




Harm Reduction Best and Worst Practice

Peer-Informed Policy and Program
Recommendations in the Time of COVID-19

Report to INPUD
Cheryl White and Russell Newcombe
3D Research, Liverpool, UK
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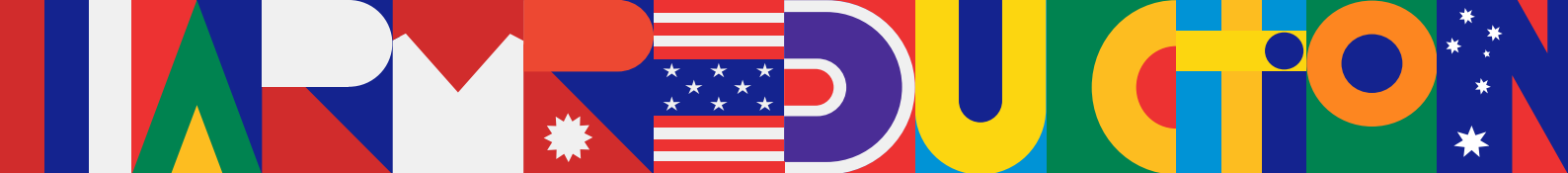
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Thanks to the 20 drug user activists around the world, whose interviews provided the basis for the ideas and recommendations presented here. Thanks for the support and assistance provided by Judy Chang and INPUD staffers, Eliot Albers, and Shona Schonning.

Dedicated to the memory of Raffi Balian and Judith Byrne - two pioneers of harm reduction and drug user activism whose early deaths were brought about by the egregious constraints of drugs prohibition. Their wonderful ideas and wise words contributed to the research which helped produce this document.



Harm Reduction: Best and Worst Practice

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1. Introduction

“Prohibition is the reason we have all these harms. We are overdosing and getting harmed and dying because of the war on drug users. When we finally acknowledge and confront the cause of almost all the harms – drugs prohibition – we will be much closer to finally putting an end to them. Until such a time, harm reduction saves lives.”

Canadian Project Interviewee, 2016

In 2016, INPUD commissioned a project that used in-depth, qualitative interviews with twenty peer drug user activists and harm reduction specialists from a range of different countries to develop a comprehensive set of seventeen key harm reduction interventions based on ‘best and worst practices’ in these areas. The result was a “Harm Reduction Best Practices Tool Kit”, intended for harm reduction service providers around the world (Newcombe & White, 2016). It is outside the scope of this brief to address all seventeen areas discussed by the project’s participants. Instead, we make use of this forum to focus on three key harm reduction interventions whose practices are widespread and sufficiently established enough to have relevance to policy and programming experts around the world. These interventions are:

- **Opioid and Stimulant Agonist Therapies (OATs/SATs)**
- **Needle and Syringe Programs (NSPs)**
- **Overdose Prevention Interventions (ODP)**

The intention of this brief is to provide globally relevant recommendations for best practices in harm reduction policy and programming while drawing attention to some of the main obstacles that currently hamper these efforts. Peer-based expertise is utilised to provide an insider inventory of best and worst practices in the three harm reduction interventions identified above. These peer-informed recommendations are relevant to and centred around the needs and priorities of fellow drug users working in and making use of these programmes and services across the globe.

Although these interviews took place several years ago, it is fair to say that peer-driven advancements within OATs/SATs, NSPs, and ODP interventions around the globe have been slow in coming. This is true both in the general adoption of harm reduction interventions in countries that formerly or currently lack them, as well as within the services of those countries that do provide them. And maddeningly, the majority of harm reduction services continue to be staffed by non-drug users and other professionals and tend to prioritise their needs over those of drug using clients and, where they exist at all, drug using staff members. This continued lack of peer-led interventions means that the feedback of the interviewees continues to hold relevance today and there is much we can take away from it, as the following pages illustrate.

1.1 Best and worst practices in three key harm reduction interventions

The decision to focus on OATs/SATs, NSPs, and ODP interventions was based on the fact that these programmes and strategies have been described as central in importance in the field of drug related harm reduction. This is because they are the most widespread, have the strongest evidence bases, and are supported by key international bodies and expert groups - see, for example, Hunt (2010), Harm Reduction International (2021), and World Health Organization (2020).

In the original interviews, Stimulant Agonist Therapies (SATs) comprised their own section and interviewees discussed a broad range of worst and best practices associated with them. Amongst a host of problems they discussed, the majority of interviewees lamented the continued lack of access to this intervention in almost all countries around the globe. As a means of overcoming these problems, project participants suggested best practices that address the specific needs of stimulant drug users, most notably the on-going need to gain access to currently unavailable programs. However, in the interests of brevity, the glaring lack of SAT programming currently in existence, and the general applicability of most strategies from Opioid Agonist Therapies to SATs, we will collapse them here into one section and highlight best and worst practices applicable to both as identified by our peer interviewees.

1.2 Peer-led research

The project's twenty interviewees were asked to identify both 'best' and 'worst' practices currently in place within the three harm reduction interventions that comprise the focus of this brief. The interviews were then subjected to thematic analysis in an effort to fully flush out effective and problematic approaches to service provision in these areas. Finally, the feedback of interviewees was used to create a narrative that includes a comprehensive inventory of harm reduction policy and programming recommendations. These recommendations build on successful strategies while effectively drawing attention to those areas that continue to require changes and improvements. While the recommendations of interviewees are neither exhaustive nor mutually exclusive, they do represent expert, peer-based analysis covering the most salient issues with respect to policy and programming in OATs/SATs, NSPs, and ODP interventions world-wide.

The countries represented by the participants in this project included Canada, Australia, USA, Ukraine, Nepal, India, Russia, UK, Netherlands, Sweden, Lithuania, Thailand, and South Africa. Sadly, some of these people are no longer with us and their deaths impoverish our global efforts. But we are fortunate and grateful to have their contributions within the pool of specialist knowledge we draw upon here.

The information gleaned from these interviews constitutes the expert views of a geographically diverse group of peers who have specialised in the design, creation, and implementation of front-line harm reduction services and interventions. Many of them, including the authors of

this brief, have been pioneers in the field of drug-related harm reduction and global drug user activism from their inception in the 1980's and 1990's. Moreover, all are members of the *International Network of People who Use Drugs – INPUD*, and many were instrumental in helping to build this, and other drug user networks and organisations around the globe. And all are active, in a variety of ways, in local, regional, national, and international levels of organisation, implementation, and/or evaluation of peer-driven harm reduction programmes and services that make use of best practice interventions.

Each of the participants identified as a drug user and these drugs included a broad range of illegal and stigmatised psychoactive substances and/or they were clients of the legal but demonised Opioid Agonist Therapies (OATs). And many had either injected in the past or continued to inject at the time the interviews were conducted. Crucially, respondents had direct experiences working as drug users in harm reduction programs/services, or they have served in managerial positions providing oversight to and supervision of other harm reduction program employees. Finally, all the project participants had direct experiences working cooperatively with other harm reduction specialists and drug user activists to share best practices and problem solve on-going barriers to service access worldwide. Working through drug user networks like INPUD and the women's network within INPUD, *INWUD - the International Network of Women Who Use Drugs*, many of these activists and harm reduction experts also assisted in securing fiscal support from a range of international funding bodies such as the WHO and various UN agencies, notably the UNODC and UNAIDS to subsidise and finance peer-based harm reduction interventions and drug user organising efforts around the globe.

It is critical to note here that while all those interviewed clearly identified as drug users, some were necessarily forced to keep this identity secret owing to the harsh prohibitionist laws and stigma attending this behaviour in their countries of origin. In fact, had they outed themselves and been public about their drug use, they may have found themselves out of jobs and possibly in legal trouble with potentially harsh repercussions. For these reasons, we consider their participation in this project as acts of political and personal bravery and commend and thank them for taking part. It was with this consideration in mind that we designed the project to keep their identities anonymous.

While the demographic details and names of those interviewed will not be used in this brief, the quotes do reference their countries of origin (see Appendix for details). The feedback generated by respondents is intended to assist in the creation of programming and policy best practices for harm reduction service providers and policy makers around the globe. This brief provides a platform for detailing these peer-led recommendations. We rely on direct quotes, which are *italicised*, to highlight problematic areas within each of the three interventions as well as to advance interviewee feedback on best practice strategies for overcoming the problems they identified.

