What's Next When 'Just Say No' Doesn't Work?

The Importance of Harm Reduction in Preventing and Treating Addictions

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It's difficult raising young people during an epidemic. Today we are experiencing an epidemic of opioid poisonings and opioid-related deaths. Nothing is normal in an epidemic. And raising young people in the midst of an epidemic — especially one that is intertwined with behavioral health, trauma and the actions associated with risky and youthful audacious behaviors — is not only baffling, it is deeply frightening.

We are very familiar with abstinence-only approaches to risky behaviors. And while these approaches remain popular in policies and educational programs, most of us engaged in health care and health research have seen that they tend to be spectacular failures, particularly among our most vulnerable populations. In the 1980s, First Lady Nancy Reagan's *Just Say No to Drugs* campaign, together with mandatory minimums for drug offenses and three-strikes-and-you're-out felony policies, ushered in almost 40 years of hyper-incarceration—devastating individuals, families and communities throughout the urban core of our nation. But it didn't stop or even decrease substance use disorders, often referred to as SUDs.[1] We have known for decades that people are not on a level playing field when it comes to biological and environmental vulnerabilities and protective factors when it comes to substance use disorders. We know that trauma—particularly repetitive and cumulative trauma—affects the brain's hardwiring.[2] The result is a nervous system more susceptible to dependence. We have the science, but we must socialize the science, and we must be vigilant in the face of leaders who want to return to a "simpler" and more punitive just-say-no approach to substance use disorders. *Just Say No* didn't work in the '80s, and it won't work now.

Sitting at the other end of the spectrum is the universal legalization and decriminalization approach to drug use coupled with the expanded treatment of substance use disorders. A few western European countries, such as Portugal and Switzerland, have famously embraced these policies.[3] While there have been many positive outcomes of these policies, there is really no reproducibility for the U.S. Those countries have much broader safety nets for their citizens and social determinants, universal access and capacity for health care, and a far different approach to criminal justice and criminal diversion programs. They also do not have direct-to-patient medication marketing campaigns, 80% of the world's opioids,[4] and a 1,900-mile border with Mexico.

Our society is mobilizing itself toward expanding treatment, intercepting shipments, and researching new protective and treatment options against substance use disorders. At the same time, however, youth do not stop pushing boundaries, and their elders don't stop wonder-

ing about options for educating, protecting and rescuing young people from life-threatening substances. What do we know that works in prevention and treatment?

PREVENTION STRATEGIES FOR YOUTH

Three types of preventive interventions have data that support efficacy: social resistance skills training, normative education and competence enhancement skills training. Social resistance skills teach youth how to recognize situations, including media messaging, in which they are likely to be confronted with peer pressure to use. They are taught not only to recognize, but how to avoid and/or respond to these situations with specific refusal messages and behaviors. Youth learn to express what values and activities are important to them; for example, "I don't want to take something that changes how I think." "Smoking is not something that I want—my health is important to me and smoking isn't healthy."[5]

Normative education, or denormalization, is a technique that focuses on high-risk youth, for example, children of parents who have substance use disorders. For these youth, SUDs—and the behaviors associated with them—are the norm. Successful interventions include education about real use rates among peers and similar populations and the consequences of risky use of substances.

Competence enhancement skills training has been used in other settings in which young people may have poor social skills around high-risk behaviors, such as early onset of sexual activity. This training works to enhance life skills and build on assets that young people already possess. Combined with coping and resistance-training, this kind of training increases the independence and autonomy of youth.

But prevention messages are not always effective, even among the most resourced youth in the most stable of environments. When use commences, and the young person progresses down the path of occasional use to regular use and to dependence, what are our options to help?

Opiates are natural products derived from an opium poppy. Examples include codeine, morphine and opium.

Opioids are at least part synthetic/man-made. **Semisynthetic opioids** are similar in structure to opiates, such as hydrocodone, oxycodone, oxymorphone and hydromorphone. **Synthetic opioids** have structures different from opiates and include methadone, tramadol, fentanyl and carfentanil.

