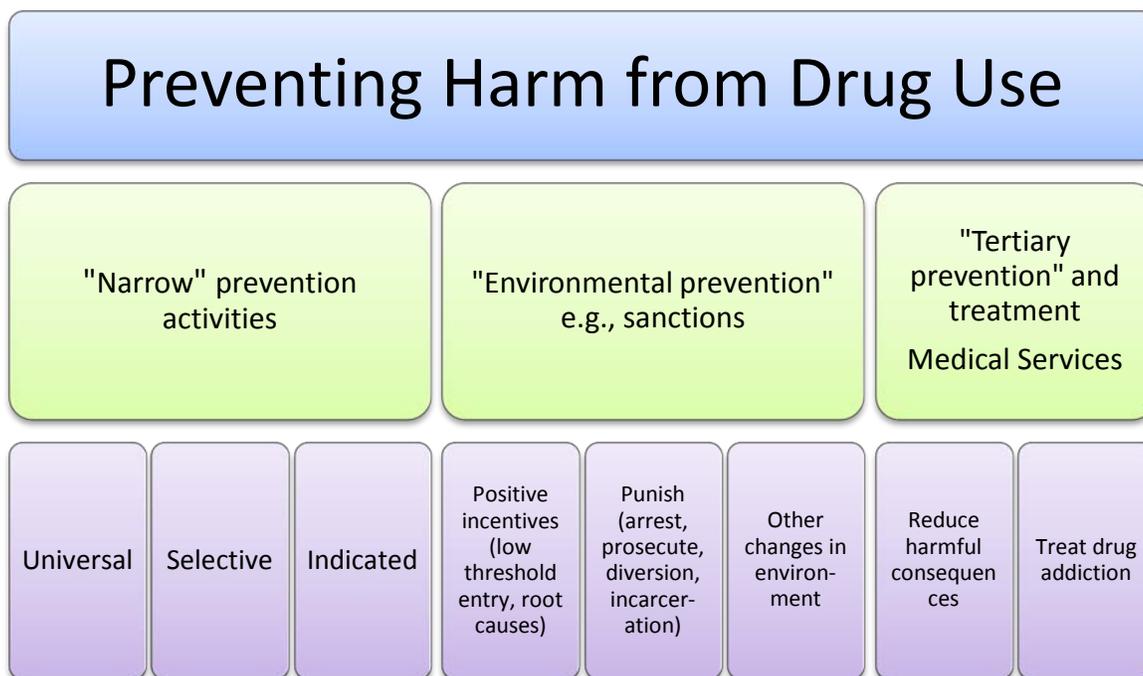


Figure 1 Public Health Classification of Harm Reduction Activities

Adapted from Gordon. R. S. (1983).

4.1 Investing "Upstream"

The Affordable Care Act of 2010 and the public health framework both recognize the value of prevention interventions. But there is also an argument for transformational public health initiatives that focus on legislative

and policy interventions and promote structural change in societal inequities that contribute to poor health, unhealthy behaviors, and disability.

In his 1974 address to the American Heart Association, John McKinlay called for public health to address the “broad social structural factors influencing the onset” of disease and at-risk behaviors, in other words the social, political, and economic contexts involved in disease initiation. His analogy borrowed from Irving Zola who was talking about treating patients presenting with disease:

“...sometimes it feels like this. There I am standing by the shore of a swiftly flowing river and I hear the cry of a drowning man. So I jump into the river, put my arms around him, pull him to shore and apply artificial respiration. Just when he begins to breathe, there is another cry for help. So I jump into the river, reach him, pull him to shore, apply artificial respiration, and then just as he begins to breathe, another cry for help. So back in the river again, reaching, pulling, applying, without end, goes the sequences. You know, I am so busy jumping in, pulling them to shore, applying artificial respiration, that I have no time to see who the hell is upstream pushing them all in”¹ (p 578).

Translated, this excerpt calls for public health initiatives to refocus attention away from groups living with chronic conditions such as obesity, cardio-vascular disease, or end-stage addiction and towards the political and economic forces that have shoved people into the river in the first place. Punishing people “for not being able to swim” after the “manufacturers of illness” (e.g., cigarette, alcohol, and pharmaceutical manufacturers) means blaming the victim (p 583).

4.2 Gradualism Concept of Addiction Treatment

Scott Kellogg introduced the idea of redefining the addiction treatment system by introducing services that recognize and support the incremental nature of human behavior change, or gradualism. This concept views harm reduction, moderation in use, substance use treatment, and abstinence as occurring on a therapeutic continuum. The concept of gradualism explains why moderation and safe use of drugs are useful goals for many individuals at certain stages of change, and that incremental steps may lead to the individual recognizing and choosing abstinence as the ultimate goal. The implication is that to have a larger appeal and to engage more individuals, treatment agencies should expand their treatment goals to match the drug user’s stage (Figure 2).

Active drug user willing to practice safer use	Active drug user experimenting in reducing drug use or finding alternative activities	Personal goal of experimenting with abstinence and seeks increased skills for positive change
<ul style="list-style-type: none"> • Naloxone education and distribution • Designated driver • Low-threshold opioid substitution therapy • Syringe exchange & education • Housing First • Harm reduction therapy 	<ul style="list-style-type: none"> • Brief counseling and active follow-up in primary care • Motivational interviewing (what do they want to change?) • Job training, skill building • Housing First • Harm reduction therapy 	<ul style="list-style-type: none"> • Motivational interviewing • Integrated care • Address chronic pain with interdisciplinary team • Support for positive change • Peer empowerment • Sober housing

Figure 2 Gradualism applied to treatment programs implies a continuum of expanded activities

Adapted from Kellogg, S.H. (2003)

In sum, gradualism implies expanding the focus of the addiction treatment system to support incremental changes as a drug user learns and decides to replace unhealthy behaviors with healthier ones, which eventually

¹ McKinlay, J. B. (2009). A case of refocusing upstream: The political economy of illness. In P. Conrad (Ed.), *The Sociology of Health & Illness: Critical Perspectives* (Eighth ed., pp. 578-591). New York, NY: Worth Publishers.

may involve treatment and choosing abstinence. Gradualism means applying a long-term approach to engaging all individuals with unhealthy drug use and addressing their accompanying chronic conditions.

Further Reading on Harm Reduction Models and Concepts

Kellogg, S. H. (2003). On "Gradualism" and the building of the harm reduction-abstinence continuum. [Editorial Material]. *Journal of Substance Abuse Treatment*, 25(4), 241-247

Gordon, R. S. (1983). An operational classification of disease prevention. *Public Health Reports*. March-April 1983, Vol. 96, No. 2 107-109

McKinlay, J. B. (2009). A case of refocusing upstream: The political economy of illness. In P. Conrad (Ed.), *The Sociology of Health & Illness: Critical Perspectives* (Eighth ed., pp. 578-591). New York, NY: Worth Publishers

Miller, W.R. and Rollnick, S. (2012). *Motivational Interviewing: Preparing People to Change Addictive Behavior*. Third Edition. New York: The Guildford Press.

(The) National Prevention Council (2011). *National Prevention Strategy: America's Plan for Better Health and Wellness*. Washington, DC: U.S. DHHS, Office of the Surgeon General.

Stout, D. (2009). *Coming to harm reduction kicking and screaming: Looking for harm reduction in a 12-step world*. Bloomington, IN.

5. HARM REDUCTION STRATEGIES

The spectrum of harm reduction strategies now being used in the U.S. is broad and includes HIV/AIDS related interventions, drug treatment without requiring abstinence, drug use management, and advocacy for drug policy change. While the earliest discussion of harm reduction in the U.S. (and elsewhere) was motivated by the HIV epidemic among injection drug users, this white paper extends the focus of harm reduction beyond ‘traditional’ activities (while not neglecting them), and highlights new target populations and a range of activities already underway. Harm reduction strategies used in the U.S. today often comprise a “combination intervention” or package of activities adapted to a local context.

This section is organized by the three groups of actors or change agents: medical systems of care, addiction systems of care, and harm reduction organizations with other systems and coalitions. Each section provides background information on the problem and context, a list of suggested strategies, and brief descriptions of model programs.

5.1 *Upstream Strategies in Personal Health Care*

The 1978 Alma-Ata Declaration states that primary health care is essential health care “based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community” and offered “as close as possible to where people live and work”¹. It calls for a broad conceptualization of health, to include mental and social well-being as well as physical health. It recommends that primary health care evolve from local conditions and incorporate preventive, curative, and chronic aspects. The declaration recommends using a team approach to provide integrated care, under one roof or in partnership with different providers, agencies, and organizations. Its authors call for bridging family medicine, public health, preventive medicine, and community-based care.

More than thirty years after this seminal declaration, Alma-Ata and its goals have yet to be realized. An integrated approach to personal and family care remains valued today and harm reduction should be an overarching lens for that integrated approach. Health care providers, programs, and systems should adopt a range of service-delivery strategies to reduce the personal and family harm associated with drug and alcohol use, particularly among those with abuse and dependence that remains untreated.

Passage of the Affordable Care Act (ACA) in March 2010 has changed the policy context for low-income, uninsured people in the U.S., and for all citizens living with chronic illness. ACA has implications for drug users and the organizations that serve them. As part of the general impetus provided by the ACA to offer integrated specialty and general medical services, specific opportunities built on harm reduction principles can now be considered, including: (a) integrating substance use and mental health services into primary care, (b) packaging as billable certain harm reduction services, and (c) advocating for prevention, screening and treatment of HIV and viral hepatitis in essential health-care services.

Strategies

Personal care is provided in many settings, from hospitals to community clinics, managed care programs, pharmacies, schools, jails and prisons, and mobile units bringing health care where people live or work. All of these settings could deliver care using a harm reduction lens. New integration/support is needed in primary care settings to support harm reduction, and there are strategies that can be implemented in primary care settings that are clear examples of harm reduction. These include techniques such as brief screening and counseling for addiction that can be integrated into personal care for all patients, whether substance use is apparent or not.

¹ See Hixon, A. L., & Maskarinec, G. G. (2008). The declaration of Alma Ata on its 30th anniversary: Relevance for family medicine today. [Essays and Commentaries]. *Family Medicine*, 40(8), 585-588.

Other strategies such as motivational interviewing are targeted for those with identified substance use, while others such as health homes can be appropriate for those identified with a problem.

1. Build new expectations and infrastructure for preventative initiatives.

Harm reduction is becoming part of treatment and provider consciousness. Medical training curricula now include aspects of harm reduction, e.g. brief intervention and motivational interviewing, which may be aimed at harm reduction goals when implemented in emergency departments. The current prescription drug epidemic is prompting harm reduction to become main stream and is triggering a therapeutic intervention response as opposed to the criminal justice response of the past. Government agencies that oversee harm reduction and treatment services in turn are beginning to expand their view of recovery and acknowledge that abstinence is not the only option, though they may not call their approach harm reduction. However, progress to date is slow. The movement of change in harm reduction attitudes and consciousness may be more of a steady creep. Although, on the positive side, support is emerging for overdose protection through Emergency Departments, and, buprenorphine brings back the role of the medical care provider in harm reduction.

An integrative model of health care views harm reduction as incorporating basic principles of good clinical practice into the treatment of addictive behaviors and, this paper argues, into primary health care also. A patient-centered primary health care package for individuals with suspected unhealthy drug use includes screening for blood-borne infections, sexually-transmitted infections, and tuberculosis, multiple vaccinations that are not otherwise offered to most adults, and appropriate access to treatment for HIV and viral hepatitis. Some settings deliver integrated primary health care under one roof; others may ally with other settings thus providing access to a continuum of integrated personal care, while others may expand their current services and offer new ones.

Clinical Care for Pregnant Women using Methamphetamine: PATH

Drug use during pregnancy is a complex problem often combined with poverty, interpersonal violence, psychiatric comorbidity, polysubstance use, nutritional deficiencies, inadequate health care and stressful life experiences. Engaging and keeping drug-using pregnant women in prenatal care is key to improving birth outcomes. In 2006, the Hawaii State Legislature funded The Perinatal Addiction Treatment (PATH) Clinic of Hawaii as a pilot project. It was built on a harm-reduction model, encompassing comprehensive services: perinatal care, transportation, child-care, social services, family planning, motivational incentives, and addiction medicine. During its first 3 years, 213 women with a past or present history of addiction (86% methamphetamine) were seen, 132 were pregnant and 97 women had 103 live-born infants, and all but 4 (96%) women had negative urine toxicology at the time of delivery. Overwhelmingly, the women were parenting their children; greater than 90% retained custody at 8 weeks. Long-term follow-up showed that women who maintained custody chose long-acting contraceptive methods. State funding for PATH has ended but the program is being maintained by a community health center on the Salvation Army campus in Oahu.

Several informants noted that family planning and reproductive health services are being brought into drug treatment and harm reduction clinics. Informants also noted that providing substance-using clients with access to preventive dental care can be an important public health harm reduction strategy.

2. Create a Medical Home for Drug Users with Chronic Health Problems.

A specific form of integrated health care for populations with two or more chronic conditions is being promoted by the Affordable Care Act of 2010, the Health Home. For eligible individuals with chronic conditions, health home services can be provided by a designated provider or a team of health care professionals. When serving a drug using population, these teams and providers should adopt a harm reduction philosophy and be skilled in patient-centered care. The medical home services permitted under Medicaid include:

- comprehensive care management
- care coordination and health promotion
- comprehensive transitional care

- patient and family support
- referral to community & social support services
- health information technology to link services

Routine and restorative dental care may be particularly urgent for many drug users. For example, among methamphetamine users, “meth” mouth refers to the horrible tooth decay due to the dry mouth accompanying chronic meth use and effects of the acidic materials used to cut methamphetamines. Mouth or tooth pain and rotten teeth impact self-esteem and motivation to change. Healthy teeth and gums reduce stigmatization and increase employability. Restorative dental treatment is needed for individuals for whom disfiguring tooth decay or loss leads to employment stigma.

3. Address patients’ chronic pain.

According to the American Academy of Pain Management (AAPM) Web site, pain is the number one reason patients seek medical care. Chronic pain affects 100 million Americans with the leading cause being low back pain (27%). Pain is a public health problem that costs society between \$560 and \$635 billion annually due to health care and lost productivity costs, yet very little progress has been made in treating pain and suffering.¹

The overall quality of treatment of pain is viewed by many as unacceptable for patients with acute and persistent pain, leading to suffering, abuse, addiction and sometimes even more serious consequences. For example, abuse of prescription drugs was the second leading cause of accidental death in 2007, second only to motor vehicle crash deaths.² Death caused by prescription pain drugs is higher than deaths caused by cocaine and heroin combined,³ and mean annual health care costs are more than eight times higher for opioid abusers than for non-abusers.⁴

Too often in the current medical model of care, the physician is the team leader who ‘does something’ to the patient, e.g., prescribes a medication, and the patient becomes a passive participant in the relationship. This approach is particularly ineffective for patients with chronic pain, as it leads to lack of ownership for their condition and frustration with medical care that cannot cure their pain. Chronic pain occurs with very high prevalence among individuals with chronic alcohol and drug problems⁵, and persistent moderate-to-severe pain is associated with poor functioning and fuels return to alcohol and drug abuse.

One promise of the medical home is an integrated, interdisciplinary team that can better monitor persons with chronic medical conditions. An integrative and interdisciplinary approach includes the following care components: complementary and integrative therapies, pain treatment medicine, osteopathic manipulation, primary care pain management, a stepped care model, and a musculoskeletal action plan. Even in the absence of a medical home, primary care providers who serve patients with chronic alcohol and drug problems should adopt an integrative, interdisciplinary approach to managing patients’ pain, which means a redesign of the way care is provided. Essential ingredients include⁶:

¹ http://www.painmed.org/patientcenter/facts_on_pain.aspx

² CDC (2010) Unintentional Drug Poisoning in the United States. <http://www.cdc.gov/homeandrecreationalafety/pdf/poison-issue-brief.pdf>

³ <http://www.cdc.gov/homeandrecreationalafety/pdf/poison-issue-brief.pdf>

⁴ White, A. G., Birbaum, H.G., et al. (2005). Direct cost of opioid abuse in an insured population in the United States. *J Manag Care Pharm*, 11(6):469-79.

⁵ Savage, R., Kirsh, K. L., and Passick, S. D. (2008). Challenges in using opioids to treat pain in persons with substance use disorders. *Addiction Science & Clinical Practice* 4(2), 4-25.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2797112/#_ffn_sectitle

⁶ For more details of this approach see the report of the U.S. Army Pain Management Task Force,

http://www.armymedicine.army.mil/reports/Pain_Management_Task_Force.pdf

⁸ Wodarski, J. S., Macmaster, S., & Miller, N. K. (2012). The use of computer technology to reduce and prevent college drinking. *Soc Work Public Health*, 27(3), 270-282

- Incorporate complementary and alternative therapies (e.g., yoga, mindfulness) into an individualized pain management plan of care
- Educate all physicians, nurses, patients, and families about the full range of pain treatments
- Train primary care providers on safe opioid prescribing practices including the risk factors of prescription drug misuse
- Chart pain as the “fifth vital sign” and give prompt response to unrelieved pain
- Use expert consultants and “high technology” pain treatment interventions for the small number of cases where simpler measures do not suffice
- Provide other palliative treatments such as counseling, cognitive treatment for symptoms, exercise regimens, and other supportive care to supplement medications to treat pain symptoms
- Respect patients' and families' values and preferences regarding care

4. Identify and screen patients for excessive drinking using ‘SBIRT’, implement provider reminder systems for and use alternative methods for providing ‘SBIRT’.

Screening, brief Intervention, and referral to treatment (SBIRT) is now being integrated into residency training such as OB/GYN, and into medical school training (similar to addition of post-partum screening into OB/GYN practice). Brief Intervention is appropriate in routine annual medical exams, and may be a useful strategy in other

Using Technology to Deliver Brief Alcohol Intervention with College Students

Underage drinking, or binge drinking, is a major concern in the U.S. At The University of Tennessee (UT) a 3-year computer-based intervention with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) was provided to all college students via UT's computer network system. More than 54,000 graduate and undergraduate students completed a computerized, standardized assessment of alcohol use online, and received a brief intervention if warranted based on the students' information. The intervention targeted students who were at highest risk for developing unsafe alcohol behaviors and/or increasing prior alcohol consumption habits in their first year of college. Since the launch of the program binge drinking has dropped 27% on campus, frequent binge drinking dropped 44%, and the number of liquor law violations to 18- to 20-year-olds decreased from 542 in 2004 to approximately 158 in 2007. The use of a computer-based intervention was comprehensive, low cost, and required low maintenance.⁸

circumstances as well, with patients visiting mental health providers, or when an individual is suspected to have a traumatic brain injury. Brief interventions in school settings can be used with high school and college students to reduce binge drinking (See also college model program).