With this last point in mind, it is worth drawing attention here to a paramount suggestion that all interviewees advanced; **that it is crucial to have *all* harm reduction interventions guided by and centred around the diverse and particular needs of drug using and injecting peers.** All respondents, in various ways, identified this as a guiding principle for helping to ensure that best practice is achieved in all aspects of harm reduction policy and programming. The following suggestions from an American interviewee provide a good example of how this sentiment was more specifically expressed:

“So first, people should go out into the community, consulting with drug users, accessing them through other programmes that they frequent and get their feedback and build a program that is centred on their needs. Then make sure they are working for the program. Have the experts in a front-line capacity...”

The insights provided by peer, drug using experts in this project promote a broad range of concrete suggestions and practical strategies towards maximising the positive and minimising the negative experiences of stigmatised drug-using peers working in or accessing harm reduction programmes and services around the globe.

1.3 Harm reduction in the time of global pandemics

Those of us involved in this project (authors and interviewees alike) have worked to advance the human rights and public health goals of our global community of drug using peers for decades. These efforts have culminated in the universal condemnation of drugs prohibition, identifying it as the overwhelming cause of drug-related harms and deaths. Our fight to mitigate the negative consequences of drugs prohibition have fuelled demands for world-wide legal regulation of drug use and drug markets. All of our efforts to effect such changes have taken place in the context of global health pandemics disproportionately affecting our communities, including HIV/AIDS, hepatitis C (hereafter HCV), and tuberculosis (hereafter TB). More recently, there have been an unprecedented number of overdose deaths associated with suspect prescribing practices and the arrival of fentanyl into the illicit opioid market, especially in North America. These overdoses, owing to their large numbers, constitute epidemic levels within those injecting drug using communities and are thus worthy of mention here in the context of this discussion.

Our long-standing practice of providing services to marginalised drug users in the context of health pandemics meant that the impact of the worldwide outbreak of COVID-19 (SARS-CoV-2 infection) was not unprecedented in our experience. However, the lockdowns of 2020, 2021, and 2022 highlighted many failings as well as potential improvements of current harm reduction programs and made the risks and harms of drugs prohibition more glaring than ever. This has propelled us to publish our conclusions on peer-driven harm reduction worst and best practices in these key interventions now.

1.4 Harm reduction lessons learned from the COVID-19 pandemic

Around the world, drug user activists, harm reduction specialists, and researchers have all been working to more clearly identify both the shortcomings and the potential improvements to harm reduction services that COVID-19 has brought into focus - see, for example, Picchio et al. (2020), Karamouzian et al. (2020), Roxburgh et al. (2021), and May et al. (2022). The extreme measures that were implemented around the globe to reduce the spread and negative repercussions of COVID-19 transmission led to both positive and negative changes to the ways that harm reduction services were carried out. These changes have particular relevance to the harm reduction interventions occupying the focus of this brief because, as pointed out earlier, these policies and practices are the most widespread and best researched.

In June of 2020, INPUD released the results of an online survey documenting the experiences of peer members of our global drug using community with respect to the COVID-19 pandemic and its impact on key harm reduction interventions and programmes with a focus on lock-down issues: <https://www.inpud.net/en/covid-19-survey-reports-health-rights-people-who-use-drugs-pandemic-environment>

Although some participants in the survey identified several progressive changes made to harm reduction services during the lockdowns, many reported no real changes or a decreased access to services owing, in large part, to the fact that many harm reduction services work out of larger community-based organisations, such as health centres and clinics and many of these were closed during the lockdowns. But even in the few countries where services were changed to accommodate the new realities associated with the lockdowns, many survey respondents expressed serious concerns regarding the permanency of these changes, rightly worrying that less progressive policies and practices would recommence upon the ending of the lockdowns.

When it came to the more negative trends surrounding drug use and harm reduction service provision during the COVID-19 pandemic, the INPUD survey documented a significant increase in online drugs purchases with a corresponding decrease in safe supply. This was especially the case where adulterants were concerned, with new and more dangerous mixes infiltrating the global drugs market during the lockdowns. And, distressingly, a number of respondents discussed the fact that naloxone take-home doses were not increased during the lockdowns despite the obvious increase in the risk of opioid overdoses that isolated opioid users were facing. And, finally, when it came to changes to drug laws, survey respondents reported that there were almost no significant gains made. Where laws and practices were changed, respondents noted that those changes almost always benefited those in authority positions, especially those involved in community policing who were given broader powers to stop, search, and detain citizens who ventured out during the lockdowns.

Examples of improvements to harm reduction services included reports by survey respondents in some countries that several of the more restrictive and oppressive policies and practices that attend Opioid Agonist Therapies were relaxed during the lockdowns. Thus, for example, several respondents reported that the number of take-home doses was increased, while the number of oppressive and invasive urine screens were reduced. Similarly, with respect to Needle and Syringe Programs, it was noted that in some countries, especially where peer-run, stand-alone services existed, the number of harm reduction materials that a drug user could obtain in a single encounter was increased. We learned from survey respondents that programs that had the potential to deliver harm reduction supplies to the homes and hangouts of drug users, or to use alternative delivery systems like the postal service were more successful in maintaining contact with vulnerable drug users and injectors during the lockdowns.

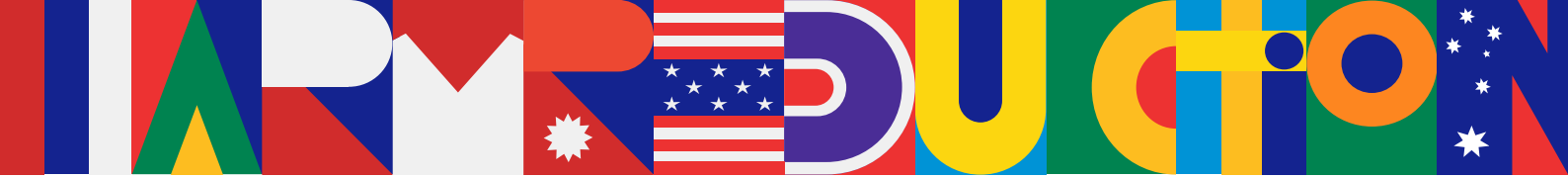
The INPUD survey showed that the greatest relaxation of restrictive rules and increases in innovative harm reduction service provision took place in higher-income countries, while drug users in lower and middle-income countries continued to experience more restrictive policies and practices, even during the lockdowns. Predictably, the most marginalised drug users around the world, the same people who make the most use of harm reduction services, tended to fall through the cracks in the majority of countries. Populations including the homeless and street-based sex workers tended to experience some of the most harsh treatment both during the lockdowns and upon their termination.

It is outside the scope of this project to include a more robust analysis of the impacts of the COVID-19 pandemic on harm reduction services and drug using populations around the globe. However, efforts will be made to draw the links between what we've learned from the pandemic and improvements we can make to the harm reduction interventions this brief does address.

1.5 Fundamental best practices across all harm reduction interventions

Before we move on to the specific feedback of respondents with respect to OATs/SATs, NSPs, and ODP interventions, there are several progressive recommendations from the interviewees that are equally relevant and applicable to all areas of service provision in the field of drug related harm reduction:

- Ensure that drug using peers are employed, especially in the front-line of harm reduction services, as properly compensated staff and not, as is generally the case, underpaid or unpaid volunteers. This applies equally to specialised programming for particularly marginalised drug users such as those living with HIV, HCV, youth, women, members of the trans community, the homeless, prisoners, those from middle- and low-income countries, and sex workers. **Bottom line: Hire peers to work with peers and compensate them fairly for their experience and expertise.**



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- **Ensure that all programme and materials development are informed by and centred around the specific and diverse needs, circumstances, and priorities of drug using clients** - who, as peers, are overwhelmingly made up of marginalised minorities - rather than the needs and experiences of the non-drug using majority (who continue to dominate the field of drug related harm reduction the world over).
- **Ensure that all services and materials distributed are free of cost and universally accessible**, and that service provision is voluntary, confidential, and when appropriate, anonymous.