WHAT'S NEXT WHEN ABSTINENCE-ONLY EDUCATION FAILS?

Some of the most touching educational messages regarding opioids I have experienced are those from parents who have lost a child to an overdose. From short videos, such as the ARCHway Institute's "I Wish I Knew" series,[6] to longer documentaries, like the #HopeDealer movement's "Not My Child: Helping families understand substance use disorders and recovery,"[7] parents' messages are surprisingly similar.

- I wish I had known the warning signs.
- I wish I could have put two and two together.
- I wish I had known the drug had hijacked my child.
- I wish I had known that I needed to take care of myself and my other family members.
- I wish I had known about Narcan.

Narcan (the brand name of naloxone) is the medication that can reverse an opioid overdose. It is a key tool in harm reduction. Because if we know nothing else for sure in the opioid epidemic, it's that dead people don't recover.

HARM REDUCTION: PUTTING THE PERSON AT THE CENTER OF RECOVERY

Harm reduction is a strategy that mitigates unintended negative consequences of potentially risky behavior. The term tends to be linked to large public health efforts like syringe access programs to decrease the spread of infectious diseases associated with shared syringe use in IV drug practices, or use of condoms to decrease the spread of HIV and other sexually-transmitted diseases during unprotected sex.[8] But we have been using versions of these techniques for as long we've been raising the next generation: don't drink and drive; if you're going out in this weather, at least wear a coat; if you're going to play contact sports, wear padding and a helmet; and, no matter what happens, know that you can always talk to me.

Harm reduction focuses on the individual who is engaging in the risky behavior and our opportunities to provide support where the person is right here and right now. The primary goal is to help the person stay alive until he or she can clearly choose a path out of risk into thriving. Our role is

to open or protect lines of communication, avoid messaging stigma and other negative messages about weakness and failure, and provide options to minimize risks associated with risky behaviors. Harm reduction can be unsettling, because, when we use this approach, we're acknowledging the primacy of someone else's timeline over our own.

Successful harm reduction techniques during an opioid epidemic include:

- Recognizing the signs of someone experiencing an opioid overdose[9]
- Distributing Narcan (naloxone) to every individual who uses opioids and every household with an opioid supply. Everyone in the household should know how to recognize an overdose and how to administer Narcan
- Expanding syringe access programs, where community health workers and other professionals can assess a client's interest in seeking treatment as they swap out used syringes for new syringes.
- Understanding and educating others of situations when overdose is most common—after a break in using, when combining drugs, when using drugs from an unfamiliar source, and when people are alone, tired, sick or dehydrated.

Harm reduction is a difficult topic for adults working with youth. We want to keep our youth safe by any means possible. But we also know we can easily alienate trusting relationships if we lie and exaggerate. Moreover, one of the unintended consequences of an abstinence-only education is broken lines of communication; if young people feel they have disappointed their elders when they participate in risky behaviors, fears of retribution and loss of esteem can shut down further communication.

Critics of harm reduction use the E-word —

WAS JESUS A HARM-REDUCTIONIST?

Jesus was no buzzkill. The gospels lead us to believe that Jesus was invited to some of the liveliest dinner parties in Israel. He welcomed the companionship of tax collectors, prostitutes, Romans and other sinners— people who were marginalized in his community.

Jesus accepted people as they were. "As they were" was scandalous to the Pharisees. Jesus upset the social order in accepting people who displayed unacceptable behavior.

Common sense informs us that Jesus was a popular dinner guest, likely because he was either a great conversationalist, or because he demonstrated genuine interest in his host and other guests, or both. Certainly he wasn't popular because he harangued his guests about their immorality and immediate need for behavioral change or harped about their character defects.