5.2 Upstream Strategies for Addiction Systems of Care

Bringing harm reduction principles to addiction treatment could mean that more individuals begin to engage in the harm reduction and begin use of addiction treatment that is consistent with their personal goals. This engagement would further increase the cost-efficiency and effectiveness of public investments.

1. Recognize the potential of patient-centered, psychosocial treatment approaches that foster harm reduction.

A harm reduction approach to addiction systems of care means providing access to psychosocial services such as therapy and client-driven case management, even when individuals may still be using drugs or alcohol. Psychosocial approaches have been shown to reduce the harm from unhealthy drug use, reduce drug use, and engage individuals in treatment initiation. Two examples of psychosocial approaches that addiction services can use to engage active drug users in harm reduction are motivational interviewing and harm reduction therapy.

Motivational Interviewing. Motivational Interviewing is a collaborative, person-centered approach to elicit and strengthen motivation to change. It offers providers a useful framework for being with and interacting with people who are experiencing or struggling with substance use, mental illness, homelessness, and traumatic

experiences. Motivational Interviewing is rooted in an understanding of how hard it is to change learned behaviors, many of which have been essential to survival on the streets. Motivational interviewing is used by practitioners to facilitate positive behavior change toward reduced use, not necessarily abstinence. More than half of substance abuse treatment services (55.7%) already report using motivational interviewing often as a clinical therapeutic approach, and another 28.4% report they use it sometimes.¹ It is recommended that providers continue to use motivational interviewing to facilitate positive behavior change, and brief interventions to identify potential unhealthy drug use, especially for adolescents and young adults, and women of reproductive age.

Harm reduction therapy (HRT). HRT is an approach based on acceptance that each individual needs person-centric services or care. This care encourages each person to make his/her own decision about goals for therapy and treatment. HRT can engage individuals who are considered “untreatable” by many addiction programs because it recognizes the value of psychosocial support to individuals for “where they are at”, an idea well-explained by Alan Marlatt.² Addiction programs can partner with informal and public health settings which specialize in HRT where the primary purpose is to mitigate harm from drug use and improve mental health. Often offered in a group setting, HRT groups have different goals from traditional substance use treatment groups. Each group member is encouraged to determine for him or herself what they need most. Such groups accept their members’ diversity of drug use patterns, goals, and progress toward change.

2. Use incentives to engage drug users into services.

Financial incentives activate the same brain reward systems that drive repeated drug use and other risky behavior, such as consuming fatty foods. Evidence from laboratory research, treatment settings, and epidemiological studies show that impoverished environments enforce resistance to change, in part due to a bias towards the short-term or present, as opposed to the long-term or future. Thus “the more immediate euphoria of drug use” holds sway “over the delayed health benefits of a drug-free lifestyle”.³ Lower income or educational achievement contributes to this bias toward the “present”.

Financial incentive programs with individuals with unhealthy drug use have potential to reduce harm. Pilot programs are needed to gather evidence on the cost-effectiveness, outcomes, and patient experiences of using incentives to reduce the harm from unhealthy drug use, particularly in disadvantaged communities.

Financial incentives activate the same brain regions that respond to drug use. Thus financial incentives and other material incentives can “reinforce healthy choices and enlist the same powerful process of reinforcement and associated neurobiological processes that drive unhealthy behavior”. The brain and behavior effects of financial incentives may be particularly urgent in deprived or resource-poor environments. Voucher-based incentives integrated with vocational training have been shown to produce long-term abstinence among inner-city, chronically addicted illicit drug abusers and homeless alcoholics, again populations for whom effective interventions are sorely needed.

3. Adopt low-threshold approaches for drug users not in treatment.

The homeless population has higher rates of substance abuse than housed populations. Traditionally, homeless shelters ban alcohol. Housing First is an evidence-based practice that looks at housing as a tool, rather than a reward, for positive change. It is an approach to ending homelessness that centers on providing permanent housing first and then providing services as needed and requested. Pioneered by Dr. Sam Tsemberis from Pathways to Housing in New York City, and also supported in many communities by a large SAMHSA/VA/HRSA

¹ Office of Applied Studies, Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS), 2007. <http://oas.samhsa.gov/nssats2k7/NSSATS2k7Tbl4.10.htm>. Accessed July 9, 2013.

² Marlatt, G. A., Larimer, M. E., & Witkiewitz, K. A. (Eds.). (2011). *Harm reduction: Pragmatic strategies for managing high-risk behaviors* (Second ed.). New York, NY: Guilford Press

³ See Higgins, S. T., Silverman, K., Sigmon, S. C., & Naito, N. A. (2012). Incentives and health: an introduction. *Prev Med, 55 Suppl, S2-6*. doi: 10.1016/j.ypmed.2012.04.008

demonstration, Housing First believes that most persons experiencing chronic homelessness are ready for housing. Housing First as a harm reduction strategy can involve changing official and unofficial housing policies that deny housing to drug users or convicted drug users who would be otherwise ineligible for housing and welfare subsidies.

Nurse-Managed Clinics and Housing First

The San Francisco Department of Public Health has been providing “Housing First” permanent supportive housing for chronically homeless, mentally ill, substance using adults since 1999. They manage approximately 1,500 units of housing in 30 buildings. In eight of the 30 buildings, on-site nurse-managed clinics provide nursing case management and support based on harm reduction principles. Each site is staffed with supportive social services as well. For individuals housed in these supportive housing apartments, analysis has shown that the cost of housing and on-site services plus healthcare costs after housing is less than the cost of healthcare services alone prior to housing placement. A case study of two sites with full-time Nurse-Managed Clinic showed a decrease in need for emergency services, a decrease in average inpatient hospital days, a decrease in mental health relapse rate, and increased housing retention, despite continuing drug and alcohol use among the tenants.

4. Create an integrated service network with seamless access to support services for positive change.

States and communities can bring together treatment and other support services providers from different communities and referral organizations to create an integrated service network. SAMHSA’s Access to Recovery (ATR) grant program (grants awarded 2004-2010) found that most state and tribal systems believe the ATR integrated service systems they have built are an important advance toward providing holistic care for individuals seeking positive change regarding their drug use. ATR is based on the knowledge that there are many pathways to recovery from substance use (note, this program is geared towards abstinence but has features that support positive change even when abstinence is not the goal). The promise of this initiative, founded on a belief in individual choice, is ensuring that a full range of treatment options are available, which in some communities includes non-traditional services such as acknowledging a person’s choice to rely on faith-based organizations. Once a client is assessed and a recovery plan established, the client can choose any authorized recovery provider for each service identified. Funds for these services are reserved for this person/family member using a voucher. Some examples of the recovery services available are: mental health counseling, preventive services for client family members, transportation, transitional housing, child care and job readiness/vocational counseling. While this model has been based on an ‘abstinence’ orientation, its features could be adapted to expand services to persons who have harm reduction goals but who have not committed to abstinence.

Organizations with different funding streams have begun to work together to provide an integrated service network with seamless access to recovery support services. While the ATR program does not explicitly endorse principles of harm reduction, its elements focus on systems change and on sustainability. States with ATR programs could explore transforming the program to incorporate harm reduction principles as one way to enhance outcomes of the whole addiction and recovery support system. The program elements, consistent with harm reduction principles, are¹:

- Expansion of services: Services other than clinical treatment are introduced into systems of care. Multiple needs and strengths are supported through the delivery of positive-change support services.

¹ For further information see the Access to Recovery Implementation Toolkit, <http://store.samhsa.gov/product/Access-to-Recovery-Implementation-Toolkit/SMA10-ATRKIT>.

- Expansion of providers: New substance abuse services are delivered by support services providers and from agencies outside the formal addiction treatment system, including providers of transitional housing, job training and employment services, community reentry services, family and children services, primary health care, legal services, and transportation services.
- Client choice: Clients are involved in directing their own care and given choices of providers. Pre-authorized services reimbursed through clients' vouchers.
- Increased reporting of outcomes data.

The following box provides an example of ATR in Washington State.

Access To Recovery Grant in Washington State

The State of Washington directly funded six counties to implement an ATR voucher program with relative autonomy. Most participating counties worked directly with community-based and faith-based organizations to design and implement voucher programs, to define the array of ATR-eligible services that would be made available in each county, and to determine how best to coordinate and track services. The state's multistage process for eligibility determination, assessment, and service planning typically begins with a client advocate who performs an initial screening to determine whether or not there may be a substance use disorder and shares with likely clients an informational brochure on Washington ATR. The client advocate then elects to access a choice of agencies where they can engage with a recovery support system (RSS) representative who verifies ATR eligibility, and in partnership with the individual seeking services, develops a recovery plan. The RSS issues vouchers to procure the desired recovery support services from the ATR-enrolled providers and refers the individual to a treatment provider for an assessment. Vouchers will also cover treatment services when access to appropriate services would not otherwise be available. Washington State reports that ATR has had a number of beneficial effects. It has led to a more person-centered approach to services in which individual choice and preference have heightened importance, there is greater emphasis on culturally specific services, and there is openness to and acceptance of spiritual support and other services that have not historically been funded. In addition, ATR has played a role in moving the State toward a service paradigm designed to support recovery.

5.3 Upstream Strategies for Harm Reduction Organizations Working with Other Systems and Community Coalitions

This time is a critical juncture for reframing the debate about how to use limited public expenditures to reduce harm from drug use. There is increasing public debate about the best use of public health funds and public safety funds and how to expand cost-effective approaches in an era of more limited government funds. While harm reduction approaches have been highly valued by many advocacy and policy organizations, such as the Harm Reduction Coalition, Drug Policy Alliance, and numerous grass-roots organizations,¹ this White Paper attempts to reframe the discussion of harm reduction in order to promote collaboration among the broadest range of community organizations on the common goal of reducing harms from drug use.

Public perceptions are changing about the effectiveness of criminalization of drug use. There is new dialogue about cost-effective strategies to ensure and increase public safety. Criminal justice resources spent in pursuit and incarceration of non-violent drug users appear highly inefficient and have contributed to bulging, costly, correctional systems in many states.² Despite good intentions, some advocates believe that initiatives such as drug courts have made the criminal justice system more punitive toward addiction, not less. Strengthening community-wide approaches to harm from drug use requires convening and educating professionals and

¹ <http://www.harmreductiontherapy.org/content/harm-reduction-organizations>

² The Pew Charitable Trusts report

http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/sentencing_and_corrections/Prison_Time_Served.pdf

organizations for mutual understanding of approaches. This convening should include public health and public safety systems as well as grassroots organizations comprised of people who formerly or actively use drugs.

The feasibility of community-driven strategies to promote change for people using alcohol and drugs was demonstrated by The Open Society Foundations' demonstration project *Closing the Addiction Treatment Gap (CATG)*. The CATG initiative successfully implemented a series of national advocacy initiatives, and ten community coalitions were successful at promoting practices and policies to expand access to addiction treatment, including forming alliances to reform drug policy, and increasing funding for addiction treatment from local sources.¹

The authors of this White Paper recognize that the public health system and the public safety (i.e., criminal justice) system in each community appear seemingly at odds, both in approach and focus regarding treatment of drug users; but, indeed these systems share many common goals.² A local criminal justice system has the broad goal of protecting the community by reducing risks from crime and offenders. It strives to reduce risk and crime *in part* by reducing the likelihood, frequency, and severity of new crimes (re-offending) by persons already arrested and possibly incarcerated. When considering resources to apply to drug users who are arrested, it triages its resources using information it compiles on high risk repeat crimes. The tools used by the public safety system derive from legal coercion, including incarceration and community-based approaches such as supervision, community service, drug testing electronic monitoring house-arrest.

A local public health system is focused on providing services to improve health and social productivity. The public health system often uses a first-come, first-served approach (e.g., respond to requests rather than active outreach), it does not coerce use of services, and may not have a mechanism to triage resources to those posing the most public health risk. Also, it rarely triages resources based on assessment of risk to public safety (e.g., likelihood of violent or repeated crimes). Nevertheless, the public health and public safety systems do share common goals: to reduce harm from drug use, to reduce spread of infectious disease (i.e., HIV and hepatitis), increase use of early intervention strategies, diversion to treatment, and treatment on-demand.

Community partnerships can work together to build “on ramps” to affordable health care and “off ramps” via diversion to community-based and treatment.

The differing lens of the public health and public safety systems have presented barriers to coordination and collaboration on approaches and services for people harmed by drug use even regarding common goals. However, successful development of upstream prevention activities, and to get full benefit from implementing new provisions of the Affordable Care Act for people with harm from drug use and those arrested and/or incarcerated because of drug offenses requires a cohesive partnership among the organizations and professional involved in drug policy advocacy, public health, and public safety. These partnerships can change the drug policy environment if they are based on a mutual understanding of the issues. Community partnerships can work together to build “on ramps” to health care coverage and medical care and “off ramps” via diversion to community-based and treatment.¹⁴

Strategies

1. Change media representations of harm reduction and chronic drug users.

Harm reduction remains poorly understood by the popular media, despite the efforts of advocates, researchers, and fieldworkers. Even as needle exchanges were defunded nationally, journalists largely remained mum about the deeper principles this funding ban violated. Media coverage of harm reduction may maintain fallacies and perpetuate negative attitudes towards individuals using drugs and alcohol. Coverage may touch on both the

¹ <http://www.opensocietyfoundations.org/publications/closing-addiction-treatment-gap-early-accomplishments-three-year-initiative>

² We are indebted to Kathleen Dennehy, paper contributor and former commission of corrections, Commonwealth of Massachusetts, for the ideas related to the shared goals and unique tools of public health and public safety systems.

individual level stories and a greater framing of policy debates. Conducting a scan of media outlets (print, broadcast, and online) that the general public and policy makers in any given geographic area may be accessing is one way to begin to change media representations of harm reduction and chronic drug users. Questions to guide your scan can include: Do media representations adequately describe harm reduction as a philosophy? Does the narrative presented promote humane and effective interventions for substance users and other vulnerable populations, or does it promote a needlessly radicalized perspective on the practice? Once you have completed your scan, you can determine next steps. Begin by asking: What can professionals involved in research and outreach do to recontextualize harm reduction and push it towards common acceptance?

2. Make health reform work for harm reduction.

Rachel McLean of the California Department of Public Health encourages the harm reduction community to help primary care clinicians and other health professionals working in federally qualified health centers (FQHCs) and other health care settings outreach to people using drugs and other disadvantaged groups.¹ She has identified many potential roles for harm reduction organizations which are already working to reduce harm from unhealthy drug use and include the Harm Reduction Coalition, the Drug Policy Alliance, and the North American Syringe Exchange Network.²

Ms. McLean suggests:

- **Apply for and collaborate with new awardees.** By extension, the harm reduction community should identify and work in collaboration with awardees receiving funds from new initiatives being launched by the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention, and the Agency for Healthcare Research and Quality. (See the Table of Innovations in the Appendix which includes a summary of key projects sponsored by CMS.)
- **Develop and promote best practices and clinical guidelines.** Currently, there is no consensus document on best practices or a set of clinical guidelines about delivering comprehensive, harm reduction-based preventive services which incorporates mental health care, drug treatment, and health and dental care when serving people with chronic drug use histories. Such a document could be used to assess the patient-centeredness of mainstream medical programs serving populations with chronic disease, including drug addiction. Topics of such a guide should include infectious disease testing, prevention, and treatment, syringe exchange, drug treatment, overdose prevention, and soft tissue infections.
- **Train on and disseminate best practices.** Training, adoption, and dissemination of these best practices could be the focus of other activities within the harm reduction community. Assessment of public health capacity-building programs should include whether the needs of persons with drug addiction are adequately addressed.
- **Seek payment for harm reduction services.** Many initiatives are underway to bundle payments for services or integrate services into a chronic disease model. Harm reduction specialists and organizations should reach out to awardees, grantees, FQHCs, and primary care practices to contribute their services, their expertise, and their ability to expand the capacity of local programs. Reimbursement for these contributions should be included in the budgeting for these services under Medicaid, Medicare, and participating private practices. Ms. McLean offers the example of a local health clinic that wants to begin services for people with hepatitis C, but currently lacks experience providing social support to current and former drug users. As part of this collaboration, a partnership with a harm reduction organization or an addiction treatment provider that could provide expertise in providing peer support groups and patient navigation would be natural. The organization could train doctors and health professionals on programs for prescribing and patient education around naloxone for opiate-using patients (in particular those they prescribe opiates to) to reduce the risk of overdose.

¹ see <http://harmreduction.org/wp-content/uploads/2011/12/Communication16.pdf>

² To see a list of harm reduction organizations, see <http://www.harmreductiontherapy.org/content/harm-reduction-organizations>

- **Hold accountable those agencies developing health reform regulations.** Finally, as states and local governments develop health reform-related guidelines and regulations, harm reduction organizations and coalitions representing a range of substance use and harm reduction stakeholders should ensure that they will address the interests of drug users and their family members as well. Are the local policies, guidelines and regulations attentive to preventing and reducing harm among active drug users and inclusive of the continuum of service including low-threshold care such as syringe exchange?

San Mateo County Health System

San Mateo (California) County Health System Behavioral Health & Recovery Services (BHRS) has adopted a harm reduction approach under its Primary Prevention Framework process. The BHRS identified four prevention strategies that are intended to stem the flow of people who need intensive behavioral health services. These strategies focus on 1) enhancing place, 2) connecting people, 3) fostering prosperity, and 4) expanding partnerships. By integrating these strategies into the practices, policies, and everyday operations at BHRS, as well as into other departments within government and other sectors in the community, the social, physical, economic, and cultural environments can be modified to improve behavioral health outcomes and quality of life for people in San Mateo County. Intended outcomes of these four strategies include: Increased safety and physical environments that support social connection; reduced exposure to violence for children and youth, and supported families; reduced stigma and increased economic self-sufficiency for individuals at risk for mental health problems and substance abuse; and engaged community stakeholders including government sector, business community, and community residents.