With these expert, peer suggestions for improving all harm reduction services in mind, we turn now to the insights gained from the interviews with respect to the three interventions in focus: OATs/SATs, NSPs, and ODP.

2. Best and Worst Practice in Opioid and Stimulant Agonist Therapies (OATs/SATs)

Opioid Agonist Therapies (hereafter OATs) represent some of the first harm reduction interventions that became available to opioid dependent users in some western countries. Over the decades since their inception, they have become increasingly available to opioid dependant users in several non-western countries as well. That said, there is still a dearth of programming in many countries around the globe and this is even more true for Stimulant Agonist Therapies (hereafter SATs). This section presents an overview of the main ‘best’ and ‘worst’ practices that were identified by our interviewees. They address a broad range of strategies that came out of the interviews and are supplemented with direct quotes in italics. These views thus represent an inclusive, if not mutually exclusive inventory of best and worst practices for OAT and SAT interventions.

2.1 Adversarial and punitive nature of OATs/SATs

From the outset, respondents identified and criticised the punitive and adversarial nature of the way the vast majority of OATs are operated. As one Australian interviewee bluntly stated:

“I’ve been on methadone for over 25 years and I still feel like I’m being punished every day.”

Another participant from Sweden reiterated the point saying:

“...[t]he problem with (current OATs) is the adversarial nature of (them). We are forced to lie to our doctors in order to not be punished for behaviours that are often beyond our control. The lying makes it almost impossible for us to be honest about... our health care needs. This compromises our overall health as both drug users and regular patients.”

In response to these problems, respondents prioritised the need to stop all punitive practices and unethical regulations within OATs/SATs. As a critical starting point, interviewees called for an immediate cessation of urine testing, which is both unnecessary and degrading, particularly when it is supervised as a majority of programmes mandate. They called for the elimination of all penalty systems for ‘rule infringements’ that result in dose reductions or the withholding of prescriptions as a form of punishment. Instead, they advocated for best practice in these interventions through the promotion and adoption of respectful relationships between service users and providers based on compassion and mutual trust (a ‘user-friendly’ style of service delivery).

2.2 Chronic under-dosing of new clients in OATs/SATs

Many interviewees criticised the continued and widespread practice of forcing new clients to keep accessing illegal drug markets due to systemically unrealistic assessments of what the starting dose should be. In particular, interviewees pointed out the widespread practice of under-dosing clients with long-term habits and high tolerances to the prescribed drug(s). As one American respondent pointed out:

"...[bad practice is] ... starting people off on doses that are way too low... so they still have to cop illegal heroin for the first few weeks - otherwise they're going to be sick."

Interviewees stressed that it is morally and professionally negligent to force service users into continued illegal drug use by starting them on unreasonably low doses, by reducing their dose without their involvement, or by limiting them to unsuitable service options. They argued that the risks associated with overdosing on starting doses could easily be mitigated by having clients consume their first dose in a safe place where trained staff can be on standby with naloxone, an effective opioid overdose antidote (a more in-depth discussion on OD prevention and naloxone follows in *section 4* of this brief).

2.3 Limited range of opioid drugs in OATs

Interviewees recognised that while a few OATs in a limited number of mostly western countries provide some choice in the opioid substitution drugs generally on offer - including, for example, methadone, Suboxone and Buprenorphine - the majority of programs lack more than one option for service users. Moreover, the choices are made by prescribers rather than clients. And, sadly, as interviewees pointed out, when it came to diamorphine or heroin prescribing, we could and still can count the number of countries that provide it on one hand. Lack of access to this particular drug, the most in demand and effective of all potentially prescribed opioids, was addressed by this South African participant who said:

"[m]ost people here in South Africa, when they're buying heroin, they don't know exactly what they're buying; they don't know what it's cut with. So, in that regard, if something like heroin prescribing could be started here, it would be amazing."

In the tiny number of countries where diamorphine is prescribed to a small minority of opioid users, as in the UK, Canada and Switzerland, the programmes have been a resounding success with high patient retention rates and increased client satisfaction. This is simply because the vast majority of heroin users would rather be prescribed diamorphine than less effective opioid substitutes. There are good reasons for this, and a number of interviewees pointed out problems with heroin substitute drugs. One Canadian project participant who was denied access to prescribed heroin and forced to use a synthetic substitute stated:

"I hate Suboxone. I hate the taste in my mouth. I hate the way I feel. It blocks at least one of your opiate receptors and it's the one that is associated with feeling well. Here in Toronto, most of my service users who are on it have expressed the same feelings."

Several of the interviewees referenced the growing evidence for the effectiveness of prescribing diamorphine, especially to long-term users and injecting drug users. Best practice for prescribing options, they suggested, should provide clients with the choice of a range of substitution opioids (and stimulants, though this issue is addressed more fully below), and the provision of diamorphine

alone or with other opioids, notably methadone. Finally, they went on to suggest that prescribed drugs should also be provided in a variety of forms including pills, powders, liquids, smokables, sprays, and ampoules for injection.

2.4 Contingencies, rules and funding problems in OATs/SATs

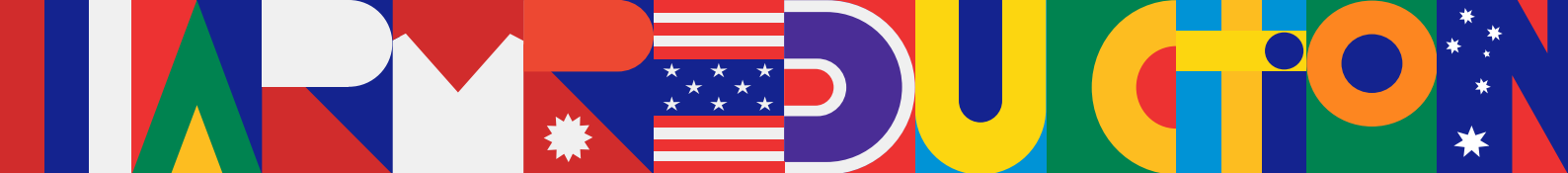
Though it was recognised that some OATs provide on-going maintenance prescribing, interviewees complained that others only offer time-limited tapering programs or rapid detoxes. Moreover, some of those interviewed pointed out that, in keeping with the adversarial nature of the bulk of these programs, some countries used the failure to complete the program or to comply with the restrictive rules as grounds for removing clients, not only from prescribing programs, but from welfare supports or employment. In the worst cases, those failing to adhere to program rules and who were on probation or parole were re-incarcerated, a practice that only ever maximises the harms faced by these service users. A Ukrainian interviewee stated the case thus:

“Bad practice is only having very few options that are state mandated (methadone, Suboxone, NA/AA) with the consequences of jail time... or being kicked off welfare as they do here in the Ukraine if treatment is not fully completed, thus forcing people to do what they realistically cannot do.”

In response to these worst practices, interviewees argued that failure to complete an OAT/SAT program or to meet particular regulations should never result in the wholesale removal of vulnerable clients. Neither should these failures result in the loss of social assistance programs, employment opportunities, or as a reason to put a client back in jail or in any kind of forced treatment setting, including hospitals and detox centres. Instead, they suggested that best practice strategies should empower service users to be honest about problems they are having in meeting program demands and they also advocated that mutually agreeable solutions should be worked out between clients and service providers.

Several interviewees discussed ongoing problems with the funding of OAT interventions in their countries. They pointed out that lower- and middle-income countries become particularly vulnerable to funding schemes that require service users to enrol in other health-related programs such as HIV, HCV, or tuberculosis testing and treatment. Others stated that access to programs was sometimes dependant upon employment status and individual wealth since these services were not government-funded. Problems with such contingencies were spelled out by this interviewee from India who revealed the following:

“So what we see is that it’s preferable to contract HIV to get into the OAT, supported by the government or the Global Fund, rather than going into prison or paying for it yourself. Or [clients] are expected to have and hold jobs to get on OAT. This approach is terrible, it’s terrible that it states that OAT is only for HIV prevention, or for those



who can get a job and overcome their poverty... this approach has stuck in the minds of our [health care and policy specialists] and now they say that the viral epidemics among drug injectors are getting low so there's no need for OATs anymore. That's what we have come to!"