Was Jesus a harm-reductionist? He supported people at the margins of society. He engaged with people whose behaviors posed risks to themselves. His only agenda was promoting the well-being of individuals and communities. He healed people who others perceived as untouchable or tainted—whether the malady be leprosy, irregular bleeding or demonic possession. People didn't have to adhere to certain standards of behavior or be apostle-approved to gain access to him or receive the services he had to offer whether it be conversation, education or healing. His approach to building relationships and building community were unconventional and available to anyone who sought him out. He allowed children to run to him, an "unclean" woman to touch him, and a paralyzed man to enter a home he was visiting through some creative rooftop deconstruction.

Jesus told story after story of leaving security and routine in order to find the lost individual.

I read the tale of the prodigal son with fresh eyes now that I have focused my practice in addiction medicine. The voice of the father is the voice of every parent whose child has found recovery — usually after years of struggling to keep the child alive, often at the expense of personal and family health. *"'Son, you are always with me, and all that is mine is yours. But we had to celebrate and rejoice, because this brother of yours was dead and has come to life; he was lost and has been found.'" (Luke 15:31-32, NRSVCE)*

Jesus met people where they were, conveyed care and interest in individuals as individuals, and started conversations focused on their priorities — those are the first steps of harm reduction.

enabling. Despite lack of evidence, critics will perpetuate the urban myth of Narcan parties—where young people get together to use dangerous doses of opioids just to bring each other back from the brink with a Narcan injection. Anyone who has witnessed such a Narcan reversal knows how uncomfortable a Narcan rescue is—and realizes how only pathological cravings, not just adolescent impulsivity, can drive a person to repeatedly take such risks. We have lived through similar messages untethered by facts, such as availability of condoms drives youth to sex, and availability of clean syringes drives youth to IV drug use. There is no evidence that availability of condoms or syringes promotes initiation of sexual activity or drug use; however, there are bodies of literature that the availability of condoms and syringes for those already engaged in sexual activity or IV drug use produces positive outcome. Both interventions greatly reduce the transmission of HIV and other sexually-transmitted and injection-transmitted illnesses if used appropriately and consistently.

Harm reduction requires us to surrender false notions of control. In situations with opioids, we must remember that it's impossible to control a condition that hijacks the brain of a person, rewires communication pathways, and elevates cravings as the driver of every situation. Harm reduction acknowledges that everyone is not on the same timetable to recovery. But it can also help someone stay alive until a person is ready to engage in healing.

COUNSELING YOUTH DURING THE OPIOID EPIDEMIC

While we can't guarantee the safety of the young people in our lives, we should honestly add more tools to our toolbelts.

- Educate yourself and others about harm reduction. Harm reduction approaches can range from very specific to very audacious. Explore resources that offer approaches that may challenge your notions of health and the messages you were taught as a child. The Harm Reduction Coalition[10] was established in 1993 and holds the only national harm reduction conference in the U.S. It works to promote sound public health policy for those who use drugs, and decrease stigma and marginalization of those who use. Students for Sensible Drug Policy, [11] founded in 1998, is an international organization that wants to end the "War on Drugs" and promote safer and more sensible approaches to drug policies—particularly policies impacting youth.
- Normalize the topics of behavioral health, toxic stress and resilience, and promote communication with difficult topics. Think of the parents who are teaching us what they wish they had known: if we don't communicate, we won't know.
- Stop demonizing and disparaging those in your life who struggle with substance use disorders. Our language remains with our youth. If they initiate substance use, our words can become barriers to conversation and accessing care.
- Strive to maintain communication, even when the young person you remember seems hidden in disorder and chaos.

Harm reduction is the beginning, not the end. Harm reduction is necessary, but it is not sufficient.

We must be realistic and vocal when it comes to prevention and treatment. We have an almost limitless supply of opioids in our communities. While we are reducing the number of medical prescriptions of opioids, we have unprecedented amounts of opioids coming into the country by land, sea and air. And the high to exceedingly high potency of synthetic and semisynthetic drugs allows shipping and mailing of these products in almost undetectable amounts. Known street drugs, such as heroin, are up to five times more potent than they were in the 1950s, and, in most regions of the U.S., supplies of heroin are purposely contaminated and potentiated by synthetic opioids such as fentanyl and carfentanil. When one use of a street drug can result in death, the days of "normal youthful experimentation" and boundary-pushing are over.

