



## **An Overview of Harm Reduction Programs**

The growing drug overdose epidemic has led to the development of a wide variety of substance use prevention and harm reduction programs and practices. In most cases, terminology and program names are not standardized. This has led to certain terms, such as “rapid response team,” being used differently in different communities. This document provides an overview of some of the more common harm reduction programs as well as some of the terms used for these programs. This list is not exhaustive; numerous other options exist to provide harm reduction services.

### **Syringe Service Programs**

At their most basic, syringe services programs (SSP) provide sterile syringes and needles to individuals who inject substances. Most SSPs provide additional services such as HIV/hepatitis C testing, information on less risky substance use, and referrals to treatment programs for those who are ready to stop using substances. SSPs are very effective at reducing drug overdose events and the transmission of communicable diseases.<sup>1</sup> SSPs were initially called needle exchanges, but that name has fallen from favor because of perceptions that it has negative connotations or stigmatizes individuals who inject substances. For more information about SSP, see: [www.cdc.gov/ssp/index.html](http://www.cdc.gov/ssp/index.html).

### **Naloxone Distribution Programs**

Naloxone, which is often referred to by the brand name Narcan<sup>®</sup>, can temporarily reverse the effects of an opioid overdose. Most drug overdose fatalities result from opioid overdose, so distribution of naloxone to various populations can significantly increase the likelihood of an individual surviving an overdose.<sup>2</sup> Naloxone may be administered by injecting into a vein or muscle, or under the skin, and also via a nasal spray. Because they are easier and quicker to use, most public distribution programs provide naloxone in nasal spray form to their clients.

Some naloxone distribution programs focus on getting the medication into the hands of emergency responders (e.g., law enforcement officers, firefighters, rescue personnel, etc.), while other programs provide naloxone—along with training in its use—directly to substance users and their associates. This increases the likelihood that naloxone will be immediately available if the individual experiences a drug overdose.

Some naloxone distribution programs operate through a syringe service program (see above). Others operate from community centers or social service organizations or go directly to potential clients through the use of mobile harm reduction vehicles and/or “on-the-street” distribution. Mobile programs offer advantages such as the ability to target high-risk neighborhoods and the ability to reach individuals who may not be able to travel to a fixed site.

In addition to its availability through public or first responder distribution programs, naloxone is available without a prescription at most pharmacies in Kentucky. Physicians may also prescribe naloxone for patients who receive prescriptions for opioid medications. For more information about naloxone, see: [nida.nih.gov/publications/drugfacts/naloxone](https://nida.nih.gov/publications/drugfacts/naloxone).

## Leave-Behind Programs

Leave-behind programs are a type of naloxone distribution program. Individuals who have suffered a drug overdose are significantly more likely to suffer additional overdose events and to die from a drug overdose than the general population of people who use substances. Despite their increased risk, some individuals who experience a drug overdose choose to decline ambulance transport and are not seen by a physician. In a leave-behind program, emergency responders who treat an individual for a drug overdose leave additional doses of naloxone with that individual or his or her associates. This helps to ensure that naloxone is immediately available if the individual experiences another life-threatening overdose.<sup>3</sup>

## Emergency Department Initiation of Medication-Assisted Treatment

Medication-assisted treatment (MAT) involves the use of specific medications to minimize withdrawal symptoms and reduce substance craving among individuals who use opioids. Buprenorphine (Subutex®, Suboxone®) and methadone are commonly used for this purpose.

The traditional emergency department response to opioid overdose cases has been to stabilize the patient medically and then to refer them to a substance use disorder (SUD) treatment program. Enrolling in an SUD treatment program may take several days, and many programs require that the patient not be undergoing active withdrawal symptoms (i.e., “detoxing”) at the time of enrollment. In the emergency department initiation of MAT model, initial SUD treatment begins during the ER visit. The patient is prescribed a few days’ supply of buprenorphine and then referred to ongoing care, often with the assistance of a peer support specialist or case manager to help the patient navigate the enrollment process.<sup>4</sup> Individuals have been found to be more willing to consider treatment when they know that they will not have to experience the symptoms of opioid withdrawal.

## Post-Overdose Response Teams / Quick Response Teams

A post-overdose response team (PORT) follows up with drug overdose survivors—typically within 24 to 72 hours of the overdose event—in order to offer information and resources for harm reduction and, where appropriate, referral to a substance use disorder treatment program. In Kentucky, these teams are most often referred to as quick response teams (QRTs). A PORT/QRT may include a public health nurse or health educator, a harm reduction specialist, a peer support specialist, a law enforcement officer, a paramedic or EMT, a social worker, or other qualified individuals. The best practice is to include an individual with prior substance use experience, such as a peer support specialist.<sup>5</sup> PORT/QRT typically work cooperatively with public safety agencies and/or healthcare providers and receive notification of drug overdose events and contact information for victims from such organizations.

While quick response team is the most common term for these teams in Kentucky, a number of different terms are used for PORTs in different communities and across the nation. Some of these terms, including “quick response team,” are also sometimes used to describe rapid assessment and response

teams/spike response teams (see below). This can lead to confusion regarding the specific types of services being offered within a particular community so it is important to determine exactly what services are offered by a particular team when assessing resources available in a community.

## Rapid Assessment and Response Team / Spike Response Team

Sudden outbreaks of drug overdose events, where the number of overdoses increases significantly within a relatively short period of time, occur in most communities. Such outbreaks are often called “spikes.” Gaining a rapid understanding of the reasons for a drug overdose spike and taking appropriate action can help reduce the length and severity of the spike.

Resources such as the Overdose Detection Mapping Application Program (ODMAP) can help communities identify the occurrence of a drug overdose spike.<sup>6</sup> Once a spike has been identified, quick action is required to have a hope of intervening successfully.

The rapid assessment and response (RAR) process is a model developed by the World Health Organization to assess complex health issues and behavior within a short time frame. The goal is to rapidly gain sufficient understanding of a health problem to enable the development and deployment of an effective intervention. The process appears to be effective in linking assessment to the development of appropriate interventions.<sup>7</sup> Researchers have recommended that RAR be “given a central role as a generic public-health technology for both developed and developing countries.”<sup>8</sup>

“The rapid assessment approach is characterized by speed and the use of multiple methods (including analysis of existing data, key informant interviews, focus groups, observations, mapping, and population estimation) and multiple data sources. Rapid assessment promotes an investigative orientation. ...”<sup>7</sup> The process is similar to the process used by public health officials to track down the source of an illness, such as a salmonella outbreak, but with the process adapted for speed and flexibility.

Once activated by a spike alert, an RAR team gathers data from emergency responders, drug overdose survivors and witnesses, coroners, and other individuals with knowledge of the overdose circumstances, substance(s) used, etc. When sufficient data are available to support an inductive analysis, team members attempt to isolate the factors that lead to the drug overdose spike. Finally, they provide actionable recommendations for interventions, which range from targeted naloxone distribution and public warnings regarding the specific hazards associated with the spike (e.g., fentanyl being sold as another substance) to increased law enforcement pressure on individuals selling the substance and a short-term increase in EMS resources.

Unlike traditional public health epidemiology, which often focuses on obtaining sufficient quantities of validated data to conduct meaningful statistical analysis, RAR is conducted more like a mystery investigation. The goal isn’t to produce a statistically valid analysis but simply to gather enough data to justify and target a public health intervention. Gen. George S. Patton might have been summarizing the RAR philosophy when he said, “A good plan, violently executed now, is better than a perfect plan next week.” During a drug overdose spike, when each day may bring additional fatalities, speed is essential.

## REFERENCES

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