Another interviewee from Australia put the matter this way:

"Some service providers in Australia use methadone programs to make people have hep C and HIV testing and they're talking about using methadone as a way to get people on the hep C treatment and I think that's problematic. OATs shouldn't be used to get people into treatment for other things that the government want to get done to the injecting drug using community."

In response to such worst practices, interviewees argued that OATs/SATs should never be used to force or coerce drug users into testing and treatment for BBVs such as HIV or HCV. Instead, they posited that access to information about these treatments and testing options should be available at dispensing and prescribing sites and they also advocated for universal, equitable, and free access to services in countries where they are currently unavailable or where they require payment. Moreover, they suggested that funding for OATs/SATs, especially in middle- and lower-income countries should never be contingent upon enrolment in testing or treatment schemes designed to channel drug users into treatment and research programs that may use their vulnerabilities as marginalised patients to force them to receive treatments they may not want. All forms of drug therapies including anti-viral and anti-bacterial treatments should always be free, voluntary, and universally accessible, regardless of enrolment in substitute prescribing programs, as many interviewees pointed out. Finally, project participants were adamant that prevalence rates for BBVs such as HIV and HCV should not be used to determine whether or not opioid and stimulant dependant drug users should have access to OATs/SATs interventions. Instead, they suggested that all countries should be equipped to provide these crucial harm reduction interventions regardless of prevalence rates of BBVs. They pointed out that these programs constitute integral human and health rights for drug users. Because of this, interviewees made the case that these programs are deserving of funding and support based on many decades of research and practice proving their efficacy, both in reducing BBVs and mitigating the harms associated with illicit drug use in unregulated and dangerous drugs markets.

2.5 On- and off-site consumption of OAT/SAT drugs

Most respondents had much to say when it came to on-site consumption and daily pick-up practices associated with OATs/SATs, arguing that such practices are borne of systemic discrimination against users based on the view that they are unreliable and untrustworthy. They pointed out that after a safe and effective dose has been established, new clients should no longer be required to consume their prescription at the dispensing site. Similarly, daily

pick-ups should also be phased out once the client has demonstrated they can consume their prescription safely, with OAT/SAT clients being provided with enough doses to last them from one week to one month. Interviewees rightly pointed out that this is standard practice with almost all other prescription medicines. When on-site consumption is required, interviewees suggested that dispensers should use discretion in providing it and the client should be able to consume their dose privately. One interviewee from Lithuania summed it up like this:

“People should be able to pick up their doses and leave with them or, if we have to consume it on site, there should be a private space provided for us to do it... so there needs to be sensitisation training for pharmacists and all other dispensers”.

2.6 Stimulant Agonist Therapies (SATs)

When it came to accessing Stimulant Agonist Therapies (SATs), respondents lamented that there is currently a glaring lack of programs or even pilot studies being conducted around the globe. As one of the Canadian interviewees pointed out:

“SAT is a good approach, but unfortunately not enough is happening. Not enough research is happening...(and) one of the reasons it's not happening is our fear of pleasure. People are afraid of pleasure and I think that contributes to a lot of people not wanting to prescribe stimulant substitution because they don't want to help people feel 'up', feel good.”

Based on this reality, several interviewees advocated for the promotion of open and respectful debate on the twin discourses of ‘pleasure and drug use’ in global policy and practice forums. Refusal to enter into such discussion, they argued, is currently causing significant harm to stimulant users seeking these much-needed drug prescribing/substitution therapies.

Interviewees agreed that, as with OATs, SAT services should provide a full spectrum of stimulant drugs as substitutes for use of illegal stimulants like amphetamine sulphate, methamphetamine (e.g., ice), and cocaine freebase (crack). They suggested that some viable options to be explored and evaluated include cocaine, dexamphetamine, methylphenidate, and modafinil. And they advocated that user activists and clients should lobby governments to provide this service and substitute drug prescriptions free of cost, and to document the efficacy of these programs and practices. As an interviewee from Australia put it:

“Look, we drug users are the experts about what we need. We already use drugs and we know how they work with our bodies. So, in the context of a prohibitionist war on illegal drug users, we should be able to select whatever drug it is we want prescribed. It's the best harm reduction strategy for illegal and habituated stimulant users – it's the same as OAT for opiate users – what the hell's the difference?”

2.7 Working with Aboriginal communities to reduce discrimination and prohibition harms

Many interviewees recognised the importance of working in solidarity with local Aboriginal communities to explore and develop traditional natural drugs which may be effective both in substitution programs and in psychotherapeutic interventions for conditions underlying drug problems (e.g., trauma, depression). The most promising examples include khat, coca, kava, kratom, ibogaine, changa, psilocybe, MDMA, and peyote. As several interviewees pointed out, working with local Aboriginal communities is an excellent strategy for forging political alliances with people who, like marginalised drug users, face a plethora of forms of discrimination in the countries where they live. Countries like Canada, the United States, and Australia, for example, have long and continuing histories of treating resident Aboriginal communities with gross disrespect and callous disregard for their health and human rights. Such relations are characterised by out and out discrimination and infantilising policies and practices. All of these stem from the colonialist invasion of these lands and the resultant explicit racism and classism that attend these histories. Moreover, as a direct result of such oppressive policies and practices, there are elevated rates of drug use amongst these populations which gives such communities excellent insights into which kinds of peer-based harm reduction strategies will work best for them. Promoting mutually supportive political relations between stigmatised drug users and Aboriginal communities, a grammatical distinction in this case, is very much in keeping with the general political aspirations of international drug user organisations such as INPUD. As one of the Canadian interviewees pointed out:

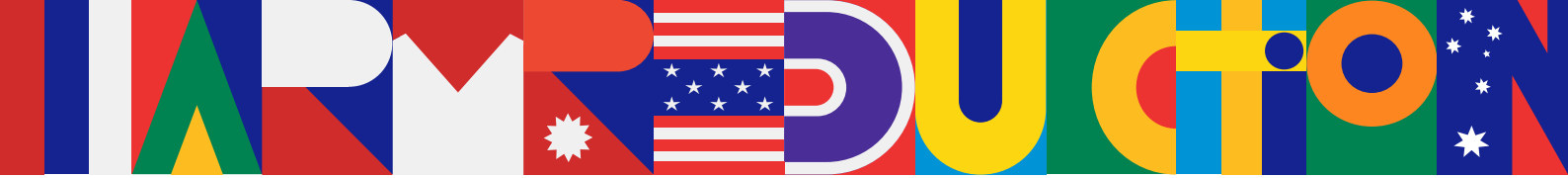
“We are always stronger working in solidarity with others who share experiences and aspirations that seek an end to the many problems associated both with drugs prohibition and systemic forms of discrimination based on race, class, culture, and language, to name only a few.”

2.8 Lessons from the COVID-19 pandemic regarding OAT/SAT Interventions

The INPUD COVID-19 Survey (2020), referred to earlier in this brief brought to light some important changes that were observed during the lockdowns with respect to how OAT services were carried out. In particular, respondents from several countries pointed to positive changes to program rules and practices that included:

- Some increases in take-home doses as opposed to on-site consumption
- Some increases in the number of take-home doses
- Some decreases in invasive and compulsive urine screening
- Some easing of the procedures involved in entering programs

Obviously, there were discrepancies between the changes that drug user respondents identified owing to the divergent ways that countries implement this service. But it is worth highlighting that a more relaxed, less policed and punishing approach to OATs seen in some



Harm Reduction: Best and Worst Practice

countries during the COVID-19 lockdowns adds weight to the progressive changes that drug users and activists have been advocating for around the globe. More specifically, we have seen that it is possible to carry out this therapy without compromising the human and health rights of opioid drug users and these findings are in accordance with the suggestions made by our interviewees. And they are no less applicable to SAT interventions. We leave off our discussion on these interventions and move now to an inventory of the best and worst practices associated with Needle and Syringe Programs as discussed by the project participants.