3. Invest in the community's capacity to operate the full spectrum of prevention activities related to reducing harm from drug use.

An effective prevention strategy will target not just individual behaviors but also the environment in which they occur. Primary prevention focuses on the environment, the broad social and environmental context in which personal choices are made. According to Larry Cohen's seminal book¹, community prevention activities include:

- Influencing policy and legislation
- Promoting community education
- Educating providers
- Fostering coalitions and networks
- Changing organizational practices
- Strengthening individual knowledge and skills

4. Distribute naloxone and train good Samaritans to prevent opioid overdose.

Overdose deaths have increased steadily over the past decade. Rates of deaths and emergency department visits have increased dramatically, particularly for women aged 40 to 64. Since 2007, more women have died each year from unintentional drug overdose, particularly due to opioid pain relievers, than from motor vehicle accidents. Administering naloxone can reverse an opioid overdose and prevent these unintentional deaths. The overdose prevention drug can be administered by a lay person on the street or in a home or by medical staff in emergency departments. States with existing naloxone overdose prevention laws as of June 2013 include California,

¹ Chavez V. "The Imperative for Primary Prevention", in Cohen L and Chehimi S, ch 1, Prevention is primary: Strategies for community wellbeing, Second Edition, Jossey Bass, 2010.

Connecticut, Illinois, Massachusetts, New Mexico, New York, Rhode Island, and Washington. Law elements can include preventing individuals administering naloxone from being subject to criminal prosecution or civil liability.¹

Lazarus Project, North Carolina

In 2007, Wilkes County, North Carolina had the third highest drug overdose death rate in the nation, largely due to prescription opioid abuse. In response, Project Lazarus initiated a comprehensive, community-based drug abuse and overdose prevention program organized around five components:

- Community activation and coalition building
- Data collection and monitoring
- Primary care education on safe prescribing
- School-based education
- Distribution of naloxone to providers and patients to prevent overdose fatalities.

Project Lazarus coordinates these activities in collaboration with community organizers, local government, hospitals, law enforcement, the state’s Medicaid authority, schools, and state public health and mental health agencies, as well as clinicians, non-profit groups, social service and substance abuse treatment providers, and academic partners. Project strategies have included:

- Expand access to effective forms of substance abuse treatment
- Modify hospital emergency department policies on dispensing pain medicines
- Implement support groups for pain patients
- Train families, peers, and patients to recognize and reverse an opioid overdose with naloxone
- Educate physicians on managing chronic pain using toolkits developed by the community
- Monitor success through prescription history data collected through the state Prescription Drug Monitoring Program (PDMPs).

Overdose deaths decreased by 69% in Wilkes County between 2009 and 2011, with 28 straight months of steady declines. Between 2009 and 2011, hospital emergency department visits for overdose and substance abuse in the county were down 15%, while rates in the rest of the state increased by 7%.

5. Adopt and expand needle and syringe exchange programs.

Needle and syringe exchange programs (NSPs) provide sterile syringes free of charge without prescription. Such programs may also provide “sharps containers” for used syringes, to keep them off the streets and out of parks and dumpsters. In the U.S., NSPs are often offered through mobile vans. In NYC, now 21 sites are funded 80-90 percent by the city and state departments of public health.

Pharmacy access to needles may not be an appropriate substitution for the educational services that accompany harm-reduction oriented NSPs. In September 2006, Massachusetts legalized over-the-counter sales of syringes in pharmacies. After the legislation was passed, state syringe exchange programs saw a sharp decline in the number of program participants, but over time the number of visits to some exchanges grew to be equal to or greater than before pharmacy access. Reports from participants about their experiences and potential reasons for returning to syringe exchange programs include misinformation, poor treatment, and price gouging at pharmacies. Additionally participants do not receive any information about safer injection strategies, there’s no access to mental health/substance use treatment options, and there is no community knowledge sharing or support. While pharmacy access is important for prevention of HIV and viral hepatitis, experiences in Massachusetts show that there are unforeseen challenges with syringe access without the complimentary information, services and support. Needle exchange programs have been shown to reduce HIV incidence by 33% in New Haven and 70% in NYC.²

¹ See <http://lawatlas.org/preview?dataset=laws-regulating-administration-of-naloxone> for a map showing states with Naloxone overdose prevention laws.

² Hilton, B. A., Thompson, R., Moore-Dempsey, L., & Janzen, R. G. (2001). Harm reduction theories and strategies for control of human immunodeficiency virus: a review of the literature. *J Adv Nurs*, 33(3), 357-370

6. Develop and collaborate on harm reduction training for law enforcement personnel.

Efforts to increase awareness of the positive impacts that harm reduction efforts can have on individuals, their families, and communities are sorely needed, though they may at times fall on deaf ears. The term harm reduction remains a ‘branding’ challenge, equated with encouragement to use drugs. A focus on the disease model of addiction may also be a challenge to harm reduction, as the structural issues that underlie addiction and exacerbate harm may be ignored. Further, adherents to the disease model sometimes resist use of evidence-based medication-assisted treatment. Even when there is support for harm reduction and legal changes intended to reduce harm are passed, police may still enforce outdated laws. For example, in NYC police are still prosecuting individuals who call 911 to report an overdose or who carry new or used syringes.

The North Carolina Harm Reduction Coalition brought law enforcement trainings across the entire state that addressed attitudes on injection drug use, syringe decriminalization, and harm reduction. The coalition was comprised of harm reduction advocates and law enforcement, two unlikely partners, collaborating together in order to reduce the spread of HIV/AIDS and syringe-related public health issues within North Carolina. In this process, the coalition incorporated the law enforcement community into legislative advocacy as part of efforts to decriminalize possession of syringes.

7. Create a data-driven criminal justice approach for low-risk, non-violent drug users who are being prosecuted.

Some communities and states have already embarked on decriminalizing marijuana use, and others have regulations supporting medical use of marijuana products. While decriminalization is outside the scope of this White Paper, many communities are now recognizing that public safety does not require incarceration of low-risk, non-violent drug users. Nevertheless, while there has been a general decline in crimes and arrests in the U.S., alcohol and other drug arrests have continued to increase and they have become a larger proportion of all arrests. Nevertheless, there is little evidence that any amount of jail and prison time, or that devoting substantial criminal justice resources directed at convicted alcohol and drug users, will increase public safety or reduce recidivism. What has been demonstrated is that more arrests, more jail and prison time, and more expenditures have exploded the costs of the criminal justice system. The financial crisis of states is a product of many converging trends – one widely recognized contributor is the draining of public resources by bigger and bigger corrections populations in most states and a larger share of public expenditures going to criminal justice activities.¹

“ As we reserve more of our expensive [prison] bed space for truly dangerous criminals [we] free up revenue to deal with those who are not necessarily dangerous but are in many ways in trouble because of various addictions.”

—Georgia Governor Nathan Deal (R), May 1, 2012

Further, the criminal justice approach to drug- and alcohol-related arrests contributes to disparity in community groups affected. For example, Santa Cruz analyzed its own data for the last 35 years, and after adjusting for population changes, they identified that arrests of Latinos for marijuana possession rose 6 times faster than for whites while arrest rates for “dangerous drug” possession (such as cocaine and methamphetamine) rose sharply for whites (248%), but fell for Latinos (-5%).

An effective public health-driven solution to assist alcohol and drug users engaged in low-risk offenses is needed to address the current serious problems of prison and jail overcrowding, and the unsustainable trends of budget-busting correctional systems. California was under court order to address its overcrowding problem. It did so by “realignment”, passing Assembly Bill 109 in 2011, which in essence does not permit low-risk prisoners to be housed in state prisons, but rather requires them to be retained in county jails and jurisdiction. This action has

¹ The Pew Charitable Trusts report

http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/sentencing_and_corrections/Prison_Time_Served.pdf

created an urgent need for California counties to be creative, or else absorb a huge growth in jailed offenders. Analysis has identified this low-risk offender population is comprised predominately of alcohol and drug-related cases – the group for whom correctional responses have been so ineffective.

Through the utilization of data-driven analysis, justice administrators can target deliberate interventions for the non-violent, non-serious, non-sex (“non-non-non”) offender population. This low-risk offender group is predominately comprised of alcohol and drug users. Santa Cruz California has reduced reliance on local and state incarceration and demonstrated that incarceration does not need to be the dominant component of a local criminal justice action plan. On the other hand, investment in community-based alternatives, which promote long-term public safety, can be an essential component.

In Santa Cruz’s study of jail capacity utilization, it learned that a third of jail capacity was used on direct drug and alcohol violations, hence it is pursuing expanded use of treatment and probation in order to conserve jail space for those that don’t need to be there.

8. Build pre-booking diversion programs through collaboration of harm reduction organizations and law enforcement.

Jail diversion programs (both pre-booking and post-booking diversion) have emerged as a viable and human solution to the criminalization and inappropriate criminal detention of individuals with mental disorders, who often have co-occurring substance use disorders.¹ Pre-booking diversion occurs after arrest but the person is not booked on the charge. Post-booking identifies and diverts individuals after they have been charged. Specialty courts are an example of post-booking diversion. Some key features for creating a successful jail diversion program are:

- Interagency collaboration
- Active involvement
- Boundary-spanner
- Leadership
- Early identification
- Cross-trained case managers

The Warrant Reduction Project (WRAP), Santa Cruz, CA

WRAP reconnects probationers on the verge of triggering an arrest warrant with probation officers and the courts, who collaborate with a local community-based organization to assist probationers in maintaining contact with department staff.

¹ SAMHSA. What is Jail Diversion? SAMHSA GAINS Center for Behavioral Health and Justice Transformation. http://gainscenter.samhsa.gov/topical_resources/jail.asp. Accessed July 9, 2013.

The Law Enforcement Assisted Diversion (LEAD) Program, Seattle, Washington

A broad coalition of criminal justice stakeholders, policy makers, drug policy reform advocates, public defenders,, and neighborhood residents implemented a pilot program in October 2011 called Law Enforcement Assisted Diversion (LEAD). LEAD is a pre-booking diversion program operating in the Belltown neighborhood of Seattle, WA. LEAD allows law enforcement officers to redirect low-level offenders engaged in drug or prostitution activity to community-based services, instead of jail and prosecution. Case managers develop and implement an individual intervention plan based on a harm reduction philosophy to address the needs of each participant. LEAD attempts to reduce both addiction and crime in one of the more prevalent open-air drug markets in the downtown core of Seattle. Differences of opinions have occasionally emerged during this collaboration on what should be the individual consequences of low-level offenses. The social service providers organize to assist individuals with their addiction problems, find stable housing, and access other necessary services. Utilizing harm reduction has allowed individuals to become engaged in supportive services and gain some form of stability.

9. Use community policing, “smart policing”, that reduces crime not simply increases arrests.

While reforming the sentencing process and focus of state corrections agencies for alcohol- and drug-related offenses may lead to substantial cost savings, it will not necessarily stem the rate of new crimes. Advocates for SMART (Strategically Managed, Analysis and Research-driven, Technology-based) policing describe it as a strategy that uses technology, research, and analysis to support the strategic management of police activities. Many jurisdictions are already employing some SMART policing approaches, such as the use of new technologies for more efficient data collection and mapping, information sharing, and data analysis. SMART policing programs can be grown in law enforcement agencies across the country through a comprehensive, federally driven, national technical assistance program. However, SMART policing tactics must be transparent and monitored to learn if it disproportionately targets low-income communities or encourages arrests for drug possession or other low-risk non-violent groups who are disadvantaged (see New York City Organizing below).

The primary goal of SMART policing is to improve overall police performance (as measured by clearance rates and crimes reported to police) through the more efficient use of police resources. Examples of efficiencies include the deployment of law enforcement assets to locations where crimes are likely to occur and improved response times for crimes in progress, although concern has been raised that some departments are increasing efficiency by stop and frisk practices targeting people of color, as evidenced in a disproportionate growth of arrests for marijuana possession. According to a White Paper on the topic, SMART policing has three primary components¹:

- **Strategic Management:** Strategic management begins with an assessment of criminal and terrorist activity, threats, and vulnerabilities. This assessment may include a gap analysis or capabilities review, and is followed by the selection of strategic goals and objectives for improving police performance. Forging community partnerships and garnering public support for policing initiatives is important as well as monitoring the program and assessing its effectiveness to guide adjustments and modifications
- **Analysis and Research:** Research and the analysis of historical data are important for setting strategic priorities, AND for informing about trends, and for leadership to make better decisions about resource allocation and deployment
- **Technology:** Advanced technology and tools are needed to improve data capture, display and analysis, information sharing, and surveillance activities, such as: artificial intelligence software, internet

¹<http://m.smartpolicinginitiative.com/resource/cna-smart-policing-white-paper-full?device=mobile>

communication programs that enhance situational awareness, networking software, and electronic surveillance technologies

NYC Organizing for Community Safety Act

According to community activists who have formed a coalition in NYC for police reform, the NYC police department is using policing strategies in like stop and frisk in a biased way that has resulted in tens of thousands of unlawful marijuana arrests. Their coalition states this has humiliated and alienated hundreds of thousands of Black and Latino New Yorkers, and has eroded the trust and confidence many in our communities have in the police. That's why VOCAL-NY, a grassroots membership union that support harm reduction, has spent years challenging what it perceives to be biased policing practices that undermine public health and criminalize HIV prevention, discriminate against communities of color and people who are LGBTQ, and help fuel the war on drugs and mass incarceration that hold low-income communities of color back.

10. Integrate use of data from the state prescription drug monitoring program (PDMP) into community prevention efforts.

Rates of prescription drug overdoses and deaths have skyrocketed in recent years as more individuals receive opiates for chronic pain treatment. The increasing prescription rate has led to dramatic increases in doctor-shopping, and other signs of prescription drug abuse at the same time overdoses and deaths have increased.

More communities are using prescription history data from a state PDMP to support their drug abuse prevention program with a particular focus on reducing drug overdose deaths. Presentations are made to community groups using charts showing data on the prescribing of controlled substances, numbers of individuals meeting thresholds of possible questionable activity (e.g., doctor shopping), rates of prescriber and pharmacy enrollment in the PDMP, and adverse health outcomes related to prescription drug diversion and abuse, including overdoses, deaths and emergency room and hospital visits. County prescription and health outcome data can be shown, and compared to surrounding counties, and the state as a whole. (See above description of the Lazarus Project).

11. Enable access to legal services in communities disproportionately affected by drug offenses.

The likelihood of arrest from drug-related activities is disproportionately increased for people of color and low-income communities, perhaps reflecting greater police presence in underprivileged neighborhoods. This implies disadvantages are imposed on people of color and low-income communities disproportionate to their drug use patterns. With criminal justice involvement, unfortunately, comes a hefty collateral consequence, which may include barriers to housing, employment, driver's licenses, benefits, and other resources critical to being a productive member of the community and family. This raises the importance of civil and criminal legal services as an important harm reduction activity for work with drug-involved individuals. In Seattle's LEAD project, participants who are working with the program's case managers also have access to a program lawyer to address their legal needs. This built-in component of legal services has been key to LEAD, as many participants have found themselves entangled in a web of numerous legal issues, such as criminal cases, court fines, driver license suspensions, child support, child custody, debt, and benefits termination and denial.

12. Work collaboratively to reform sentencing practices.

A criminal justice coalition in California, including the Drug Policy Alliance, introduced a bill to roll back drug possession sentences. California Senate Bill 1506 (SB 1506) proposed to reduce all current drug possession felonies to misdemeanors. This was aimed at reducing the harm associated with a felony conviction, which carries significant collateral consequences, including barriers to housing, employment, and benefits. The rationale is that there is no evidence that longer sentences reduce or prevent drug use, and there is some evidence that states with misdemeanor charges have higher rates of intake to treatment and lower crime rates.

The Closing the Addiction Treatment Gap initiative also was successful in collaborating on initiatives in several states that resulted in sentencing reform. New York and New Jersey shifted away from mandatory minimum sentences to community alternatives including treatment as a sentencing alternative, while Arkansas expanded access to juvenile drug courts. In Wisconsin, individuals on probation and parole now have improved access to more comprehensive treatment. In New Jersey, more incarcerated people who are parenting children are re-entering their communities with treatment access.

13. Create opportunity for economic empowerment of drug users.

Employment training, services, and supports targeted at chronic drug users leads to attacking a root cause of chronic drug use and addiction. Economic empowerment efforts can provide self-esteem from skill mastery, improve life stability, reduce motivation to engage in drug sales or sex for drugs, and reinforce people's efforts to reduce reliance on drugs.

Increasingly, social service programs hire former clients including those who remain active drug users. According to one of the paper's key informers, hiring someone who is an active drug user may mean that she or he eliminates or cuts on back drug use within a few weeks. For example, the LEAD program in Seattle, Washington had four men who within one year moved from being drug addicts living in crack houses to being trained in hazardous material clean up and learning how to decontaminate ships before breaking them down; now they are going to China to train others in hazardous clean up.

Create a social movement that empowers drug users. Similar to social movements of individuals living with chronic conditions worldwide, engaging drug users in fighting stigma and advocating for policy change can be effective and can result in empowerment of the individuals involved, useful data and evidence of the impact on real lives, and grass-roots advocacy that changes hearts and minds. Addressing stigma by organizing and developing drug users as leaders in the fight for change – results in policy changes and changes the debate/conversation; users have intimate knowledge of the issue.

VOCAL-NY and POWER

Voices Of Community Activists & Leaders (VOCAL-NY) is a statewide grassroots membership organization building power among low-income people affected by HIV/AIDS, the drug war and mass incarceration, along with the organizations that serve us, to create healthy and just communities. The NY Users Union is led by low-income people who are active and former drug users committed to a human rights and health-based approach to drug use. It views people as powerful agents to improve their own lives and communities, even if they continue actively using drugs. It accomplishes its mission through community organizing, leadership development, public education, participatory research and direct action. One program of VOCAL, is POWER (People Organized for Power & Equal Rights) Academy, a leadership development program that prepares VOCAL-NY members to more effectively participate in policymaking that affects their lives. POWER Academy utilizes popular education methods that rely on the lived experience of our members to develop their skills and issue knowledge. POWER Academy courses include: Campaign strategy, Understanding power relations, Outreach and recruitment, Holding effective meetings, Action planning, Media relations, Coalition building. <http://www.vocal-ny.org/about-us/>.