And there is no end in sight for the personal safety and public threats of substance use disorders. In addition to opioids, we're grappling with high-potency cannabis, overprescription of benzodiazepines (such as Xanax, Ativan and Librium), and the resurgence of methamphetamines.[12] So, is this, as many fear, the new normal? If it is, we need to adjust our educational messages and our own role modeling.

Harm reduction is a good first step. And for many youth, harm reduction is necessary before treatment. Because treatment will only work when it happens on the young person's timetable, not on ours. Only with a frank, open and informed discussion of a substance use disorder can someone move from harm reduction to treatment to recovery to thriving. In order for our young peo-

ple to have the kind of life we dream of for them, they need to stay alive. In the meantime, we have an obligation to educate ourselves and those we love about the science of addiction and risky drug use.

After all, we are living in an epidemic.

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NOTES

1. "Just Say No," Editors–History Channel.com, May 31, 2017, https://www.history.com/topics/1980s/just-say-no.
2. Alive and Well Communities, https://www.awcommunities.org/.
3. Drake Baer, "5 Countries Experimenting with Liberal Drug Laws," *Business Insider*, March 30, 2016, https://www.businessinsider.com/countries-experimenting-with-liberal-drug-laws-2016-3.
4. Dina Gusovsky, "Americans Still Lead the World in Something: Use of Highly Addictive Opioids," CNBC, April 27, 2016, https://www.cnbc.com/2016/04/27/americans-consume-almost-all-of-the-global-opioid-supply.html.
5. Abigail J. Herron and Timothy Koehler Brennan, *The ASAM Essentials of Addiction Medicine*, second edition (Philadelphia: Wolters Kluwer, 2015), 575-78.
6. I Wish I Knew Video Series: https://thearchwayinstitute.org/i-wish-i-knew-video-series/.
7. Not My Child: https://www.notmychildfilm.com/?fbclid=IwAR0wc6VE3MvXQuPw_hhHaIvg8j9GY-I7Hkg_kqaT4K106nMmdd8BG4PNcpewas.
8. Centers for Disease Control and Prevention, Syringe Services Programs: https://www.cdc.gov/hiv/risk/ssps.html.
9. Harm Reduction Coalition, Opioid Overdose Basics: https://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/.
10. Harm Reduction Coalition: https://harmreduction.org/.
11. Students for Sensible Drug Policy: https://ssdp.org/.
12. National Institute on Drug Abuse, Overdose Death Rates, Jan. 29, 2019: https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates.

QUESTIONS FOR DISCUSSION

Fred Rottnek, MD, is convinced that the opioid epidemic won't be solved by simple admonitions to "just say no" or responses of "three strikes and you're out" when teens do use. He advocates an approach known as "harm reduction," which acknowledges that risky behavior is already underway, and supports the young person through the state of danger until better choices can be made.

1. What do you think of the concept of harm reduction? How is it different from more traditional approaches to substance use disorders? When you think of young people brought to your emergency departments for opioid overdoses or alcohol poisoning, are they getting the treatment that could most help them? Are you aware of any harm reduction programs or support groups in your community?

2. Rottnek notes that the protocols for dealing with substance use disorders in parts of Western Europe are less punitive and more focused on broader safety nets for their citizens, prioritizing social determinants of health and universal access. How do you think growing awareness of the social determinants affects our understanding of causes of diseases and the care of people who have them? Give some examples and envision some possibilities.

3. Rottnek's sidebar asks, "Was Jesus a Harm-Reductionist?' It points out that the Jesus known through the Gospels lived in the thick of risky events and questionable people of his society — prostitutes, tax collectors, lepers and riffraff. What does that mean in terms of the care your hospital or health system offers? Think specifically of language, staffing, whole person care, pastoral care and respect for family members. How do you prepare coworkers to manage their unconscious biases when caring for people who are poor and vulnerable?

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