3. Best and Worst Practice in Needle and Syringe Programs (NSPs)

Like OATs, needle and syringe programs (NSPs) were some of the first and most effective harm reduction interventions. They emerged in the late 1980's and early 1990's in many countries around the globe. They have been sufficiently researched and evaluated and have proven to be integral in the health promotion and harm reduction of injecting drug users (IDUs) in particular. They gained popularity and implementation with the significant rise in cases of HIV amongst injecting drug using communities in many western countries in the 1980's and early 1990's. This was followed by an explosion of HCV infections within these same communities in the early to mid 1990s - a trend that has continued to disproportionately affect injecting drug users to this day. Thus, it was the rise in the spread of BBVs affecting IDU communities worldwide that provided the impetus for the creation of NSPs. This section highlights the best and worst practices and policy discussed by interviewees with respect to this crucial harm reduction intervention.

3.1 Policy and practice problems with 'exchange' of drug taking equipment

Without doubt, one of the most important worst practices identified by interviewees was the policy of 'needle exchanges', or the demand that service users return used drug taking equipment in order to receive new supplies. The majority of interviewees spoke out directly against this practice with a Russian participant stating:

"...[h]ere in Russia they expect the syringes back. So it's not "distribution", it's an exchange kind of thing. And the law of the land is that if you carry a syringe with you, you'll be arrested and charged with possession of drug paraphernalia. So the law will not allow me to carry syringes, but my service provider asks me to bring back the used ones to get new ones. So there are two opposing things happening here."

Interviewees stressed that best practice for supplies distribution in NSPs is to do away with exchange policies that either limit the number of materials given out (within reason) or which require a client to return materials before being given more. More specifically, they argued for the abandonment of the notion of 'needle exchange' by providing a variety of ways for clients to safely dispose of used materials. As many pointed out, this is particularly important for service users who have been in conflict with the law and who face severe repercussions for having drug-taking equipment on their person. As one interviewee from the Netherlands stated:

"Many people who access harm reduction programs are on probation or parole and have stipulations that forbid their having drugs or paraphernalia on them and so it would be unfair and inhumane to ask individuals such as these to place themselves at increased risk of being sent back to jail for having NSP materials they must return to the project site."

Interviewees suggested several strategies that would better enable NSP clients to access new materials while safely disposing of used ones, with one interviewee from Australia advocating:

“Everyone should be taught how to dispose of their used works safely and then various methods should be implemented throughout the community; you should be able to return your works to pharmacies, to hospital emergency wards, dump your works off at drug consumption rooms – train all the staff there, in terms of NSP safest practices/ universal precautions obviously.”

As interviewees pointed out, by creating a variety of means for returning used drug-taking equipment at both the NSP fixed site and through the outreach components and other easy to access and discreet locations, the problems associated with having injecting drug users throw away supplies in unsafe ways are thus reduced or eliminated.

3.2 Boundary maintenance and hiring IDU peers as NSP staff

Interviewees advocated that, in consultation with community drug users and local drug user agencies and organisations, best practices involve drafting and implementing comprehensive harm reduction programming with peer-staffed NSPs that fully support the human and health rights of marginalised drug using and injecting community members. Due to the illicit status of the most widely used injectable drugs, interviewees argued that it is essential that service users see themselves represented amongst program staff and volunteers in order to help establish trust in the program. As many pointed out, there are unique ‘boundary maintenance’ issues involved in doing this job that necessitate having other injectors employed in these services. One interviewee from Canada spelled out the issues this way:

“The risk for turning into an injector on this job is pretty high, and boundary maintenance practices can be difficult to implement so that it’s too much of a risk to put non-injectors in a front-line capacity working with other injectors. They come into contact with injectors regularly, this behaviour becomes demystified and normalised, and so they are more vulnerable to pressures to start using and injecting or to use more. Also, some clients are just so happy to be getting non-judgemental services that they offer inappropriate tokens of gratitude such as free sex or drugs. All these issues need to be taken care of in training. So best practice will be a program that already has the real experts employed in those positions: injecting peers working with peers.”

Interviewees suggested various best practices for overcoming these kinds of work-related problems for injecting drug using peers, including ongoing boundary maintenance training workshops as well as workplace supports to limit problems that can arise in this line of employment - problems frequently caused by the judgemental attitudes of and isolation from fellow non-drug using staff, resulting in possible over-identification with service users. Having supportive environments where peer staff are encouraged to come to fellow employees and

managers with work-related problems was identified by interviewees as crucial best practice in mitigating and eliminating many of these problems.

3.3 Program accessibility - working to meet the needs of peer service users

Most project participants addressed the issues surrounding program accessibility and the imperative of designing program services with the lived realities and diverse needs of drug using clients in mind. Some of the specific problems surrounding this matter were addressed by this interviewee from Thailand:

“A lot of programs have alternating times that they are open (different times and days of the week) and from week to week they change, or they are stuck on limited hours that work for non-drug using staff, (not clients), and people have a difficult time remembering this info, so you have to have it open as much as possible – making it accessible as much as you can.”

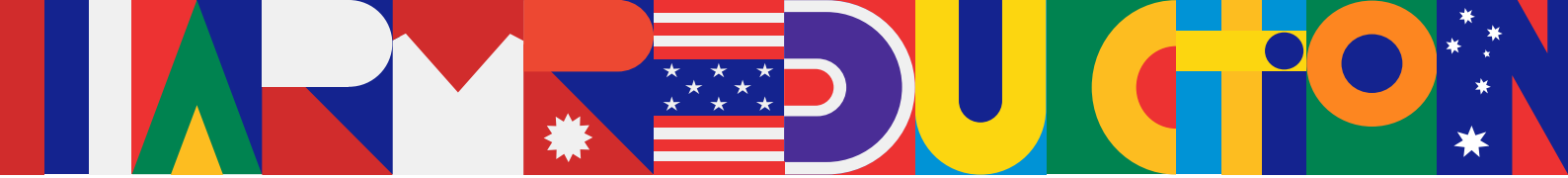
Another project participant from Canada echoed this sentiment:

“Ideally, every NSP should be open 24 hours, 7 days a week. However the reality is that most programs work around the needs of the non-using staff that still comprise the bulk of paid workers at most harm reduction projects around the globe.”

Most interviewees agreed that there were a number of strategies that NSPs could employ towards increasing program accessibility, especially by drawing upon the experiences of programs with high success rates owing to their long-standing employment of peers. Thus, for example, the same interviewee from Canada went on to state that:

“...[t]he smartest projects really know how to make use of the resources that the drug using community already has access to – so training drug users and dealers to become service providers, for example, is just smart, good practice that will really expand the services a project can provide for its clients.”

This last comment makes reference to a kind of programming that an interviewee from Canada had had in place in the NSP they had been coordinating for over two decades. It involves increasing client access to drug using materials by making use of the homes and hangouts of drug dealers and drug users as ‘satellite NSP providers’, training and paying them for their work. These satellite NSP sites can provide access to materials and info to a range of clients when no other services are open or accessible and will increase the program’s ability to reach the most hard to access clients - those who will never visit the fixed site location. Furthermore, several interviewees discussed how increased outreach capacity for NSPs can be obtained by having ‘mobile outreach services’ making use of foot patrols, bicycles, motorbikes, vans, and other vehicles to widen the geographical outreach capabilities of the program.



One final issue that many project participants raised was the crucial lack of access to NSP materials and safer drug using information in countries where it is currently illegal to buy or possess injecting drug using equipment without a prescription. As one interviewee from Russia lamented:

“... in my country I cannot buy new syringes because I need a prescription...because of the law.”

In response to this critical issue, various interviewees advocated for pharmacies to work with local NSPs to provide free injecting and drug smoking equipment packs to drug and steroid users as is currently the practice in countries like England, for example. They further argued that in those countries where it is currently illegal to purchase injecting equipment without a prescription, drug user activists should work with local politicians and health and rights-based organisations to lobby the government to change this legislation as an integral harm reduction and health promotion strategy. Project participants pointed out that drug user activists can draw upon the vast amounts of research that unequivocally prove the efficacy of NSP interventions both in the prevention of the spread of lethal BBVs as well as in the promotion of the health and human rights of drug users and injectors.