5.4 Conclusion

This section has described a range of harm reduction strategies that were recommended by expert informants, have an evidence-base, and are relevant to personal health, community well-being, or both. The strategies selected to be described in this paper come from a more comprehensive list of harm reduction strategies for medical systems of care, addiction systems of care, and community coalitions to consider using in efforts to reduce harms from unhealthy drug use. Building on a harm reduction strategies list developed by Kellogg (see

prior discussion of gradualism for treatment), the Figure below provides a more comprehensive list and notes their use or potential use by medical systems to care, addiction systems of care, and community coalitions for harm reduction.

Figure 3 List of Harm Reduction Strategies

Harm Reduction Strategy/Intervention	Harm Reduction Stakeholders		
	Medical Systems of Care	Addiction Systems of Care	Community Coalitions for Harm Reduction
Acupuncture and herbal treatments	x		
Screening, brief intervention & referral to treatment (SBIRT)	x		
Moderation interventions	x	x	
Medical and allied health curricula and trainings	x	x	
Person-centered health care and social services	x	x	
Substance use management support	x	x	
Motivational Interviewing implementation and training	x	x	
Integration of dental, medical and other services	x	x	x
Drug and alcohol education for patients	x	x	x
Specialized and low threshold services to keep pregnant women who use drugs in prenatal care	x	x	x
Peer-delivered services and empowerment	x	x	x
Needle/syringe exchange	x	x	x
Safe injection information	x	x	x
Pharmacologic treatment of alcohol disorder, i.e., naltrexone, vivitrol, acamprosate	x	x	x
Opioid substitution therapy, i.e. buprenorphine, methadone	x	x	x
Recovery support services	x	x	x
Re-entry support	x	x	x
Harm reduction therapy		x	x
Contingency management; positive incentives to reward gradual behavior change	x	x	x
Naloxone training and distribution , i.e., overdose prevention	x	x	x
Dance drug/"Ecstasy" testing	x		x
Low threshold methadone (and other addiction) treatment		x	x
Job training, creation of economic opportunities, supported employment		x	x
Recovery courts and diversion		x	x
Harm reduction education and collaboration with law enforcement, criminal justice			x
Permanent, low-threshold housing with support services (e.g., Housing First)			x
Pre-booking diversion			x
Designated drivers			x
Drop in centers			x
Safe injection sites/drug consumption rooms			x
Reclassification of alcopops			x
Safety glassware in bars			x
Sentencing reform for low-risk, non-violent convicted drug users			x
Server training			x

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6. THE IMPORTANCE OF ACCOUNTABILITY AND EVALUATION

A comprehensive approach to evaluation in which harm reduction activities are shown to achieve success/meet their goals is critical if harm reduction initiatives are to receive broad-based support. Harm reduction works on multiple levels, and to be most effective, communities must adopt interventions that incorporate policy, community, and individual behavior change components. These components are highlighted in the conceptual logic model proposed in Figure 4 in which a classic public health logic model was adapted to the initiatives and goals of harm reduction.

To increase support for community harm reduction activities, and to engage in quality improvement, communities must discuss and adopt a community-wide approach to evaluation.

Summit County Ohio's Accountable Care Community

Summit County Ohio may be the first community to establish an “accountable care community, distinguished from an Accountable Care Organization in that it is not dependent upon a single healthcare system. Its goal is to improve the health of the entire community by enhancing care, lowering medical costs, increasing access and reducing disease. Thus its initiatives encompass not only the county’s medical care providers, but also the public health system and community stakeholders whose work spans the spectrum of the determinants of health.

The community model focuses on health outcomes of the entire population of the county rather than silos of health consumers in one health insurance entity or one provider group. The model’s key components include: (1) development of integrated medical and public health models to deliver clinical care in tandem with health promotion and disease prevention efforts; (2) utilization of inter-disciplinary teams to align care management; (3) enhanced timely patient health information and execution of effective care transitions across the continuum of providers; and (4) integrated and fully mineable surveillance and data warehouse to measure population changes over time and assess the impact of intervention strategies

Robust data collection and impact measurement metrics also are key components. This is essential both to track progress and to refine the model, through formative evaluation as it moves through implementation. Outcome measures are instrumental to assess effectiveness, quality, cost, and patient experiences of any intervention undertaken with the population under consideration. Systematic improvements in the health of the community, patient care, long-term outcomes, and local burden of disease can be measured as the ACO initiative reaches maturity. These are outcomes that would otherwise prove difficult to achieve without implementing an ACO model. Broad categories of measurement for evaluation should include community participation and local, national and regional burden of disease.

Glasgow, Vogt, and Boles proposed a model in 1999, termed the RE-AIM model, for evaluating comprehensive public health interventions. As a conceptual approach, it suggests assessing or evaluating five dimensions to determine the long-term impact of a policy or program. These dimensions are: reach, efficacy, adoption, implementation, and maintenance. These dimensions can be applied at multiple levels (e.g., individual, clinic or organization, and community) and interact to determine the public health or population-based impact of a program or policy. A brief definition of these dimensions is provided here:

- **Reach** is a measure of expanded individual participation and the representativeness of the participants in terms of their needs relative to all persons in need. It taps into concepts of fairness, disparity, and risk of need. For example, restricting housing services to people who abstain from all alcohol and drug use creates disparity.
- **Efficacy** is a measure of both the positive and negative consequences of the policy or program, measured on multiple outcomes, assuming it is fully implemented. Negative consequences include measures of

potential harm that is imposed on a target population (e.g., incarcerating drug users can result in loss of Medicaid coverage and access to preventive medical care).

- **Adoption** is a measure of the number of unique actors or organizations that are required to change, the type of change that is required, and the barriers to adoption of the change. More complicated policies and programs are less likely to be successfully adopted.
- **Implementation and Maintenance** are two measures (one immediate, one more long-term) of whether the program or policy is delivered as intended. The efficacy of a program interacted with the degree of implementation yields the program's effectiveness. *Maintenance* is the long-term behavior change of the program's individuals and organizations.

Brandeis University applied this framework when evaluating the potential impact of policy and programmatic changes that were championed by the OSI-funded *Closing the Addiction Treatment Gap (CATG)* grantees. CATG grantees demonstrated that it was feasible for communities to adopt several 'high impact' actions for policy change initiatives to expand treatment resources. For example, it is estimated that three Medicaid initiatives have potentially provided access to between 5.7% to 9.2% of the drug users in the "treatment gap", and generally were more successful in reach than expansion initiatives for other populations which potentially provided access to between 1% and 4.6% of the "treatment gap".

Evaluation and accountability are necessary concepts for using limited health care and social service resources wisely. These concepts are incorporated into new approaches of resource allocation reviewed in the final section, such as: performance based funding (which incorporates performance monitoring), and social investment models which require careful specification of intended outcome in order to distribute returns on investment.

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Upstream Opportunities

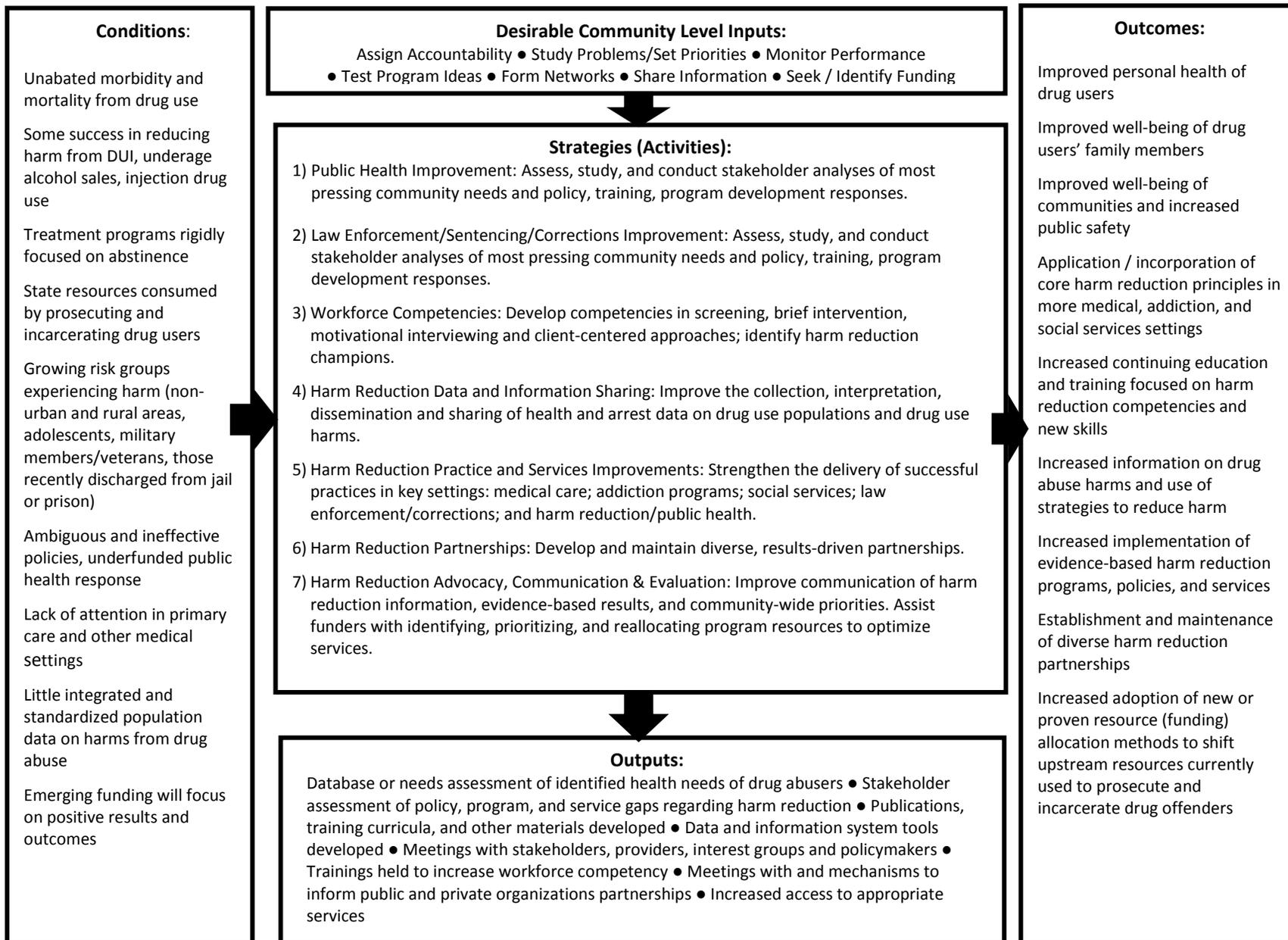


Figure 4 Harm Reduction Logic Model

Source: Adapted from The National Prevention Council. National Prevention Strategy: America's Plan for Better Health and Wellness. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011

7. FINANCING APPROACHES FOR HARM REDUCTION SERVICES

Alternative and diverse sources of funds are desirable for financing expanded programs aimed at reducing drug use harms. Many social services, public health programs, and advocacy initiatives identified for comprehensive programming do not qualify under traditional health benefits that are usually reserved for personal health services. Some effective personal health harm reduction services are delivered by community workers who are not eligible for reimbursement under traditional health benefits.

This section identifies three venues where new opportunities exist for increasing the funds available for harm reduction activities. Communities interested in harm reduction must advocate for inclusion of both prevention and personal health services in funding proposals, and must advocate that all infrastructure improvements under proposals to reform health systems and criminal justice systems include harm reduction as preventive services. The specific opportunities described here include: 1) new opportunities being launched through the Affordable Care Act; 2) ideas to attract private and government ‘investment’ for harm reduction and new financing models; and, 3) other Federal grant programs.

7.1 *The Affordable Care Act (ACA)*

The Patient Protection and Affordable Care Act (the ACA, for short) became law with President Obama's signature on March 23, 2010. The ACA contains provisions that became effective immediately, 90 days after enactment, and six months after enactment as well as provisions phased in through 2020. The ACA creates nearly universal health care coverage, and is also transformational. There are features to move the U.S. health care systems away from simple sources of financing, into programs that will promote public health through expectations of preventive health services.

More individuals who use drugs and their families will have health insurance coverage.

The Affordable Care Act will provide one of the largest expansions of mental health and substance use disorder coverage in recent years. It does this because new populations formerly uninsured will have insurance coverage, treatment for mental health and substance use disorders is a benefit category covered as part of the package of Essential Health Benefits, and remaining gaps in coverage will be addressed because federal parity protections are extended beginning in 2014.

According to analysis by the ASPE Office of Health Policy, through the Affordable Care Act, in total 32.1 million Americans will gain access to coverage that includes mental health and/or substance use disorder benefits that comply with federal parity requirements and an additional 30.4 million Americans who currently have some mental health and substance abuse benefits will benefit from the federal parity protections. By building on the structure of the Mental Health Parity and Addiction Equity Act, the Affordable Care Act will extend federal parity protections to 62 million Americans.¹ Under the Parity Act, health plans that provide mental health and addiction coverage must provide coverage that is comparable to other health benefits.

Under the ACA, Children can no longer be denied insurance due to “pre-existing conditions” (*e.g.*, substance abuse, mental illness, HIV, hepatitis C) and in 2014, this clause will extend to adults. Nevertheless, important population groups for harm reduction programs will still remain uninsured and safety net programs will still be needed.

- Undocumented immigrants are barred from Medicaid and from purchasing insurance through health exchanges.
- Health reform will not cover people in prisons and jails during their period of incarceration. However, some states allow people on Medicaid to put their enrollment on hold while in jail, rather than terminating their coverage. Some prisons allow people to begin the Medicaid enrollment and eligibility process in preparation for their return to the community from prison or jail.

¹ Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans. http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.pdf

Health delivery systems are being reformed.

The range of delivery system reforms under the ACA is vast, and includes payment reforms, integration of behavioral care with medical care, emphasis on home and community-based services, a focus on prevention and wellness, financial incentives to patients and providers, and use of health information technology.

Investments are being made in Primary Care. Health reform invests in training primary care doctors in public health and infectious disease and commits \$11 billion dollars over the next ten years to support federally qualified health centers (FQHCs) and other community clinics to increase their capacity to deliver primary care for newly insured low-income individuals. Within FQHCs, health reform sets up incentives for creating what they are calling “patient-centered medical homes,” a single place for coordinating the care for people on Medicaid with two or more chronic health conditions, including mental illness, substance abuse, asthma, diabetes, hypertension, and HIV.

The ACA creates other ways in which primary care services for drug users may change and hopefully be improved. The ACA will allow providers to:

- Integrate substance use and mental health services into primary care settings, such as FQHCs;
- Potentially bundle a package of harm reduction services to be billed to health insurance programs;
- Advocate for harm reduction specific (i.e., HIV and viral hepatitis) prevention, screening, and treatment, be included in the core quality measures.
- Apply for innovation funds for pilot projects to evaluate the cost effectiveness of coordinated drug user health services (HIV/HCV testing and care, syringe access, medication-assisted treatment, overdose prevention, soft tissue infection treatment, etc.)
- Target provider curricula for workforce training to patient-centered medical home and to physicians working with vulnerable populations (e.g., injection drug users)

Investments are being made in Prevention Services. Health reform makes a significant investment in public health and disease prevention. Health plans must offer all clinical preventive services that are recommended in groups A and B of the U.S. Preventive Services Task Force (USPSTF), without patient co-pay. And, in 2013 Medicaid programs get a 1 percent increase in federal match for these services. This includes many medical services that are tools for harm reduction, including hepatitis A and B vaccination for at-risk adults and screening and brief intervention for unhealthy alcohol use in primary care settings.

A remaining challenge is that USPSTF does not currently recommend other preventive services that are important for drug users, including hepatitis B and hepatitis C testing.

Specific investments in prevention are:

- a National Prevention Strategy
- Prevention and Wellness Fund, to support public health infrastructure
- Community Transformation Grants, to address structural and community-level determinants of health

The ACA creates the nation’s first mandatory Prevention and Public Health Fund, a dedicated funding stream for public health programs. In 2013 the budget request is \$1 billion. SAMHSA has disbursed funds related to prescription drug monitoring programs, SBIRT, and suicide prevention. The Centers for Disease Control and Prevention (CDC) has used the funds to award grants for developing, implementing and evaluating training and education programs for health professionals engaged in viral hepatitis prevention, and to support the development, dissemination, and management of a web-based Hepatitis Testing and Linkage to Care (HEPTLC) data collection and reporting system, among other things.

The Essential Health Benefit Package for Health Exchanges and Medicaid

The ACA of 2010 states that the essential health benefit must include at a minimum several services important to people with chronic drug use and for preventive services:

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care
- mental health and substance use disorder services, including behavioral health treatment
- prescription drugs
- rehabilitative and habilitative services
- laboratory services
- preventive and wellness services and chronic disease management, and
- pediatric services (including oral and vision care)

Medicaid Health Home

This provision gives states the option to amend the state Medicaid benefit to enroll Medicaid beneficiaries with chronic conditions into a health home selected by the beneficiary. Beginning January 1, 2011, a state may provide for medical assistance to eligible individuals with chronic conditions health home services that are provided by a designated provider, a team of health care professionals, or a health team. Health home services include:

- comprehensive care management
- care coordination and health promotion
- comprehensive transitional care
- patient and family support
- referral to community & social support services
- health information technology to link services

Center for Medicare and Medicaid Innovation (“The Innovation Center”).

The Innovation Center is already established and is testing various innovative payment and service delivery models to determine how these models reduce program expenditures while preserving or enhancing the quality of care provided to individuals enrolled in Medicare, Medicaid, and CHIP. Some of these awards relate to integrated services for persons who experience harm from alcohol and drug use, see Table 2 in the Appendix for a summary of funded innovations.

There are many other provisions of the ACA of 2010 that could be used to better serve individuals with harm from drug use; a summary created by the Legal Action Center of New York is included in Table 3 of the Appendix.

7.2 Attract Other Private and Public Investment

Among non-profit organizations with charitable missions who report to the U.S. internal revenue service (about 303,500 organizations excluding hospitals and universities), the majority (54%) of revenue is fee paid in return for services (e.g., fee-for-service), including government fees (not grants) which are increasingly at risk because of weak state economies.¹

Seek local community funds for implementation of harm reduction strategies.