3.4 The importance of gender mainstreaming and diversity in NSP service provision

All of the interviewees discussed the importance of having program staff, volunteers, and materials/information that reflects the diversity in the clients making use of the NSP services. In particular, many addressed how crucial it is to ensure that ‘gender mainstreaming’ be built into all aspects of service delivery as the best way to ensure program specificity and relevance for female service users. One of the interviewees from the Ukraine referenced this issue while recollecting best practice in the following program:

“...[w]e were speaking about gender issues, and they told us that they built a syringe exchange site inside a beauty salon in a small town – so a girl can safely come there like she goes to the beauty salon and get the syringes instead – it’s a wonderful idea! That’s a gender-specific approach which is good for small towns.”

In response to this important issue, interviewees suggested that all harm reduction policy and programming be inclusive of gender main-streaming strategies. If possible, they advocated the creation of gender-specific safe spaces within the fixed-site location and preferably ones that could safely accommodate children being present. They prioritised the creation of a Women’s Program Space in the NSP fixed site or, if this was not possible, working with local women’s projects to find suitable alternative spaces in locations friendly to drug using women and their children. And they were adamant that female drug users be central in all aspects of service design and delivery. In addition, most interviewees pointed out that

these suggestions could apply equally to women from the trans community as well as other communities of marginalised drug users. Attending to issues of gender, race, class, age, sexual orientation, and other frequently stigmatised identity traits and ensuring that program materials and peer staff represented members of these communities was consistently raised by project participants as an essential best practice in the provision of NSPs, and all harm reduction interventions.

3.5 Providing NSP service users with the materials they want and need

Many project participants addressed the important issue of providing clients of NSPs with the materials and information they want and need. They argued that best practice necessitates asking service users directly as well as by hiring drug using and injecting peers who will already know what many of these materials are. A perfect example of this is the 'low dead space syringe'. One interviewee from South Africa addressed best practice strategies on this matter in detail:

"I think that's a good tool – low dead space syringes, but unfortunately, these syringes come virtually in only a single model, which is a fixed 25 gauge 1 or ½ inch needle and that doesn't appeal to many injection drug users. So in that respect having a more comprehensive range of low dead space syringes, different models, would be critical to get this important tool into the hands of our clients."

Several project participants advanced additional best practice strategies for meeting the specific needs of injecting drug using clients with an interviewee from Nepal suggesting:

"We should also look for new and innovative approaches... I'm speaking about special instruments that make it easy to find veins, for example."

Other project participants agreed with this suggesting that, where feasible, injecting clients should be provided with access to electronic vein finders. They recognised that many programs would lack the funds for this, particularly in middle- and lower-income countries. So, in recognition of this, they suggested possibilities of providing access to cheaper, non-electronic mechanisms as well as ensuring that 'safer injecting sites/drug consumption rooms' (currently only available in a hand-full of countries) have vein finders available for clients to use to facilitate safer injecting practices. And, crucially, the majority of interviewees recognised the importance of providing regular safer injecting workshops run by peer workers. In these and other ways, project participants stated that NSPs should seek to provide their service users with the most up-to-date and effective materials and information available to them and to stay abreast of developments in this area by coordinating their strategies with other successful NSPs in their area and around the globe.

3.6 Preventing worker burnout and engaging marginalised drug users

Many of the those interviewed discussed the issue of ‘worker burnout’ owing to the high levels of stress that can attend working in NSPs. In particular, they pointed to the alienation that drug using peers can feel when working with non-drug using staff members, as is frequently the case where NSPs are part of larger community-based agencies such as health centres. One interviewee from America framed the issues this way:

“Harm reduction programs, where workers are involved in front line work, (like outreach or counselling)... can cause worker burnout. And these staff often lack community supports or even a sense of community at all.”

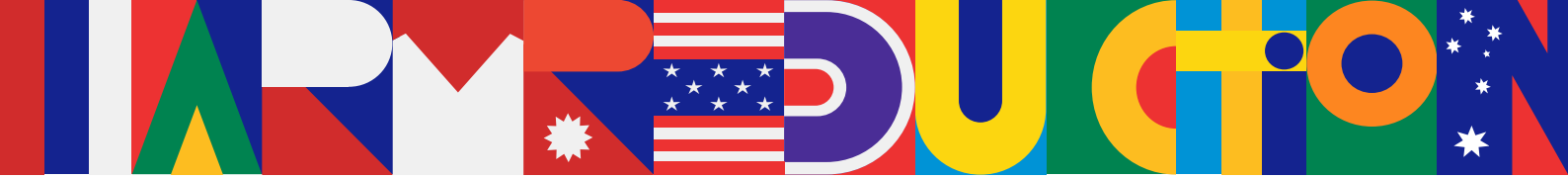
In response to such stresses and issues of alienation, several interviewees highlighted the importance of ensuring sufficient training and workplace supports to avoid burnout by peer workers, especially those that increase respectful and cooperative relations between drug using and non-using staff and management. Many project participants also promoted the creation of a supportive sense of ‘community’ for drug using clients and staff. Towards this end, they encouraged the use of the fixed-site location of the NSP to create ‘user-specific support groups’, drug users’ unions and other user-led groups and initiatives, including community newsletters and political campaigns to promote civic engagement and solidarity.

3.7 Lessons from the COVID-19 pandemic regarding NSP service delivery

Two of the fundamental issues that the COVID-19 pandemic raised were the importance of getting tested and taking the treatments, or vaccines, that eventually became available, at least in some countries. Both of these issues, getting tested and treated/vaccinated for BBVs, have been at the forefront of harm reduction interventions. In particular, providing ways for NSP clients to access free and anonymous HIV and HCV antibody testing, pre-and post-test counselling as well as treatments has comprised a significant amount of time and resources for drug user activists and harm reduction workers since the late 1980’s. Interviewees all addressed these joint issues with one from Sweden putting the matter this way:

“Serious, life-threatening and life-taking pandemics hit our communities disproportionately and while you’d think issues like HIV/HCV testing and treatment would be easy to talk about nowadays with clients, you’d be surprised. Myths and misinformation, some of it straight from governments and other sources of authority, continue to feed the fear and stigma that prevent some drug users from testing in the first place.”

These sentiments should resonate with readers because the COVID-19 pandemic brought them into the focus of international debates, much of it also fuelled by myths and misinformation. In fact, what the coronavirus pandemic helped to shed a light on was the degree to which misinformation and conspiracy theories or ‘alternative facts’, can prevent



people from seeking the testing and treatments/vaccinations they need in the face of serious, life-threatening, and communicable infections.

Though the interviews for this project took place prior to the COVID-19 pandemic, interviewees discussed matters of this nature and many suggested that NSP clients need to be provided with access to voluntary, free, and anonymous viral and bacterial testing with pre- and post-test counselling. If feasible, some interviewees also advocated the provision of voluntary, free, and anonymous hepatitis A and B as well as TB and tetanus vaccination clinics to all NSP clients who sought them. If these NSP fixed sites could not provide these services, interviewees suggested working with other health-based agencies to promote testing and vaccination as effective health promotion strategies for the entire community, not just drug users. By highlighting the importance of all community members receiving access to these interventions, interviewees rightly pointed out that the stigma and discrimination that can attend such services could be significantly reduced.

The COVID-19 pandemic also showed us that many of the limits and rules regarding the amount of supplies a client could receive from NSPs as well as the need to return used drug taking equipment before new supplies could be provided, were actually unnecessary. We saw that programs with outreach capacities were better able to stay in touch with vulnerable drug using clients and that it was feasible to give clients larger amounts of materials without requiring that they return their used works first. This is in keeping with the best practice recommendations made by interviewees and helped to prove that their suggestions would continue to work in a post-COVID environment.

While there were other recommendations that interviewees made with respect to best and worst practices in NSPs, the most salient examples have been offered here. We move now to the last section of this brief which addresses the crucial issue of overdose prevention interventions. In particular, we focus on the need to supply all clients of harm reduction programs with free access to life-saving drug overdose antidotes including, and in particular, naloxone distribution.

4. Best and Worst Practice in Overdose Prevention (ODP) Interventions

Naloxone has been around since the 1990s but did not start to become widely available in some countries to drug injectors through harm reduction programs like NSPs and safer consumption rooms until after the millennium. In the past decade there has been an explosion in the rates of overdose deaths, especially in North America, where suspect prescribing practices coincided with the heroin market becoming saturated with powerful synthetic adulterants like fentanyl. Overdose deaths continue to spiral in America and an increasing number of western countries as these synthetic opioids expand into global underground drug markets, notably the heroin trade. Specific solutions to these problems are complex and fall outside the scope of this brief but as many of the interviewees argued, an immediate cessation of drugs prohibition across the globe coupled with legalisation and market regulations as well as the immediate implementation of proven harm reduction interventions, like those described in this brief, would effectively put an end to most overdose deaths and the vast majority of drug-related harms.

When it comes specifically to naloxone distribution as a proven harm reduction intervention, there is a sad lack of access to this opioid overdose antidote in many countries around the globe. That said, there is now a plethora of research proving it is an essential life-saving intervention for those who have suffered an opiate overdose. Originally only available in injectable form, this drug more lately became available as a nasal spray, making its administration by even untrained individuals far easier and thus more likely to succeed in reversing an overdose. This section focuses on overdose prevention and best and worst practices as identified by our interviewees, specifically the distribution of naloxone. But project participants also addressed the need for the creation of additional antidotes for a range of drug types, as their feedback will show.

4.1 Identifying overdose risks and creating interventions that respond to them

“In my life, one of the main reasons for overdose was short term methods of drug treatment, for example, blood cleansing for 3-4 days. After that they let drug users leave and they know that those 3 or 4 days didn’t change anything other than to reduce tolerance.”

Interviewee, Ukraine, 2016

A majority of those interviewed addressed the fact that certain groups of drug users are at an increased risk of drug overdoses. These include injectors, prisoners coming back into the community, and those coming out of drug treatment services or ending/coming off OATs. They went on to argue that best practice for reducing the vulnerabilities of these groups involves engaging in efforts to ensure that these populations have targeted educational and supportive programming and materials in place prior to release or reintegration into the

community or when coming off OAT programs. In particular, interviewees talked about the importance of coordinating services used by vulnerable drug users as a means of ensuring that no at-risk groups fall through the cracks of service provision. With such comprehensive and cooperative strategies guiding best practice for particularly at-risk drug users, many more overdose preventions could be achieved.

4.2 Distributing naloxone as part of a comprehensive approach to safer opioid use

Many of those interviewed broached the topic of how essential it is that naloxone (and all antidote medications) be distributed as part of a comprehensive package of safer opioid/drug use and overdose prevention. As one interviewee from America stated:

“Naloxone needs to be distributed as part of a complete package of safer opiate using. People need to understand that individual reactions to this drug (naloxone) vary, with some folks requiring more or less of the drug as well as possibly other interventions to keep them breathing and alive.”

Another project participant from Australia put it this way:

“At the very least, a comprehensive approach grounded in an ethics of care and safety for the patient must prevail in order to do away with all those who get satisfaction from watching someone come out of an OD only to go into total withdrawal, thus forcing them to use straight away again to overcome the sickness and putting themselves at increased risk for another OD due to the naloxone wearing off.”

Increased risks attending the antidote drug wearing off, thus causing immediate onset of withdrawal symptoms continues to constitute one of the key reasons that opioid users who have received naloxone for an overdose go on to overdose a second time. Several interviewees suggested the provision of sensitisation training on the risks associated with naloxone for all medical emergency personnel and first responders (fire, ambulance, and police) as a means of reducing secondary overdoses for opiate users after the naloxone wears off. By ensuring that first responders and other administrators have been properly trained on the full spectrum of overdose prevention-related issues, interviewees were confident that best practices in this intervention could be more fully realised.

4.3 Best practice strategies for improving naloxone distribution and OD prevention

All of those interviewed had strong views and practical suggestions for how to improve overdose prevention interventions, and especially how to increase the efficacy and distribution of naloxone to vulnerable opioid drug users. One of the essential issues raised was the importance of reducing the stigma related to naloxone distribution, or the fear of being

identified as 'pro-junky', especially by healthcare providers. Towards this end, one of the interviewees from Canada suggested the following best practice strategy:

"Another thing we are advocating for is to get doctors to give out naloxone with every opiate prescription...so they understand that all opiate users may be at risk and not just those they think of as 'junkies'."

Thus, best practice in this case for reducing the stigma associated with distributing naloxone is to provide free naloxone and full training on its administration for all recipients of opioid prescriptions and their care providers (including family and friends). Many project participants endorsed the provision of cross-training on naloxone administration to all agencies involved in the care and support of the clients of the harm reduction project/NSP as best practice for this overdose prevention intervention and as a means of widening the safety net for opioid consumers. The same interviewee from Canada described such a practice in this way:

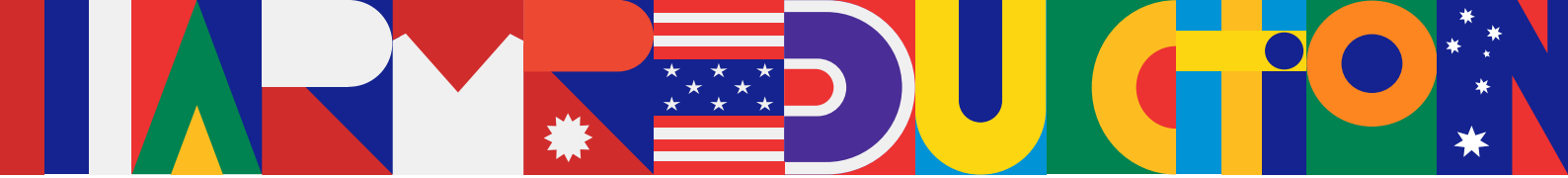
"We've done Train-the-Trainer workshops for our Satellite staff (these are drug dealers in the community who are fully trained and paid by the program) as well as other community-based partners to help better educate the whole community and to increase distribution of naloxone kits."

Making use of satellite workers and volunteers to provide naloxone and training on its administration to their peers and ensuring they are fairly compensated for their work was a key best practice suggested by interviewees for improving the distribution of naloxone kits to vulnerable opioid users.

4.4 Expanding overdose prevention and drug antidotes

Many interviewees lamented that antidotes - which are typically brain neuron receptor antagonists - are a neglected area of harm reduction and agreed they deserve much more exploration and evaluation. For instance, several project participants noted that another antagonist with as much potential to reduce overdose and death as naloxone does among opioid users, is flumazenil. This drug can reverse overdoses from most benzodiazepines, as well as from other hypnotosedatives - notably z-drugs (zopiclone, zolpidem and zaleplon). There was thus a general agreement among interviewees that inclusion of a broader range of overdose prevention antidotes would go a long way to reducing the currently unacceptable levels of drug overdoses caused by unregulated drug markets and prohibitionist policies and drug laws. As one interviewee from the Ukraine noted:

"Until such a time as we see a broader interest in the investment of energy and money towards reducing the full range of drug overdoses, drug users will continue to die unnecessarily. As drug users and harm reduction specialists we will continue to champion these efforts because, like our peer clients, our lives are also on the line."



4.5 Lessons from the COVID-19 pandemic regarding ODP interventions

Earlier in this section we addressed the issue of the extra risk of overdosing that attends particularly vulnerable populations such as exiting prisoners and those coming out of drug rehab and detox centres. The COVID-19 pandemic increased the vulnerabilities of many opioid drug users through the isolation they were forced to endure during lockdowns, resulting in dramatic increases in opioid consumers using alone. Many drug users would have been cut off from drug dealers during this time owing to the restrictive rules that a majority of countries imposed during the lockdowns. This meant that they would have only regained access to street-based drug markets once the lockdowns were lifted and that they may have started using with significantly reduced opioid tolerance leading to increased overdose risks. The research surrounding such trends is still being collected and collated as lockdowns in most countries only ended earlier this year. Moreover, some countries continue to go back and forth between lockdowns and less restrictive measures, and we therefore will not know how this impacts vulnerable opioid users until such a time as this phenomenon stops and can be studied.

In the INPUD COVID-19 Peer Response Survey (2020), discussed in the intro of this brief, it was noted that many respondents did not see any increases in the availability of take-home naloxone prescriptions and kits during the lock-downs. It was further noted that pharmacies in various countries were reluctant to provide naloxone to opioid-dependant users for fear of being seen to encourage dangerous opioid use by giving the users of these drugs a way to reverse overdoses. In fact, survey respondents noted a general lack of increased access to this life-saving drug antidote during the COVID-19 lock-downs.