Hospital Community Benefit of local community hospitals. Communities can include local hospitals in discussion about their community benefit requirement and make explicit a request that they build population health capacity within the hospital and contribute to the achievement of targeted health outcomes, such as harm reduction, in the community.

The new federal community benefit reporting requirements reinforce this shift in emphasis. The IRS has developed Schedule H which increases the transparency of nonprofit hospital charitable activities and processes. It provides a

¹ Roeger, K. L., Blackwood, A. S., and Pettijohn, S. L. (2012). *The Nonprofit Almanac 2012*. Washington, DC: The Urban Institute Press. See extracts at <http://nccsdataweb.urban.org/NCCS/extracts/nonprofitmanacflyerpdf.pdf>.

framework for detailed documentation of community health needs assessments and implementation strategies and engagement of diverse stakeholders¹. Harm reduction advocates involved in the needs assessment process can influence tax-exempt hospitals to provide benefits for more people at lower cost through strategic investments in prevention.

Community Reinvestment Act (CRA). The CRA is providing funding on the for-profit end of the “blended value” continuum. Banks are able to fulfill their CRA requirements by providing loans to businesses in underserved markets, and more recently, by investing in social-mission-driven venture capital firms.

“Builder” capital for non-profits. Non-profit organizations do not often receive builder capital, but need it. This capital helps to sustain growth by investing in infrastructure.

Develop the capacity of non-profit organizations to move along the continuum towards a Social Enterprise Model.

Kathy Brozek defines the Social Enterprise Model as “a nonprofit organization with a sustainable, scalable revenue stream generated from activities related to its social mission; it has an entrepreneurial operating model and leadership team”² (p. 14). Not all non-profits can adopt this approach, and failure can occur or the venture be high risk when the funders push nonprofits into revenue generation even when not a good fit with the organization. The organizational features associated with success of a ‘social enterprise’ are:

- Entrepreneurial vision of executive director and board
- A social mission that easily integrates with the fee revenue model
- A scalable operational model
- Alliances and resources that are uniquely combined to create value
- Close collaboration and coaching with major funders
- A multiyear funding financial commitment
- A workforce development program imbedded into the operational model (K. Brozek,⁴⁷ p. 15)

Issue Social Impact Bonds to repurpose government funding.

By issuing Social Impact Bonds, the government can transfer money from approaches that are less effective to those that are more effective. There is growing momentum in the US around Social Impact Bonds, and Pay for Success strategies in general. The social impact bond (SIB) is an innovative financing tool for social programs. Government agencies contract with external organizations to achieve measurable, positive social outcomes on a selected key issue (homelessness, juvenile delinquency). In its current variation, payment by the government is made only after the results have been achieved, there is no payment if the organization does not deliver results. Social Impact Bonds unlock new flows of capital and are revolutionary in the way they deal with social problems. Government agencies can repurpose their funding to community harm reduction activities that achieve desirable social outcomes through issuing a social impact bond. The US has now witnessed the first two government innovations to fund what works through social impact bonds. http://www.huffingtonpost.com/mark-rosenman/commercializing-the-publi_b_869265.html

Governments must make many choices when structuring their social impact bond agreements, so much will be learned as more government units attempt to use this financing tool. The goal for any government entity entering into a SIB agreement with social programs is to ensure that the outcomes are specific, measurable, and stringent, especially if the government intends to finance the eventual payment from a portion of the anticipated savings.

¹ See the Hospital Community Benefits after the ACA: *Schedule H and Hospital Community Benefit—Opportunities and Challenges for the States*, Kevin Barnett and Martha H. Somerville, Univ of Maryland, The Hilltop Institute, 2012.; http://www.phi.org/focus-areas/?program_id=1

² *Stanford Social Innovation Review*, Spring 2008. <http://www.ssireview.org/>

The three core components to an agreement that supports a social impact bond are:

- The outcome must be clearly defined and measurable while remaining ambitious but achievable within the time frame specified.
- Government funds should not be released until and unless the outcome is achieved.
- External organizations under contract should have considerable freedom to define the strategy that seeks to achieve outcomes.

British Social Impact Bond to Reduce Prisoner Re-Offending

The British Ministry of Justice issued its first Social Impact Bond in 2010, with a promise to pay a nonprofit organization, Social Finance, up to \$13 million over eight years for the nonprofit to reduce re-offending by its work with 1,000 prisoners in Peterborough (while inmates and after their release) who were serving relatively short sentences. To receive the full payment, the nonprofit has to reduce recidivism by at least 10 percent *more than* other prisons with similar populations (a nationwide control group). If the reoffending rates do not come down more in Peterborough than other similar prisons, the government pays nothing.

A caution—expanding ‘profit-seeking’ investment into the non-profit activities is controversial

Mark Rosenman, a long time nonprofit sector activist and scholar wrote in the Huffington Post, “While there is much to be commended and welcomed in the thinking behind social impact bonds (such as taking a long-range view of outcomes and employing reasonable and coherent metrics to improve program evaluation and accountability), there is no reason that these ideas cannot be more broadly applied under government and nonprofit auspices. We do need to improve and expand funding for [non-profit] efforts, but we don't need commercialization to drive them.

http://www.huffingtonpost.com/mark-rosenman/commercializing-the-public_869265.html

Investors in Social Impact Bonds are mostly socially aware institutions who want a return on their capital but also want to do good. If the nonprofit contractor is able to choose approaches that are effective, they cash in their “Social Impact Bond” and get the promised funds from government to distribute to their investors. If the nonprofit cannot accomplish the major reductions it has promised, then the investors lose their money and the taxpayer is no worse off.

Following are several examples from health, criminal justice, and other social innovations not specific to harm reduction.

Massachusetts Case Study: The Bay State first announced its interest in pursuing social impact bonds in May 2011, issuing a request for information and seeking proposals for areas where this approach may be useful and appropriate in Massachusetts. The state then solicited proposals in January 2012 from potential intermediaries and service providers in two areas: chronic homelessness and juvenile justice.

Massachusetts announced the selection of “initial successful bidders” for these contracts during the same week in August 2012 that New York City revealed its social impact bond agreement. The state intends to negotiate final contracts with the selected intermediaries and service providers.

The state has already been a leader in addressing some of the challenges inherent in the social impact bond model. In January 2012, for instance, Gov. Patrick signed legislation backing “pay for success” contracts with the full faith and credit of the government of Massachusetts and establishing a “Social Innovation Financing Trust” to hold outcome payments for the duration of a social impact bond deal. Because these agreements, by their very nature, stretch over several years, some have expressed concern about whether governments will honor the contracts if the governorship changes hands or parties.

NYC “Rikers Island Jail” Case Study: In 2012, the city of New York contracted with a nonprofit, nonpartisan social research organization (MDRC), who in turn is contracting with two nonprofit service providers to reduce the rate of recidivism by at least 10% over four years among annual cohorts of about 3,000 young men exiting Rikers Island jail. Using an evidence-based intervention, the Adolescent Behavioral Learning Experience focuses on personal responsibility education, training, and counseling. The financial structuring is linked to whether or not recidivism drops more than or equal to 10 percent. In this case study there was a private Guarantor (Bloomberg Philanthropies) and a private investor (Goldman Sachs). MDRC receives performance based payments from the NYC department of corrections, and will pay back the investment include to Goldman Sachs if successful. The results will be evaluated by the Vera Institute of Justice.¹

Identify low-hanging cost-savings opportunities from effective harm reduction initiatives that can be reinvested in further preventive harm reduction initiatives.

The CEO and Founder of Collective Health, Rick Brush, has introduced the term Health Impact Bondssm for a form of health impact investing. Collective Health works with insurers, employers, health care providers, governments and communities to generate sustainable health and lower costs². As with Social Impact Bonds, these bonds aim to reduce the severity and cost of certain chronic health conditions, and return part of the health care savings to investors and reinvest the rest in expanded upstream prevention initiatives. For example, the California Endowment awarded a \$660k grant in 2013 to Social Finance US (Fresno, CA) to launch a demonstration project to improve the health of low-income children with asthma. Fresno, CA saved \$6 million by reducing asthma-related emergencies through home-based educators and indoor air quality improvement.

In another example of a Health Impact Bond, Phoenix Arizona generated \$17 million in savings (2.4:1 Return on Investment) through an integrated health coordinator using a community approach to reduce emergency and hospital services among individuals with chronic mental and physical illnesses.

Similar to SIB, there are multiple steps to this form of health impact investing: 1) conduct analysis to identify areas where health costs can be reduced; 2) create investing options that leverage future cost savings; 3) employ health connectors to integrate evidence-based clinical and community experts who pay service providers based on outcomes; and 4) validate savings, repay investors, and reward other stakeholders by reinvesting a portion of savings in an ongoing system of better health and lower costs.

¹ For more information see the detailed write-up of John Olson and Andrea Phillips of Goldman Sachs.

<http://www.frbsf.org/community-development/files/rikers-island-first-social-impact-bond-united-states.pdf>

² See <http://www.collectivehealth.net/new/about.html>

Solicit “Prevention Trust” funding for harm reduction interventions.

“Prevention Trust” funding can be used for harm reduction interventions that increase healthy behaviors community-wide. The Massachusetts Prevention and Wellness Trust creates funding pools (\$60 million total) through small taxes on health insurers and hospitals over four years; enacted as part of cost containment legislation. The Trust will be used to fund evidence-based community prevention efforts through competitive grants and be administered by the Massachusetts Department of Public Health¹. The following purposes are targeted, and reducing the harm of substance abuse may fit within each of these areas:

- Reduce rates of the state’s most costly preventable health conditions
- Reduce health disparities
- Increase healthy behaviors
- Increase the adoption of workplace-based wellness programs
- Develop a stronger evidence-base of effective prevention programs

The legislation includes an evaluation of the impact of these investments, and advocates believe this holds promise for sustainable investments beyond the four years. One unusual feature of the Massachusetts Trust is that it requires health plans and large hospital systems to “proactively” invest upstream before the cost savings are realized.

Develop partnerships to apply for a federal “pay for success” project.

Those communities interested in broadening harm reduction activities can work together as partners of a “community safety net coalition” and apply for a federal “Pay for Success” project.² Pay for Success (PFS) projects have unprecedented funding available at the state and local level from federal allocations, including: a \$300 million PFS Incentive Fund to help state and local governments implement PFS programs with philanthropies, nonprofits, and other nongovernmental organizations and to provide credit enhancements for philanthropic investments and outcome payments for successful, money-saving services. Also, a limited number of Performance Partnership pilots designed to improve outcomes for disconnected youth, including young adults who have dropped out of school and are not employed. Approved performance partnerships designed at the State or community level could blend discretionary funds for youth-serving programs across agencies, many of which work directly with nonprofits, in exchange for greater accountability for results³.

Continue to take advantage of other Federal grant programs.

Various federal programs are offering grants that fall into the area of harm reduction.

Increased funding for Homeless Assistance Grants. HUD is providing \$60 million for new targeted rapid re-housing and \$40 million for new permanent supportive housing to be administered by nonprofits.

Increased capacity of nonprofits to use volunteers. There is a reactivated Volunteer Generation Fund to help secular and religious nonprofits leverage volunteers among other nonprofits.

Support for new evaluation practices. Funding to help nonprofits demonstrate their impact through funding of evaluations and helping nonprofits build their internal evaluation and performance management capacity; expanded “what works” clearinghouses for proven practices, such as the Department of Justice’s CrimeSolutions.gov, the Department of Education’s What Works Clearinghouse, the Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP), and the Department of Labor’s new Clearinghouse of Labor Evaluation and Research (CLEAR).

¹ See <http://www.mphaweb.org/documents/PrevandWellnessTrustFund-MPHAFactSheetupdatedOct12.pdf>

² See <http://www.whitehouse.gov/omb/budget/factsheet/strengthening-and-supporting-non-profits>

³ See also the Nonprofit Finance Fund, *Pay for Success Learning Hub* at <http://payforsuccess.org/>.

Second Chance Grants – returning to communities after incarceration. Provides federal grants to government agencies and nonprofit organizations. Supports strategies and services designed to reduce recidivism by improving outcomes for people returning from prisons, jails, and juvenile facilities. Beginning in 2012, Second Chance Act grant programs began providing priority consideration to agencies that propose a Pay for Success model. Among various grant programs, these may be most appropriate for expanding harm reduction activities:

- Demonstration grants to state and local government agencies and recognized Indian tribes to plan and implement comprehensive strategies
- Mentoring grants support nonprofit organizations and federally recognized Indian tribes that provide mentoring, case management, and other transitional services.
- Reentry court grants help establish state, local, and tribal reentry courts that monitor convicted individuals and provide them with the treatment services necessary to establish a self-sustaining and law-abiding life.
- Technology career training grants establish programs to train individuals in prisons, jails, or juvenile residential facilities for technology-based jobs and careers during the three-year period before their release.
- Recidivism reduction grants provide funding to state departments of correction to achieve reductions in recidivism rates through planning, capacity-building, and implementation of effective and evidence-based interventions.

Further Reading on Creating New Financing Resources

(The) Center for American Progress, various articles on social impact bonds at, <http://www.americanprogress.org/search/?query=social+impact+bonds>

Hanen, L. and McLean, R. (2010). Health Care Reform and Harm Reduction. Presented at the 8th National Harm Reduction Conference, Austin TX. Find at <http://www.slideshare.net/HarmReductionC/health-care-reform-and-harm-reduction-laura-hanen-rachel-mclean-hrc-2010>.

Legal Action Center (LAC) and State Associations of Addiction Services (SAAS).(2013). Advocacy and Organizational Change for Health Reform. See “what’s happening in health reform” at http://www.lac.org/doc_library/lac/publications/Legal_Action_Center_Webinar_Whats_Happening_in_2011-3.31.2011.pdf, and an Organizational Guide at http://www.saasnet.org/PDF/Implementing_Healthcare_Reform-First_Steps.pdf.

Mulgan, G., Reeder, N., Aylott, M., & Bo’sher, L. (2011). Social Impact Investment: the challenge and opportunity of Social Impact Bonds. London: The Young Foundation, www.youngfoundation.org

National Association of Counties, The Community Services Division (2012). County Jails and the Affordable Care Act: Enrolling Eligible Individuals in Health Coverage. http://www.naco.org/newsroom/pubs/Documents/Health,%20Human%20Services%20and%20Justice/WebVersion_PW_FIssueBrief.pdf

Phillips, S. D. (2012). The Affordable Care Act: Implications for Public Safety and Corrections Populations. Washington, DC: The Sentencing Project. http://sentencingproject.org/doc/publications/inc_Affordable_Care_Act.pdf Accessed June 25, 2013.

Volk, C. (2013). States Missing Out on Millions in Medicaid for Prisoners. Stateline: The Daily News Service of The Pew Charitable Trusts. <http://www.pewstates.org/projects/stateline/headlines> Accessed June 25, 2013.

Wolk, A. and Ebinger, C. G. (2010). Government and Social Innovation: Current State and Local Models. Innovations, Summer 2010: 136-157. <http://www.community-wealth.org/sites/clone.community-wealth.org/files/downloads/article-wolk-ebinger.pdf>

APPENDICES

Appendix 1. Expert Informant Methods and Model Program Identification

This paper was developed in part based on individual phone discussions with the harm reduction key informants named below, and on recommendations from Heller School colleagues and program officers at OSF. Harm reduction informants were identified based on recommendations of colleagues and OSF program officers. Using a semi-structured discussion guide (see below), the informants were contacted to understand their perspectives on:

- A definition of harm reduction
- Harm reduction populations, stakeholders, and collaborators
- Changes, challenges, and supports on the harm reduction horizon
- Innovative intervention strategies
- Funding, financing strategies, and the impact of the Affordable Care Act
- Further resources (human, organizational, and published);
- Model programs

In addition to key informant discussions, contemporary harm reduction issues were identified through a review of abstracts from the November 2012 Harm Reduction Conference, Portland, Oregon. One author highlighted relevant abstracts, and another searched for related peer-review publications using the databases PubMed and Web of Science. The selected model programs were based on the recommendations of key informants, OSF program officials, colleagues and conference abstracts. The list is not comprehensive, but illustrative, and the list is restricted to those models with published evaluation findings.

Outside Expert Informants:

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Kris Nyrop, Project Director, Racial Disparity Project, The Defender Association, Seattle, WA

Thomas P. O'Toole, MD, Director, National Homeless Veterans PACT Program and Professor of Medicine, Brown University Alpert Medical School, Providence, MA

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Discussion Guide

What is your definition of harm reduction?

What are some key target population(s) for harm reduction, from your perspective?

Who are your stakeholders and partners/collaborators – current and potential?

What positive changes and supports for harm reduction do you see on the horizon?

What challenges for harm reduction do you see on the horizon?

Who is funding most of the harm reduction work right now?

Will the Affordable Care Act change what is funded or not?

What strategies are you using to finance your efforts?

Can you suggest organizations, individuals, or programs that are models we should learn about? (Please include their contact info if possible)

Can you suggest any documentation (papers, reports, books, web sites) that would be helpful?

Appendix 2. Selected Model Programs Incorporating Harm Reduction

This table lists, in alphabetical order by name, a range of model harm reduction programs and provides information on their target population, intended goal, intervention or strategy, financing, and evidence or outcomes. A web link is provided for each model program to facilitate access to additional information. The sources used to understand evidence and outcomes in particular for these model programs is provided in footnotes.

Name	Target Pop'n	Intended Goal	Intervention/Strategy	Financing	Evidence/Outcomes
Access To Recovery – Washington State program http://www.dshs.wa.gov/dbhr/daaccessstorecovery.shtml	Individuals attempting to cut down or contemplating abstinence	Expand the range of addiction treatment and recovery support services available to individuals with substance use disorders	Contingency management; financial incentives. Voucher-based strategy. State grantees choose intended target population and contract with community programs to accept vouchers as payment for their products or services.	SAMHSA funded, discretionary grant to selected states	<ul style="list-style-type: none"> • ATR was associated with reductions in PMPM Medicaid costs. • Services aimed at facilitating engagement in treatment and aftercare appear to foster modest savings in Medicaid costs¹ • ATR services were associated with increased length of stay in treatment, increased likelihood of completing treatment, and increased likelihood of becoming employed.²

¹Wickizer TM, Mancuso D, Campbell K, Lucenko B. Evaluation of the Washington State Access to Recovery project: effects on Medicaid costs for working age disabled clients. *J Subst Abuse Treat.* Oct 2009;37(3):240-246.