When it comes to general lessons learned with respect to overdose prevention interventions and the COVID-19 pandemic, the greatest one would be that there is now, more than ever, a need to provide all opioid users with naloxone and preferably in nasal form for easy administration, and this is in keeping with the recommendations of the interviewees. They argued for training on and the free provision of this opioid antidote to anyone who receives opioid prescriptions or OAT services as a way to reduce the stigma that can attend this intervention. And they further demanded that all countries commence such practices immediately, providing vulnerable injectors and general opioid users with this intervention free of cost. Finally, they stressed the importance of researching and providing a broad range of antidote drugs as best practice in the provision of overdose prevention interventions.

5. Conclusions

It has been the intention of this brief to render explicit the necessity of utilising the experiences and expertise of drug using peers in the design and implementation of all harm reduction interventions. By focussing on three key areas of harm reduction service provision, OATs/SATs, NSPs, and ODP interventions, and by relying on the words of peer experts, we hope we have shed light on some of the worst and best practices and policies that service providers can draw upon to strengthen and improve both existing and much needed harm reduction programming and policy development in these areas. There is a solid reason why all those interviewed stressed the importance of having peers in the front lines of all harm reduction programming - because where it has existed, it has been shown over and over again to work best. Project participants shed light on a plethora of new and innovative strategies for improving services and overcoming the kinds of problems that continue to plague existing harm reduction interventions. They also pointed out the gross lack of access to any harm reduction interventions that many drug users and injectors around the world continue to experience. They made concrete suggestions for how to get these much-needed services up and running, drawing upon examples from those countries where such efforts have been successful and advocating cooperative and coordinated political alliances between groups with shared goals. These groups include local Aboriginal communities and others living with marginalised identity traits, including members of trans communities, homeless populations, and sex workers, as cases in point.

The impact of the COVID-19 pandemic on our global communities of drug users, activists, and service providers was included where it related to and could help to highlight best and worst practice suggestions made by the interviewees. It is the hope of all those who work in the field of drug-related harm reduction that any progress and improvements that were achieved during the unprecedented lockdowns will continue to be applied in a post-COVID world. Sadly, we do not yet live in this world. Nor do we live in a world that supports the whole-sale repeal of drugs prohibition despite countless examples of its harms and the deaths for which it is the direct and indirect cause. Until such a time as we start to see the repeal of draconian drug laws and practices, the lives of drug users will continue to be forfeit and the work of peer harm reduction specialists, such as those who have contributed to this project, will need to obtain the expert status and priority we have strived to give them here. But even in a post-prohibitionist world, the need for harm reduction interventions will always exist and they will achieve best practice to the extent that they are peer-driven in the ways that have been explicitly spelled out in this brief.

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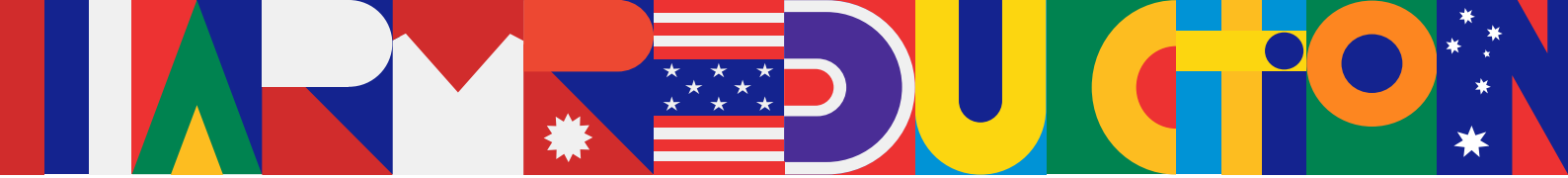
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Appendix: Details of countries of 20 drug user-activists*

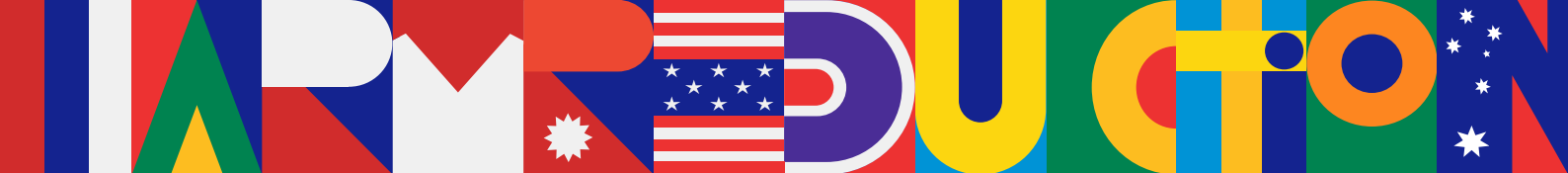
Countries



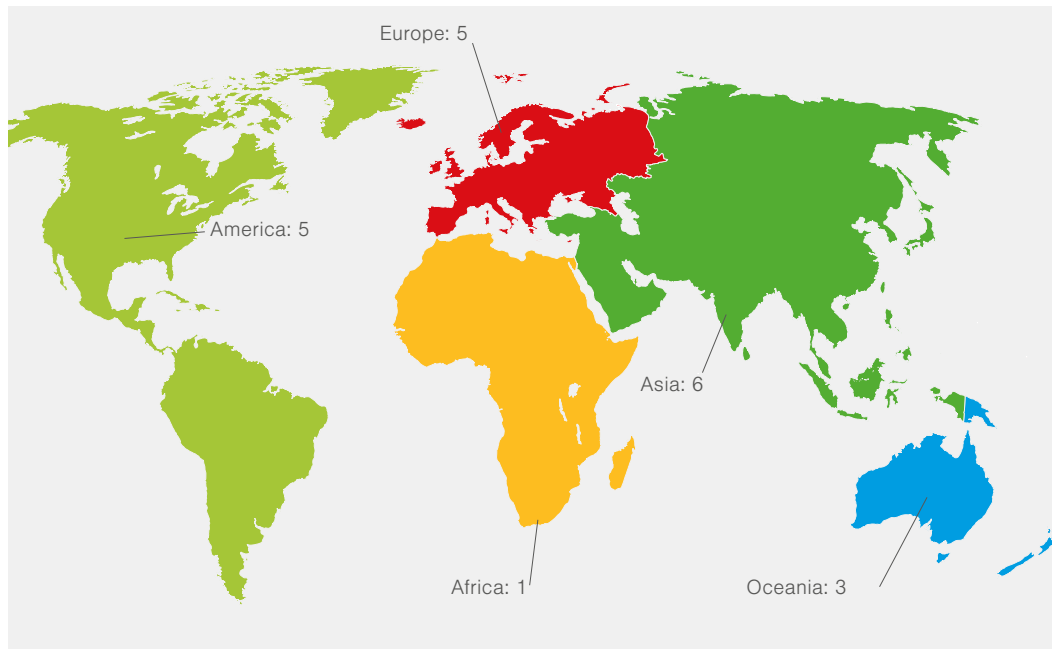
Sub-continents/regions



* Newcombe & White, 2016



Continents



The International Network of People who Use Drugs (INPUD) is a global peer-based organisation that seeks to promote the health and defend the rights of people who use drugs. INPUD will expose and challenge stigma, discrimination, and the criminalisation of people who use drugs, and its impact on the drug-using community's health and rights. INPUD will achieve this through processes of empowerment and advocacy at the international level, while supporting empowerment and advocacy at community, national and regional levels. www.inpud.net

INPUD would also like to acknowledge people who use drugs around the world who fight back against criminalisation, stigma and discrimination, harassment, abuse and violence every day. We will continue fighting to change existing local, national, regional and international drug laws and formulate an evidence-based drug policy that respects people's human rights and dignity instead of one fueled on moralism, stereotypes and lies.



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Written by: Cheryl White and Russell Newcombe

Designed by: Mike Stonelake

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INPUD Secretariat

Unit 2B15, South Bank Technopark

90 London Road, London SE1 6LN

www.inpud.net