²Krupski A, Campbell K, Joesch JM, Lucenko BA, Roy-Byrne P. Impact of Access to Recovery services on alcohol/drug treatment outcomes. *Journal of Substance Abuse Treatment.* 2009;37(4):435-442.

Upstream Opportunities

Name	Target Pop'n	Intended Goal	Intervention/Strategy	Financing	Evidence/Outcomes
<p>Accountable Care Communities, Akron OH http://www.abiakron.org/1accountable-care-community</p>	<p>All community residents</p>	<p>Improvements in community health, patient care, long-term outcomes, and reduction in local burden of disease; align care management and improve patient access and care coordination; execution of effective care transitions</p>	<p>Integrated care delivery. The ACC has the following components:</p> <ul style="list-style-type: none"> • Development of integrated medical and public health models; • Use of inter-professional teams of medicine, pharmacy, public health, nursing, social work, mental health, and nutrition; • Collaboration among health systems and public health; • Development of a robust health information technology infrastructure; • Implementation of an integrated and fully mineable surveillance and data warehouse functionality; • Development of a dissemination infrastructure to rapidly share best practices; • Design and execution of a robust ACC implementation platform, specific tactics, and impact measurement tool; and • Policy analysis and advocacy to facilitate ACC success and sustainability. 	<p>Reorganization and blending of health insurance and public health funds</p>	<p>See, Janine Janosky, HEALTHIER BY DESIGN: CREATING ACCOUNTABLE CARE COMMUNITIES: A Framework for Engagement and Sustainability. Akron OH: Austen BioInnovations Institute, February, 2012.</p>
<p>APIC Model for Jail Re-entry (Assess, Plan, Identify, Coordinate) (ATTCs) http://www.usich.gov/usich_resources/solutions/explore/the_apic_model/</p>	<p>Jail inmates with co-occurring disorders who are re-entering the community</p>	<p>Improve post-release outcomes</p>	<p>Re-entry support. Apply APIC model (Assess, Plan, Identify, Coordinate) with offenders in jail who are re-entering the community. Includes coordination of criminal justice, mental health and substance abuse treatment systems to provide appropriate services at appropriate times.</p>	<p>Unknown</p>	<p>Multi-site studies of the organization of jail mental health programs by Steadman, McCarty and Morrissey (1989), American Association of Community Psychiatrists community of care guidelines (2001) and the American Psychiatric Association's task force report on psychiatric services in jails and prisons (2000)</p>
<p>Behavioral Health & Recovery Services (BHRS), San Mateo County http://smchealth.org/aboutbhrs</p>	<p>All community residents</p>	<p>Primary prevention to stem the flow of people who need intensive behavioral health services; Improve behavioral health outcomes and quality of life</p>	<p>Primary care prevention. The BHRS Primary Prevention Framework process identified four prevention strategies: 1) enhancing place, 2) connecting people, 3) fostering prosperity, and 4) expanding partnerships. BHRS integrates these strategies into its practices, policies, and everyday operations (and advocates that other government departments do so as well) to modify the social, physical, economic, and cultural environments.</p>	<p>Unknown; county resources</p>	<p>See program write-up, Prevention Institute. A Primary Prevention Framework for Substance Abuse and Mental Health, 2009. Available at: http://preventioninstitute.org/component/jlibrary/article/id-53/127.html, downloaded April 28, 2013.</p>

Upstream Opportunities

Name	Target Pop'n	Intended Goal	Intervention/Strategy	Financing	Evidence/Outcomes
<p>Community Model for Homeless People with Mental Illness http://www.communitymodella.org/index.html</p>	<p>Homeless single adults with mental illness, many with co-occurring SUD, 20% veterans, includes individuals recently released from jail or prison</p>	<p>Improve the residential stability of homeless people by creating a life-long community where members can find a sense of belonging and improve their well-being</p>	<p>Housing First (permanent, low threshold). Peer-delivered services and empowerment.</p> <ul style="list-style-type: none"> • Life-long, mutually supportive society that develops social bonds and trust • Program services employ community members • Recognize non-linear nature of recovery • Services delivered in a non-coercive manner, without tolerating violence, theft or drug use on premises • Stress on consistent service delivery and a safe and stable environment • Open to all homeless individuals with mental illness 	<p>The California Endowment (TCE)</p> <p>Los Angeles County Department of Mental Health</p> <p>Received HUD's Community Service Excellent Award</p>	<ul style="list-style-type: none"> • Lamp Community has helped end the homelessness of thousands of individuals during the past twenty years. • Two years after placement, approximately 70% of Lamp Community's members remained stably housed in independent housing, transitional housing, or respite shelter. • Almost all participants experience an improvement in health and well-being, and a decrease in psychiatric instability and substance use.
<p>Delancey Street Foundation Institute for Social Renewal http://www.delanceystreetfoundation.org/circle_rep_socrenew.php</p>	<p>Underclass populations including ex-felons, homeless</p>	<p>Residents gain academic education, marketable skills, accountability, dignity, and integrity</p>	<p>Peer-delivered services and empowerment. Residential self-help organization. The minimum stay at Delancey Street is 2 years; average resident stays 4 years – drug, alcohol and crime-free. Residents receive a high school equivalency degree (GED) and are trained in 3 different marketable skills, learn important values, social and interpersonal skills to live successfully in the mainstream of society.</p>	<p>Daily operations are not funded; charges no fees; residents share resources. No salaries; no staff; run by residents.</p>	<p>Program statistics are the Delancey Street has graduated over 18,000 people from America's underclass into society as successful, taxpaying citizens leading decent, legitimate and productive lives. No program evaluations discovered.</p>
<p>Harm Reduction Therapy Center, San Francisco , CA http://www.harmreductiontherapy.org/</p>	<p>Marginalized individuals considered untreatable by most programs</p>	<p>Attract and engage target population in harm reduction activities</p>	<p>Harm reduction therapy.</p> <p>Drop-in or sidewalk sessions and support groups; psychiatric medications; attention paid to drug problems and other psycho-social problems; trauma-informed relational psychodynamic therapy; treatment informed community member's needs; clinical supervision and administrative supervision and support for collaborating organizations and providers</p>	<p>In-kind contributions (e.g., no rent); fee for service; subcontracts from organizations with county contracts; small county contracts; small base of individual donors</p>	<p>Of 1,100 clients (individuals) in past year:</p> <ul style="list-style-type: none"> • 60% were successfully managing their substance use; • 50% no longer presented in crisis; • 70% have more stable mental health; • 60% are taking psychiatric medications; • 60% are more stable in housing.¹

¹Little, J, &Frankoviak, P. (2010). So glad you came! Harm reduction therapy in community settings. *J ClinPsychol*, 66(2), 175-188; Tatarsky, 2003; Tatarsky&Marlatt, 2010

Upstream Opportunities

Name	Target Pop'n	Intended Goal	Intervention/Strategy	Financing	Evidence/Outcomes
Housing First Seattle, WA (1811 Eastlake) http://www.seattle.gov/housing/homeless/1811.htm	Chronically homeless individuals having multiple medical problems including serious mental illness	Reduce health care costs and service use associated with this population	Housing First (permanent, low threshold) Supportive housing (Housing First) that removes the requirements for sobriety, treatment attendance, and other barriers to housing entrance	Robert Wood Johnson Foundation	<ul style="list-style-type: none"> • Daily alcohol consumption dropped steadily at 6, 9, and 12 months in housing; • Median monthly health care costs decreased after 6 and 12 months of housing; • Total cost rate reduction of 53% for housed participants relative to wait-list controls; • Total cost offsets for Housing First participants relative to controls averaged \$2449/person/month after accounting for housing program costs.¹
Individual Placement and Support (IPS), http://homeless.samhsa.gov/resource/individual-placements-in-supported-employment-promising-results-48847.aspx	Adults with severe mental illness	IPS is a variation of supported employment that has 7 elements	Economic empowerment and supported employment. Direct, individualized search for competitive employment. Seven principles are: focus on competitive employment outcomes, open to anyone who wants to work, rapid job search, attention to client preferences in services and job searches, individualized and long-term supports, employment specialists work closely with treatment team, personalized counseling on Social Security and other benefits.	See SAMHSA tool kit	Campbell, Bond, and Drake (2011) meta-analysis of four IPS programs concluded that produces better competitive employment outcomes for persons with SMI than alternative vocational programs regardless of background demographic, clinical (including alcohol abuse, drug abuse), and employment characteristics. See SAMHSA tool kit http://www.recoverymonth.gov/Resources-Catalog/2012/Ask-the-Expert/July-Ready-Willing-and-Able-To-Work-Employment-for-People-in-Recovery.aspx
JEWEL Project, Baltimore, MD http://www.jhsph.edu/news/news-releases/2005/sherman-jewel.html	Women involved in sex work [Heroin and cocaine]	Reduce women's drug and sex-related HIV risk behaviors; and increase belief in ability to earn money through licit means	Economic empowerment and supported employment. Six 2-hour sessions divided between HIV prevention and beaded jewelry making (making, marketing and selling).	NIDA grant funding	The women sold over \$7,000 worth of jewelry. 3-months post intervention there were significant reductions in: <ul style="list-style-type: none"> • drugs or money for sex (100% versus 71.0%); • number of monthly sex trade partners (9 vs 3); • daily drug use (76.0% vs. 55.0%); • money spent on drugs daily (\$52.57 vs \$46.71); • daily crack use (27.3% versus 13.1%)²

¹Larimer ME, Malone DK, Garner MD, Atkins, DC et al. (2009).Health care and service use costs re housing for chronically homeless with alcohol problems. *JAMA*, 301(13), 1349-1357.

²Sherman SG, German D., Cheng Y, Marks M, & Bailey-Kloche M. (2006). The evaluation of the JEWEL project: an innovative economic enhancement and HIV prevention intervention study targeting drug using women involved in prostitution. *AIDS Care*, 18(1), 1-11.

Upstream Opportunities

Name	Target Pop'n	Intended Goal	Intervention/Strategy	Financing	Evidence/Outcomes
La Alianza, Increased access to Medication Assisted Treatment	Opiate drug users in Puerto Rico	Increase access to addiction treatment for opiate drug users	Buprenorphine treatment La Alianza advocated for increased access to addiction treatment. As part of this effort, the Governor enacted Act No. 140 (H.B. 2652), which increases access to addiction treatment through financing of buprenorphine treatment by both public and private insurance companies in Puerto Rico. The law, passed on September 22, 2010, requires all insurance plans providing services in Puerto Rico to include buprenorphine on the formulary of the preferred drug list for opioid addiction treatment.	OSF grant under Close the Addiction Treatment Gap (CATG)	La Alianza reported at the start of the project that less than 20% of those in treatment for opiate abuse received medication assisted treatment. In addition to Medicaid recipients, beneficiaries of private health plans are also now covered by this requirement to have buprenorphine on the preferred formulary.
LEAD Program, Seattle, WA (Law Enforcement Assisted Diversion Program) http://leadingcounty.org/	Low level drug offenders and sex workers [target is crack and heroin users and sellers]	Improve public health and safety for community individuals; Reduce recidivism rates; Preserve criminal justice resources for serious, violent offenders	Pre-booking diversion. Pre-booking diversion for low-level drug and sex work offenders; Services are client-driven and can include inpatient drug treatment, educational opportunities, housing assistance, and job training and placement; Forge collaborations among law enforcement agencies, public officials and community groups	Private foundations	No outcome evaluations as yet. Process outcomes to date: <ul style="list-style-type: none"> • Assisted individuals with SUD to find stable housing and access needed services; • Engaged individuals in supportive services and gaining some form of stability; • Established community collaborations among criminal justice, harm reduction, business and other organizations and agencies.¹
Milwaukee Addiction Treatment Initiative, Probationer/ Parolee access to publicly funded addiction treatment services	Milwaukee County probationers and parolees in need of addiction treatment services.	Delay waitlists for probationers and parolees in need of addiction treatment services.	Access to Addiction Treatment. In this system redesign or efficiency strategy, the Milwaukee Addiction Treatment Initiative (MATI) of Community Advocates worked collaboratively with the Milwaukee County Department of Health and Human Services (DHHS), Behavioral Health Division to allow probationers and parolees access to the full continuum of specialty treatment providers in the county, rather than just the limited number of providers available through the Department of Corrections. Through the DHHS, probationers and parolees now also have access to case managers and are eligible for more specialized treatment such as co-occurring and culturally and ethnically competent programs.	OSF grant to Close the Addiction Treatment Gap (CATG)	The CATG evaluation reported that although the partners did not anticipate an increase in the number of people served, DHHS expects decreases in wait times to access treatment and improved quality of treatment for probationers and parolees in need of addiction treatment services.

¹Corcoran, E. (2012). Harm reduction and law enforcement working as a collaborative. Abstracts, 2012 Harm Reduction Conference, p 23; www.leadingcounty.org

Upstream Opportunities

Name	Target Pop'n	Intended Goal	Intervention/Strategy	Financing	Evidence/Outcomes
Mobile Reproductive Health (RH) and Needle Exchange Services, Baltimore, MD http://www.icarol.info/ResultDetails.aspx?org=2046&agencynum=200591	Female exotic dancers [Crack cocaine and heroin]	Reduce unintended pregnancies, and link pregnant, substance-abusing women to further RH care	Needle/syringe exchange. Integration of dental, medical and other services. Integrated reproduction health services with needle exchange. Volunteer health care providers staff 2 mobile vans once a week, 7 to 10 pm. Pregnancy counseling, contraceptive counseling, contraceptive distribution, HIV and STI testing, vaccinations, and acute health and reproductive care referrals.	A public health, academic, and community partnership using volunteer providers, non-profit STD screening, and city vans	Reduced unintended pregnancies and connected pregnant women to care. Process outcomes: <ul style="list-style-type: none"> • Served 220 women between October 2009 and June 2011; • About 1/3rd of women returned for second visit; • Provided 166 pregnancy tests, identified 5 pregnancies and connected women to desired RH services; • Provided contraception to 138 women.¹
NIDAMED and NIDA's Center of Excellence for Physician Education ² http://www.drugabuse.gov/nidamed/centers-excellence	Medical and health professionals who prescribe controlled substances [Controlled prescription medications, in particular, opioids]	Increase safe prescribing of opioids	Medical and allied health curricula and trainings. Advanced tools for supporting the safe prescription of opioids (and other controlled substances), including CME materials, drug use screening tools, patient education materials, and an innovative "performance project"	Developed/maintained by the National Institute on Drug Abuse	Unknown
Operation OpioidSAFE, Fort Bragg, NC ³ http://www.youtube.com/watch?v=zeMZ511yDFY	Military personnel (active duty soldiers)	Reduce overdose deaths	Drug and alcohol education. Overdose reversal (naloxone distribution). A comprehensive program that educates soldiers, families, and primary care providers of the tragic side effects of long-term prescription opioids. Provide oral substitution therapy for maintenance dependence; Provide info on alternative pain therapy treatments; Establish community level support to soldiers and families with prescription pain addiction	The medical team at Ft. Bragg collaborated with Project Lazarus, a community-wide program foundation dedicated to drug prevention.	Unknown

¹Moore et al.2012.AJPH.Contraception and Clean Needles: Feasibility of combining Mobile RH and NES for Female Exotic Dancers

²www.drugabuse.gov/nidamed-medical-health-professionals

³<http://www.prnewswire.com/news-releases/operation-opioidsafe-rescues-wounded-soldiers-from-prescription-drug-addiction-179131531.html>

Upstream Opportunities

Name	Target Pop'n	Intended Goal	Intervention/Strategy	Financing	Evidence/Outcomes
Peer-Delivered Syringe Exchange (PDSE) Program, NYC http://www.cornerproject.org/services/pdse/	Harder to reach drug injector populations, e.g. transgender persons, women, sex workers, and youth.	Expand syringe access coverage, increase cultural competency of syringe exchange programs, and expand professional development opportunities for people with histories of drug use	Peer-delivered services and empowerment. Needle/syringe exchange. PDSE uses low-threshold sterile syringe delivery models via: Social networks, Stationary outreach sites, Delivery service. Strategies include: <ul style="list-style-type: none"> • Authorize and train a select number of SEP clients (workers receiving a modest stipend) to conduct syringe access services among their peer networks and within their communities; • Dispatch PDSEs to fixed locations for syringe collection and delivery (exchange). 	New York State Department of Health AIDS Institute and NYC Department of Health and Mental Hygiene	Between March 2009 and March 2010, PDSE was responsible for nearly 1/3 rd of all syringes distributed in NYC. Half of all new program enrollments during period were a result of PDSE. PDSE in NYC has been effective at: <ul style="list-style-type: none"> • Reaching people who have traditionally been disconnected from SEPs • Acquiring new SEP enrollments • Increasing the number of syringes received per client • More IDUs are being connected to services • Increased satisfaction, skill building, and sense of giving back to the community among PDSE¹
Perinatal Addiction Treatment Clinic (PATH Clinic) Oahu, HI http://honolulucounty.hi.networkofcare.org/mh/services/agency.aspx?pid=PathClinicThePerinatalAddictionTreatmentofHawaii_899_2_0	Women of reproductive age and their unborn children [methamphetamine, marijuana, cocaine, and tobacco]	Improve birth outcomes; increase ability of mothers to parent own child; reduce repeat pregnancy	Decriminalization of drug use if pregnant. Specialized pre- and post-natal care for women with SUD. Substance abuse pre-treatment (assessments, education, skill building, motivational interviewing, and counseling); healthcare and social services include pediatric care, psychiatric care, childcare, case management, referrals, classes, and activities. Provide quality OB/GYN and other medical and dental care; and also transportation, child-care	Hawaii State Legislature	From April 2007 to August 2010: <ul style="list-style-type: none"> • Served 213 women: 132 pregnant, and 103 live-born infants; • All but 4 women had negative urine toxicology at time of delivery; • 12 (12.6%) infants were born preterm, equal to national and state average, despite risk factors; • 90% retained custody at 8 weeks; • Reduced repeat pregnancy among women who maintained custody²
Project Lazarus Wilkes County, NC http://projectlazarus.org/	Individuals at risk of unintentional overdose from prescription opioids	Prevent unintentional overdoses in hospital emergency departments, prisons, and on the street	Overdose reversal (Naloxone distribution). PDMP (Prescription Drug Monitoring Program). Project components include: Community action and coalition building; data collection and monitoring, primary care education on safe prescribing, school-based education, and distribution of naloxone to providers and patients.	Gov't grants; local business grants; In-kind support; Law enforcement training and positions funded by the Nat'l Assoc of Drug Diversion Investigators	In Wilkes County, NC: <ul style="list-style-type: none"> • Overdose deaths decreased by 69% in between 2009 and 2011, with 28 straight months of steady declines; • In 2011, no residents died from a prescription opioid prescribed locally, down from 82% in 2008; • Hospital ED visits for overdose and substance abuse decreased by 15% between 2009 and 2011, while rates in the rest of the state increased by 7%.^{3,4}

¹Winklestein, E. (2011). User-to-user: Peer-delivered Syringe Exchange in New York City. Harm Reduction Coalition.

²Wright, T. E., Schuetter, R., Fombonne, E., Stephenson, J., & Haning, W. F., 3rd. (2012). Implementation and evaluation of a harm-reduction model for clinical care of substance using pregnant women. *Harm Reduct J*, 9(1), 5.

³Albert S, Brason FW, Sanford CK, Dasgupta N, Graham J, and Lovette B. (2011).Project Lazarus: Community-based overdose prevention in rural North Carolina. *Pain Medicine*, 12, S77-S85.; <http://www.projectlazarus.org>

⁴PDMP Center of Excellence at Brandeis. (2012). NF 3.2: Project Lazarus: Using PDMP data to mobilize and measure community drug abuse prevention. Notes from the Field, www.pdmpexcellence.org

Upstream Opportunities

Name	Target Pop'n	Intended Goal	Intervention/Strategy	Financing	Evidence/Outcomes
Project Mainstream https://nursing.uth.edu/centers-progs/csa/default.htm	Medical and health professionals	Enhance curriculum on basic substance abuse services at health professions training institutions	Medical and allied health curricula and trainings. The two-year, part-time training program featured training meetings, on-site and distance mentoring, and internet-based instructional materials Principle learning activities: develop independent projects in curriculum enhancement and prevention services delivery	SAMHSA/CSAT, HRSA, and in-kind contributions from AMERSA (Association for Medical Education and Research on Substance Abuse)	<ul style="list-style-type: none"> • Fellows implemented 45 distinct curricula, providing 19,000 hours of new instruction to over 5,000 trainees; • Over 80% of training was required curricular experiences; • Five peer-reviewed publications, 7 additional submitted papers, 78 presentations, and 23 awards or appointments; • Increase in faculty knowledge of SA ¹
Risk Avoidance Partnership, Hartford, CT http://www.incommunityresearch.org/programs/substanceabuse.htm	Active drug users [heroin, cocaine, crack], primarily African Americans and Puerto Ricans; homeless, often HIV positive, with Hepatitis C, prior jail or prison	Increase safer drug use practices	Peer-delivered services and empowerment. Train active drug users as Peer/Public Health Advocates (PHAs) to bring a structured, peer-led intervention into sites of illicit drug use; 10-session training program including 5 2-hour in-office sessions Mon-Fri and up to 5 community-based field sessions; RAP peer-led intervention modules organized into three categories: (1) health and harm reduction education, (2) demonstration of prevention or harm reduction practices; and (3) materials for risk prevention and harm reduction	NIDA grant	Impact on peers identified through quantitative instrument: <ul style="list-style-type: none"> • 93.5% of contacts began using rubber tips on crack pipes; • 96.3% of contacts started using or increased use of condoms; • 85.2% of contacts entered into drug treatment of detox; • 93.9% started using or increased use of needle exchange program ²

¹Brown, R. L., Marcus, M. T., Lala, S., Straussner, R. A., Graham, A. V., Madden, T., . . . Henry, R. (2006). Project MAINSTREAM's first fellowship cohort: Pilot test of a national dissemination model to enhance substance abuse curriculum at health professions schools. *Health Education Journal*, 65(3), 252-266. See also Madden, et al. (2006). *J Interprof Care*, 20(6), 655-664

²Weeks et al.2006.JDrugIssues.Risk Avoidance partnership

Upstream Opportunities

Name	Target Pop'n	Intended Goal	Intervention/Strategy	Financing	Evidence/Outcomes
<p>Santa Cruz¹, Data-driven justice system solutions, http://www.cjci.org/news/5508</p> <p>http://www.cjci.org/uploads/cjci/documents/Local Reform in a Realigned Environment.pdf</p>	<p>People charged with low-risk alcohol and drug offenses, the “non-non-non” (non-violent, non-serious, non-sex)offender population (now managed by Counties as a result of California’s ‘realignment’ legislation)</p>	<p>Increase long-term public safety; enhance arrestees’ constitutional right to due process; and, Reduce the harm associated with cycling in and out of incarceration.</p>	<p>Data driven analysis for system reorganization. Santa Cruz justice administrators embrace a practitioner/researcher relationship to use data-driven analysis to target deliberate interventions; engages in ongoing multi-agency collaborations that enhance the system-wide data analysis process --it focuses on systemic factors and outcomes, rather than exclusively on individual offender behavior. As a result, adopted strategies include:</p> <ul style="list-style-type: none"> • pre-sentence release alternatives to jail holding for non-sentenced individuals. • expanded pretrial service program and increased range of release options, based on validated, objective risk criteria: including pre-arraignment release and own-recognition. • The Warrant Reduction Project (WRAP): WRAP reconnects probationers on the verge of triggering an arrest warrant with probation officers and the courts, who collaborate with a local community-based organization to assist probationers in maintaining contact with department staff. • Expedited court sentencing to probation; based on own study planning as future reform systemic interventions and innovative approaches that utilize community programs to divert certain low-level drug offenders from incarceration. 	<p>Dedicated portion of state sales tax revenue and Vehicle License Fees (VLF) (trailer bills AB 118 and SB 89).</p> <p>CA legislature appropriates funding for 2011 Public Safety Realignment.</p>	<p>Santa Cruz remains significantly below the state average in number and proportion of non-sentenced inmates, preserving public resources.</p> <p>By 2010, Santa Cruz ranked sixth from the bottom among the state’s 58 counties in proportion of adults incarcerated.</p> <p>Crime reports appears to have been slightly slower in Santa Cruz (down 45% from 1990 to 2010) than statewide (down 52%), Santa Cruz adult arrest rates (down 48% from 1990 to 2010) fell faster than those statewide (down 41%).</p>
<p>Sex Worker Focused (SWF) Intervention, Miami, FL http://www.udel.edu/cdas/project/023/womenprotect.htm</p>	<p>Female sex workers (primarily African Americans) [Heroin and other injectable drugs]</p>	<p>Prevent HIV, Hep B and C infection</p>	<p>Peer-delivered services and empowerment. SWF Intervention: Brief protocol consisting of two one-hour peer-delivered sessions on five basic elements: engagement, education, action, testing, and referral</p>	<p>NIDA grant</p>	<p>For the 806 participants randomized to NIDA Standard Intervention or SWF Intervention,</p> <ul style="list-style-type: none"> • Participation in either intervention was effective in reducing drug use and sexual risk behaviors; • SWF was more efficacious than standard program with reductions in unprotected oral sex and violent victimization.²

¹Read also: Foglesong, T., & Rengifo, A. (2006). *How the probation department in Santa Cruz county can improve justice, reduce jail crowding, and strengthen public safety*. Washington, DC: Vera Institute.

²Surratt, H. L., & Inciardi, J. A. (2010).An effective HIV risk-reduction protocol for drug-using female sex workers. *J Prev Interv Community*, 38(2), 118-131.

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Name	Target Pop'n	Intended Goal	Intervention/Strategy	Financing	Evidence/Outcomes
SHEWAY, Vancouver, Canada http://sheway.vcn.bc.ca/	Disenfranchised women, with a psychiatric disorder; mostly 'first nation' [Alcohol, cocaine, heroin, and tobacco]	Improve neonatal and infant health outcomes	Person-centered health and social services. Specialized pre- and post-natal care for women with SUD. Integrated health and social services (both informal and formal) at a single-access site; Prenatal services, post-natal services	YWCA and provincial government agency	A review of client files from 1993 and 2002, showed that indicators of infant health (e.g. Apgar scores at birth, symptoms of withdrawal) improved or maintained steady rates, while clients' concurrent health and social problems (e.g. inadequate income and housing, infectious disease) decreased. ¹
St. Anne's Corner of Harm Reduction (SACHR), Bronx, NY http://www.sachr.org/	Disenfranchised communities (Latina/Hispanic women, homeless) [injectable drugs in particular]	Reduce health risks associated with injection drug use	Person-centered health and social services. Needle/syringe exchange. Provide self-management strategies; Integrate HR and drug treatment: Low-threshold service meeting survival needs; training in stress reduction; education and information; healing and empowerment; and social integration.	NY state and city health departments, private foundations, private donations	Sample outcomes from case study vignette: <ul style="list-style-type: none"> • Engagement in low threshold services led to access to RH care and HIV testing; • Initiation of methadone and AIDS medication, and engagement in women's group; • Self-management of medical and social needs; • Improvement in quality of life and volunteer work as peer-counselor for others.²
Step'n Out: Wilmington DE, Bridgeport CT, Portland OR, Richmond VA, Providence RI, Hartford CT http://clinicaltrials.gov/show/NCT00302575	Individuals with pre-incarceration substance use disorders initiating parole [primarily marijuana]	Reduce rearrests for new offenses, reduce parole violations	Re-entry support. Collaborative behavioral management (CBM) (an initial session between the parole office, treatment counselor, and offender followed by 12 weekly parole contacts). Graduated rewards and sanctions	NIDA, SAMHSA, CDC, NIAA, and US Department of Justice	CBM was associated with fewer months of primary drug use among parolees over 9-month follow-up and decreased use of 'non-hard' drugs. There were no differences in overall crime, and no differences in parole violations despite intensification of correctional supervision ³

¹Marshall, S. K., Charles, G., Hare, J., Ponzetti, J. J., Jr., & Stokl, M. (2005). Sheway's services for substance using pregnant and parenting women: evaluating the outcomes for infants. *Can J Commun Ment Health*, 24(1), 19-34.

²Majoor & Rivera. 2003. Journal of Substance Abuse Treatment. Example of an integrated, HR drug tx program

³Friedmann, P.D. et al. (2011). Collaborative behavioral management among parolees: drug use, crime and re-arrest in the Step'n Out randomized trial. *Addiction*, 107, 1099-1108.

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Name	Target Pop'n	Intended Goal	Intervention/Strategy	Financing	Evidence/Outcomes
Texas Juvenile Justice TBI Partnership Project http://www.hhsc.state.tx.us/hhsc_projects/abi/about.shtml	Youth entering the Texas juvenile justice system with pre-diagnosed MH or SA issues	Reduce youth recidivism; Help youth re-integrate and be responsible community members; Build service capacity and system change	Criminal justice education. Collaborations between state, county and local agencies coordinating services; Multi-agency and multi-system collaboration; Calming room and CBT; 12 week, 2 days/week program for groups of 8-10; Raise awareness among case and social workers, educators, counselors, law enforcement, and employers about brain injuries and their effects on behavior (e.g. impulsivity, poor executive functioning); Establish a special TBI Treatment Center for youth with greater behavioral dysfunction.	Federal grant (USDHHS)	<ul style="list-style-type: none"> • 45 days after institution of the calming room and CBT, referrals to security or isolation decreased by more than 50%; • Within 90 days, referral to security, isolation, injury to self, others and staff fell by 75%; • Recidivism rate after implementing a 12 week, 2 days/week program for groups of 8-10 fell from 75% to 15% in one year¹
Using technology to prevent and reduce college drinking http://www.ncbi.nlm.nih.gov/pubmed/22486431	Undergraduate college students	Reduce binge drinking on campus and reduce liquor law violations	SBIRT <ul style="list-style-type: none"> • A computerized, standardized, on-line assessment of alcohol use, followed by a brief intervention based on the students' information used by 54,000 graduate and undergraduate students 	SAMHSA	<ul style="list-style-type: none"> • Binge drinking dropped 27% on campus; • Frequent binge drinking dropped 44%; • Liquor law violations decreased from 542 to 158 for 18-22 year olds²
Veterans Jail Diversion and Trauma Recovery Project, Connecticut http://www.ct.gov/dmhas/cwp/view.asp?A=3833&Q=453950	Justice-involved veterans who may be experiencing trauma-related mental health symptoms, esp. returning from Iraq and Afghanistan	Support veterans to get necessary recovery and trauma services and build a new services recovery model within the state	Jail diversion. Recovery support. The Project diverts veterans, uses a community-focused recovery orientation model, provides case management, and links with participants to individualized treatment plans. Services include outreach, outpatient counseling, community case management, deployment health education, clinician training, transportation, and recovery support services.	SAMHSA grant to Connecticut Department of Mental Health and Addiction Services	Outcome evaluation not available at this time. The SAMHSA initiative has reshaped how communities and states address the behavioral service needs of justice-involved veterans, increased access to services for people in the VA system and in the community, coordinated services between the VHA and community-based service providers, and developed a strong presence of peers on the advisory committees and as service providers.
Veterans Treatment Court, Buffalo NY http://www.buffaloveteranscourt.org/	Veterans being arraigned in court, with underlying condition	Bring services to veterans arraigned for a crime, rather than incarcerate, so they become productive community members	Court diversion. Consolidate Veterans on one docket. VTC judge contacts the Veterans Justice Outreach Specialist (VJO) from the VHA. The VJO may go to court, recommend the level of treatment appropriate. The VTC judge orders the veteran to comply with the VA's recommendations. Veterans who lack VA benefits are assisted to obtain a disability rating (i.e., monthly disability compensation, VA's Vocational Rehabilitation and Employment (VR&E) Vet Success Program).	Veterans Health Administration supports the Veterans Justice Outreach Specialist; VTCs use resources already in the community.	VTCS are currently located in more than 50 communities across the country. These courts appear to greatly facilitate the return of veterans to contributing citizens of the community.

¹Beckworth, Bettie Peebles. (2012). TBI and the juvenile justice population. Oral presentation. 2012 NASHIA-HCBS Joint Conference. Arlington, VA: September 10. (more info: Bettie Peebles Beckworth at 512-487-3415 or bettie.beckworth@hhsc.state.tx.us or Erin M. Espinosa, 512-424-6728 or Erin.Espinosa@tjpc.state.tx.us)

²Wodarski, J. S., Macmaster, S., & Miller, N. K. (2012). The use of computer technology to reduce and prevent college drinking. [Research Support, U S Gov't, P H S]. *Soc Work Public Health*, 27(3), 270-282.

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Name	Target Pop'n	Intended Goal	Intervention/Strategy	Financing	Evidence/Outcomes
VOCAL-NY and POWER, http://www.vocal-ny.org/about-us/ .	low-income people who are active and former drug users	To create healthy and just communities that recognize the dignity of drug users	It accomplishes its mission through community organizing, leadership development, public education, participatory research and direct action. <i>POWER Academy</i> utilizes popular education methods that rely on the lived experience of our members to develop their skills and issue knowledge. <i>POWER Academy</i> courses include: Campaign strategy, Understanding power relations, Outreach and recruitment, Holding effective meetings, Action planning, Media relations, Coalition building.		
Washington State Brief Intervention Referral & Treatment (WASBIRT) http://www.dshs.wa.gov/RDA/research/4/60/	Working-age, disabled patients who qualified for Medicaid and were seen in 9 hospital EDs in 6 counties	Reduce ED use rates, medical costs, criminal behavior, disability, and death for patients with alcohol and drug problems	SBIRT Screening and brief intervention for ED patients in target population, and referral to treatment if desired. Compared changes in costs with a matched comparison group of Medicaid patients who did not receive screening or brief intervention; difference-in-differences estimates.	SAMHSA/CSAT grant	From 2004-2006, a reduction in Medicaid costs per member per month of: <ul style="list-style-type: none"> • \$366 (P=0.05) for all patients, including those referred to chemical dependency (CD) treatment • \$542 (P=0.06) for patients who did not receive a referral to treatment • Reduced in-patient medical days for patients admitted through EDs • Decreased inpatient utilization (P=0.04)¹
Woman-focused Intervention for African American Crack Abusers http://choicehiv.org/interventions/interventions.php?action=intervention_detail&intervention_id=13&render=html	African American women	Reduce sex-risk behaviors and drug use and increase employment and housing status	Economic empowerment and supported employment. The woman-focused intervention included culturally enriched content grounded in empowerment theory and African American feminism.	NIDA grant	Standard group and woman focused group made significant reductions in crack use and sex-risk behaviors. The woman-focused empowerment intervention resulted in greater improvement in employment and housing status ²

¹Estee et al.2010.Medical Care. Eval of WA State SBIRT Project in EDs

²Wechburg, W.M., Lam, W. K. K., Zule, W. A., Bobashev, G. (2004). *American Journal of Public Health*, 94(7), 1165-1173.

Appendix 3. Innovation Center Initiatives in 2010-2011

Taken from: <http://innovation.cms.gov/Files/reports/Innovation-Center-Year-One-Summary-document.pdf>. See also: <http://innovation.cms.gov/initiatives/index.html>

FEATURE	LENGTH	PARTICIPANTS/LOCATIONS
PRIMARY CARE TRANSFORMATION		
Comprehensive Primary Care Initiative Demonstration Public-private partnership to enhance primary care services for Medicare recipients, including 24-hour access, care plans, and care coordination	2012; 4 years	ARK, CO, NJ, NY (Capital District-Hudson Valley Region), OH & KY: Cincinnati-Dayton Region, OK: Greater Tulsa Region, 75 primary care practices per state; 2,347 providers
FQHC Advanced Primary Care Practice Demonstration Care coordination payments to FQHCs in support of team-led care, improved access, and enhanced primary care services	3 years ending on 10/31/14	500 FQHCs in 44 states
Multi-payer Advanced Primary Care Practice Demonstration State-led, multi-payer collaborations to help primary care practices transform into medical homes	3 years	NC, ME, MI, MN, NY, PA, RI, VT
Independence at Home Home-based care for patients with multiple chronic conditions	Summer 2012; 3 years	Up to 50 practices with at least 200 high need beneficiaries.
BUNDLED PAYMENTS FOR CARE IMPROVEMENT		
Bundled Payment for Care Improvement Initiative Episodic payments around inpatient hospitalizations to incentivize care redesign	2012; 3 years	4 payment models for acute care only or acute care bundled with post-acute care
ACCOUNTABLE CARE ORGANIZATIONS		
Pioneer Accountable Care Organization Model Initiative Experienced provider organizations taking on financial risk for improving quality and lowering costs for all of their Medicare patients	January, 2012; 3 years (opt 2-year ex)	32 ACOs—see link for full list of orgs
Accelerated Development Learning Sessions Public opportunities to learn from leading experts about successful ACO development	June 2011; 3 sessions completed	Open to leadership from developing or existing ACOs
Advanced Payment Accountable Care Organization Model Initiative Prepayment of expected shared savings to support ACO infrastructure and care coordination	Payments end June 2014	Physician-based and rural ACOs in the Shared Savings Program
Physician Group Practice Transition Demonstration A precursor to the Medicare Shared Savings Program; rewards physician groups for efficient care and high quality	January, 2011; Up to 3 years	10 group practices started the demo; 3 moved to the Pioneer ACO model
MEDICARE-MEDICAID ENROLLEES		
State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees Assistance to help states engage stakeholders in redesigning care for Medicare-Medicaid enrollees	May 2011; 18 months (w ext option)	CA, CO, CT, MA, MI, MN, NY, NC, OK, OR, SC, TN, VT, WA, WI
Financial Alignment Model Demonstrations Opportunity for States to implement new care and payment systems to better coordinate care for Medicare-Medicaid enrollees	January, 2013; 3 years	38 States and DC have submitted letters of intent

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FEATURE	LENGTH	PARTICIPANTS/LOCATIONS
CAPACITY TO SPREAD INNOVATION		
The Partnership for Patients National campaign targeting a 40% reduction in hospital-acquired conditions and a 20% reduction in 30-day readmissions	April 2011; Ongoing	26 Hospital Engagement Networks supporting over 3,200 hospitals in all 50 states
Innovation Advisors Program Training health care providers from around the country in achieving the three-part aim	January 2012; Ongoing	73 Advisors selected and started January 2012 with up to 127 more in the next cycle
Health Care Innovation Challenge A broad appeal for innovations with a focus on developing the workforce for new care models	3/30/2012; 3 years	To be determined
Community-based Care Transitions Program (CCTP) To improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measurable savings to the Medicare program.	Started 2011; 5 years	102 organizations, each with 2 year agreement
OTHER		
Medicaid Emergency Psychiatric Demonstration Expanding access to inpatient psychiatric services for Medicaid beneficiaries	Spring 2012; 3 years	Unspecified number of states
Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) Program Collaborating with States to test the effectiveness of preventive services in Medicaid	Awarded 09/13/2011; 5 years	WI, MN, NY, NV, NH, MT, HI, TX, CA, CT
Strong Start for Mothers and Newborns Initiative: Enhanced Prenatal Care Models Test and evaluate enhanced prenatal care interventions for women enrolled in Medicaid or CHIP who are at risk for having a preterm birth; improve the health outcomes of pregnant women and newborns, and decrease the anticipated total cost of medical care during pregnancy, delivery and over the first year of life for children born to mothers in Medicaid or CHIP.	Feb 2013; 4 years	27 awardees, 182 participants

Appendix 4. Affordable Care Act Sections and Applications to Harm Reduction

Developed by the Legal Action Center. Slightly adapted by authors to Harm Reduction.

Section	Legal Action Center Description	Opportunities for Advancing Harm Reduction (HR)
<p>HEALTH INSURANCE EXCHANGES</p> <p>(§ 1311)</p>	<p>Each state is required to establish an American Health Benefit Exchange to facilitate the purchase of qualified health plans, and a Small Business Health Options Program (SHOP) Exchange to assist qualified small employers with 100 or fewer employees with enrolling their employees in qualified health plans in the state’s small group market.</p> <p>Qualified health plans participating in the Exchanges must provide, at a minimum, the “essential health benefit package,” as defined by the HHS Secretary. The law states that the essential health benefit must include at a minimum:</p> <ul style="list-style-type: none"> • ambulatory patient services; • emergency services; • hospitalization; • maternity and newborn care; • mental health and substance use disorder services, including behavioral health treatment; • prescription drugs; • rehabilitative and habilitative services; • laboratory services; • preventive and wellness services and chronic disease management; and • pediatric services (including oral and vision care). <p>The HHS Secretary will ensure that the <i>scope</i> of essential health benefits offered by a qualified health plan will be equal to the scope of benefits under a “typical” employer plan. Additionally, qualified health plans participating in the state Exchanges must contract with certain “essential community providers” that serve predominantly low-income, medically-underserved individuals. Exchanges become operational January, 2014.</p>	<ul style="list-style-type: none"> • Educate state entities charged with planning the state Exchanges on appropriate HR services that meet current guidelines; • Partner with state groups receiving grant funds and collaborate to ensure states plan for inclusion of MH/SUD services within the state Exchanges.
<p>CLASS Program</p> <p>(§ 8001)</p>	<p>Creates a national voluntary insurance program for purchasing community living assistance services and supports (“CLASS”) to enable individuals with functional limitations to live independently in the community, personal choice and independence to live in the community.</p>	<p>On October 14, 2011, Secretary Sebelius transmitted a report and letter to Congress stating that the Department does not see a viable path forward for CLASS implementation at this time.</p>
<p>MEDICAID HEALTH HOMES</p> <p>(§ 2703)</p>	<p>This provision gives states the option to amend the state Medicaid benefit to enroll Medicaid beneficiaries with chronic conditions into a health home selected by the beneficiary. Beginning January 1, 2011, a state may provide for medical assistance to eligible individuals with chronic conditions health home services that are provided by a designated provider, a team of health care professionals, or a health team. Health home services include:</p> <ul style="list-style-type: none"> ▪ comprehensive care management ▪ care coordination and health promotion ▪ comprehensive transitional care 	<ul style="list-style-type: none"> • Advocate for inclusion of SUD -related conditions in eligibility requirements; • Ensure that SUD/HR providers (and non-traditional service providers) are included under authorized services; • Suggest primary care/HR -specific demonstrations (either with HR service providers designated as health homes, or with the particular needs of

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	<ul style="list-style-type: none"> ▪ patient and family support ▪ referral to community & social support services ▪ health information technology to link services <p>During the first 8 fiscal year quarters the state plan amendment is in effect, the federal medical assistance percentage applicable to these services will be 90 percent.</p> <p>State option available January 1, 2011 and planning grants awarded.</p>	<p>clients impacted by SUD/R in mind);</p> <ul style="list-style-type: none"> • Include clinical outcomes related to SUD/HR in planning grant data collection. <p>See also http://familiesusa2.org/assets/pdfs/health-system-reform/Health-Homes-in-Medicaid.pdf</p> <p>http://www.allhealth.org/briefingmaterials/BehavioralHealthandPrimaryCareIntegrationandthePerson-CenteredHealthcareHome-1547.pdf</p>
<p>CENTER FOR MEDICARE AND MEDICAID INNOVATION (§ 3021)</p>	<p>Creates a new entity within CMS: the Center for Medicare and Medicaid Innovation (“Innovation Center”). The Innovation Center will test various innovative payment and service delivery models to determine how these models reduce program expenditures while preserving or enhancing the quality of care provided to individuals enrolled in Medicare, Medicaid, and CHIP. Established January 1, 2011.</p>	<ul style="list-style-type: none"> • Encourage inclusion of SUD/HR service providers in diverse range of pilots; • Propose SUD/HR -specific demonstrations; • Include clinical outcomes related to SUD/HR in project data collection; • Develop models for primary care/SUD/HR services that match/include the priorities outlined by the Secretary. See Appendix 3. Table of Innovations
<p>Medicare Shared Savings Program (ACCOUNTABLE CARE ORGANIZATIONS) (Sec. 3022)</p>	<p>Establishes a Medicare shared savings program that incentivizes groups of providers and suppliers to work together through Accountable Care Organizations (“ACOs”) with the goal of promoting accountability, and thus better care coordination, for Medicare fee-for-service patient populations. Starting January 1, 2012, professionals who organize into certified ACOs are eligible to receive additional payments for shared savings if the ACO meets certain quality performance standards and spending benchmarks.</p>	<ul style="list-style-type: none"> • Advocate for inclusion of primary care/SUD providers in ACOs; ensure that the ACO certification process does not exclude SUD/HR providers; • Ensure that incentives to primary care providers who refer SUD/HR to treatment providers within the ACO are appropriate to address the health care needs of persons with substance use disorders (e.g. methods for gaining savings in the delivery of SUD benefits should not negatively impact care).
<p>MEDICARE PREVENTION BENEFITS (§ 4103)</p>	<p>Medicare will require a personalized prevention plan, which is an individualized plan based on a health risk assessment (HRA). Components of an HRA have not been developed yet, but may include: updating medical history, creating a comprehensive list of health service providers and/or suppliers for an individual, routine measurements and tests, establishing (and later updating) a screening schedule based on individual risk, identifying chronic disease-specific risk factors, and assessing overall health risks. It is envisioned that the HRA will be adaptable to various settings including in-person, telephone, and web-based and may also be used both in individual and group settings (e.g., traditional physician-patient encounters as well as community-based prevention programs). Medicare will cover the entire cost of personalized prevention care benefits as long as they are only provided once annually. Effective January 1, 2012.</p>	<ul style="list-style-type: none"> • Advise creation of SUD/HR outcome measures for inclusion; • Advocate for SUD/HR -specific model screening schedules to include relevant screening, assessments, treatment, and procedures. <p>See CDC A Framework for Patient-Centered Health Risk Assessments</p> <p>http://www.cdc.gov/policy/opth/hra/</p>
<p>ADULT HEALTH QUALITY</p>	<p>The ACA instructs the HHS Secretary to identify and publish a recommended core set of adult health quality measures for Medicaid eligible adults. As part of this exercise, the HHS Secretary will identify</p>	<ul style="list-style-type: none"> • Advocate for inclusion SUD/HR -specific priorities: some SUD/HR quality measures are included in the

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<p>MEASURES(Sec. 2701)</p>	<p>existing adult health quality measures applicable to Medicaid-eligible adults that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage overtime.</p> <p>Out of any funds in the Treasury not otherwise appropriated, appropriates \$60 million for each of fiscal years 2010 through 2014. Funds remain available until expended. February 2013 – specification of AQC measures.</p>	<p>initial core set, but more should be added;</p> <ul style="list-style-type: none"> • Recommend that quality measures be updated frequently to include developing SUD/HR measures; • Ensure that HHS increases investment in research to develop SUD/HR quality measures in areas where these measures are lacking.
<p>CHRONIC DISEASE PREVENTION IN MEDICAID (§ 4108)</p>	<p>Establishes a grant program to award grants to states to provide incentives for Medicaid beneficiaries who participate in programs and demonstrate changes in health risk and outcomes by meeting specific targets. For example, programs may be aimed at helping individuals with: tobacco cessation; controlling or reducing weight; lowering cholesterol or blood pressure; avoiding the onset of diabetes, or in the case of a diabetic, improving the management of that condition; and addressing co-morbidities, including depression.</p> <p>States awarded grants must:</p> <ol style="list-style-type: none"> (1) track Medicaid beneficiary participation in the program and validate the changes in health risk and outcomes with clinical data (e.g., adoption and maintenance of new health behaviors); (2) establish standards and health status targets for program participants and measure the degree to which such standards are met; (3) evaluate the overall programmatic effectiveness; (4) report processes developed and lessons learned; (5) report on preventive services as part of reporting on quality measures for Medicaid managed care programs; (6) Conduct outreach and education campaign to make Medicaid beneficiaries and providers aware of the state initiatives under the program. <p>ACA Appropriates \$100 million for the 5-year period beginning January 1, 2011</p>	<ul style="list-style-type: none"> • Advocate for inclusion of SUD/HR -related clinical outcomes or modified targets for various MH/SUD conditions; • Develop training or curriculum for state entities involved in the grants to ensure awareness of SUD/HR -specific concerns; • Advise states (and/or partnering orgs) on health risk, outcomes, and clinical data most relevant to SUD/HR; • Develop specific programs or recommendations for programs aimed at clients with SUD conditions or concerns (or adaptations for existing programs); • Partner with states receiving grant funding ; • Assist states with their outreach and education campaigns, targeting SUD/HR providers and persons eligible for Medicaid.

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<p>GRANTS TO ESTABLISH WELLNESS PROGRAMS</p> <p>(§ 10408)</p>	<p>Grants will be available to small businesses if they provide their employees with access to comprehensive workplace wellness programs. This includes employers with 100 or fewer employees who do not already provide a workplace wellness program (as of the date of enactment).</p> <p>The HHS Secretary will develop criteria for comprehensive workplace wellness programs based on, and consistent with, evidence-based research and best practices. Generally, the program must include:</p> <ol style="list-style-type: none"> (1) Health awareness initiatives (health education, preventive screenings, and risk assessments); (2) Efforts to maximize employee engagement and mechanisms to encourage employee participation; (3) Initiatives to change unhealthy behaviors and lifestyle choices (including counseling, seminars, online programs, and self-help materials); and (4) Efforts to create a supportive environment to encourage healthy lifestyles, healthy eating, increased physical activity, and improved mental health. <p>5-year funding begins fiscal years 2011 through 2015.</p>	<ul style="list-style-type: none"> • Encourage HHS Secretary to consider concerns of SUD/HR in the development of program criteria; • Disseminate information on evidence-based research and best practices for wellness initiatives aimed at persons with SUD and/or their colleagues (e.g., general health awareness initiatives – health education, risk assessments, etc.); • Develop training curriculum or best practices for small businesses receiving grants to ensure awareness of SUD-specific concerns (e.g., creating a supportive environment).
<p>NATIONAL PREVENTION AND HEALTH PROMOTION STRATEGY(§ 4001)</p>	<p>Within one year of enactment, the National Prevention, Health Promotion and Public Health Council will develop and make public a National Prevention, Health Promotion, and Public Health Strategy (“National Strategy”). The National Strategy will set specific goals for improving the health of Americans through federally-supported prevention, health promotion, and public health programs. Additionally, the National Strategy will establish specific and measurable actions and timelines, and will make recommendations to improve federal efforts relating to prevention, health promotion, public health and integrative health care.</p>	<ul style="list-style-type: none"> • Advocate for inclusion of SUD/HR prevention strategies within the National Strategy; • Make recommendations for evidenced-based SUD/HR prevention measurements and guidelines; • Establish a presence for substance use disorders/HR within the broader scope of all prevention activities.
<p>NATIONAL QUALITY STRATEGY</p> <p>(§ 3011)</p>	<p>The HHS Secretary will develop and update annually a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. The National Strategy will include a comprehensive strategic plan with agency-specific benchmarks, coordinating activities among agencies and addressing strategies to align public and private payers with regard to quality and patient safety efforts.</p> <p>Appropriate priorities are those that:</p> <ol style="list-style-type: none"> (1) Improve health outcomes, efficiency, and patient-centeredness of health care; (2) Identify areas with potential for rapid improvement (especially quality & efficiency of patient care); (3) Address gaps in quality, efficiency, and health outcomes measures and data aggregation; (4) Address gaps in comparative effectiveness information; (5) Improve federal payment policy; (6) Enhance the use of health care data; (7) Address the health care provided to patients with high-cost chronic diseases; (8) Improve research and dissemination of strategies and best practices; and (9) Reduce health disparities. <p>January 1, 2011: National Quality Strategy established, submitted to Congress, published on website</p>	<ul style="list-style-type: none"> • Advocate for inclusion of SUD/HR -specific priorities in the National Strategy; • Establish a presence for MH/SUD within the broader scope of all priorities (e.g., show the role of MH/SUD in disparities, patient-centered care, use of health data and health IT, etc.); • Highlight the potential for rapid improvement with MH/SUD care (e.g., ability to focus on a specific population in smaller pilot projects); • Advise inclusion of broader MH/SUD goals in agency-specific benchmarks; • Promote collaboration and inclusion of MH/SUD in more “non-traditional” areas; • Encourage linking MH/SUD-specific outcomes measures to broader priorities.

Upstream Opportunities

<p>DATA COLLECTION TO REDUCE HEALTH CARE DISPARITIES</p> <p>(§ 4302)</p>	<p>Within 2 years of enactment, every federally conducted or supported healthcare program, activity, or survey must collect and report data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations (on smallest geographic level, if it can be aggregated). This provision also addresses healthcare disparities in Medicaid and CHIP by standardizing collection requirements.</p> <p>The National Coordinator for Health Information Technology will develop national standards for management of the data collected. The analyses will be available to the Office of Minority Health, the National Center on Minority Health and Health Disparities, AHRQ, CMS, CDC, the Indian Health Services, Office of Rural Health, and other agencies within HHS.</p> <p>Unspecified funding authorized, but not appropriated, beginning FY 2012. “Data may not be collected under this section unless funds are directly appropriated for this purpose in an appropriations act. “</p>	<ul style="list-style-type: none"> • Advocate for the need of robust data collection on health disparities to ensure that this provision is funded; • Advocate for inclusion of MH/SUD-specific health outcomes (clinical or population) in federally-required data collection; • Recommend best practices for necessary (or additional) data security measures for MH/SUD status; • Advise the appropriate population threshold for reporting aggregate MH/SUD data (or guidelines on how to determine when MH/SUD data are too small to be reported in aggregate)
<p>CHANGES TO TAX-FREE SAVINGS ACCOUNTS</p> <p>(§ 9003)</p>	<p>Changes the existing definition of a “qualified medical expense” for the purposes of reimbursement from health flexible spending arrangements (FSAs) or health reimbursement arrangements (HRAs) and distributions from health savings accounts (HSAs) or Archer medical savings accounts (Archer MSAs).</p> <p>Going forward, over-the-counter drugs <u>not prescribed</u> by a doctor cannot be reimbursed with excludible income through health FSAs, HRAs, HSAs, or Archer MSAs, with the exception of insulin. The tax penalty on expenditures from a HSA or an Archer MSA that are not used for qualified medical expenses increase to 20% of the amount used.</p> <p>Applicable in tax years beginning after December 31, 2010.</p>	<ul style="list-style-type: none"> • National efforts. Advise HHS on how this change impacts people with SUD conditions and concerns specifically.