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Editorial

Harm reduction and the opioid crisis: Emerging policy challenges

Introduction

Globally an overdose epidemic has claimed thousands of lives in the past several years (BC Coroners Service, 2018; Ciccarone, 2017; Government of Canada, 2019b; National Institute on Drug Abuse, 2019). For instance, from January 2016 to September 2018, more than 10,300 deaths were attributed to opioid overdoses in Canada alone (Government of Canada, 2019b). The growing number of opioid-related overdose deaths has led to declarations of a public health crisis across North America (Government of Canada, 2019a; National Institute on Drug Abuse, 2019).

The epidemic has confronted and challenged policymakers, service providers, researchers, and the community alike. The crisis has been complex and has had a significant impact on the public health system and its resources (Canadian Institute for Health Informaton, 2018). A myriad of groups, including peer-based organisations, harm reduction agencies, and government bodies have advocated for greater attention to these issues and have been successful in shifting policy agendas. Issues that have gained attention include developing interventions to curb overdose rates (Fairbairn, Coffin, & Walley, 2017) such as drug safety testing (Tupper, McCrae, Garber, Lysyshyn, & Wood, 2018), addressing the supply of opioids (Elder, DePalma, & Pines, 2018), expanding injectable opioid programs (Bell, Belackova, & Lintzeris, 2018), navigating pain management and prescription practices (Stopka et al., 2019), promoting policy solutions to address an increasingly toxic drug supply (Ciccarone, 2017), and addressing stigma (Corrigan & Nieweglowski, 2018).

Amid the crisis in May 2018, the 12th annual conference for the International Society for the Study of Drug Policy (ISSDP) took place in Vancouver, Canada. Harm reduction policy and program interventions was a dominant theme of the conference, and presents ongoing issues and challenges for drug policy scholars. The articles in this special section, including three commentaries and four research papers, were presented at the conference. They present insight into the escalating trends in overdose (e.g., Ciccarone, this section), the responses (e.g., Strike & Watson, this section), and the challenges related to harm reduction (e.g., Hyshka et al., this section), both as a policy approach and a set of interventions to reduce the harms related to the opioid crisis.

Scaling up harm reduction interventions

The opioid crisis has been a catalyst for the scale-up of harm reduction interventions across North America and elsewhere. In examining these developments, authors in this special section have illustrated expansion of political support, funding, and programs and policies across North America. For instance in Canada, funding to support harm reduction has increased, even in jurisdictions that historically have not supported harm reduction (Hyshka et al., this section; Strike & Watson, this section). Needle and syringe distribution has continued, and supervised consumption spaces are being implemented or considered in new jurisdictions (Ciccarone, this section; Strike & Watson, this section) – for instance, as of April 2019, the Government of Canada approved more than 25 supervised consumption spaces (Government of Canada, 2019b)

Naloxone distribution programs and policy reforms have also been growing across Canada and the United States. Naloxone programs have been a key intervention during the epidemic by equipping people at risk of an overdose and bystanders alike with a life-saving medication that can temporarily reverse the effects of opioids upon administration (Strike & Watson, this section). In an evaluation of a provincial take-home naloxone program in British Columbia, Karamouzian and colleagues (this section) quantitatively demonstrated increased confidence in responding to overdose among people with naloxone, while concerns about police presence at overdoses has decreased. Evaluations such as this demonstrating effectiveness can be utilised to expand harm reduction interventions across other regions.

Another example is injectable opioid agonist therapy (i-OAT), which provides access to pharmaceutical-grade opioids through a medically regulated system. Several authors have noted the need to expand OAT interventions, including access to a diversity of opioids including methadone, buprenorphine, and hydromorphone, to address overdose (Larney & Hall, 2019; Oviedo-Joekes et al., 2008). Belackova et al.'s (this section) contribution focusses on the need and difficulties in implementing i-OAT in Australia. The authors note that while the evidence base for this therapy has mostly been supportive to date, including randomised control trials which demonstrate the effectiveness of i-OAT for treatment-resistant opioid dependent individuals, establishing this intervention has many challenges. Patient exit strategies, the high cost of treatment, and focus on abstinence have all been raised as concerns (Belackova et al., this section). Another concern is that even if i-OAT were widely expanded, these programs still operate as a medical intervention within prohibitionist regimes, rather than as an overarching human right (Strike & Watson, this section; Belackova et al., this section). Given the relatively few evaluations of i-OAT internationally, gaining political support can be difficult – particularly at the federal level (Belackova et al., this section; Strike & Watson, this section). Bearing in mind the extent of policy reform required across multiple layers of government, authors speculate that the scale up of such programs are unlikely to occur at high speed (Strike & Watson, this section; Hyshka et al., this section).

Harm reduction policy making and implementation challenges

While the proliferation of opioid-related overdose deaths has

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garnered political attention and support for harm reduction interventions, authors comment that the reach of this support has been mixed (Strike & Watson, this section; Hyshka et al., this section; Belackova et al., this section; Dassieu et al., this section). Strike and Watson (this section) note regions that have shown continued resistance to harm reduction initiatives, as well as other regions showing a "concerning and backwards policy trends". They unpack some of the major challenges within politicised policymaking environments, noting gaps in evidence that have made it difficult to gain support or expand initiatives. The authors suggest population-level evaluations could make a clearer case for the impact of harm reduction efforts, but are difficult to implement.

Formal harm reduction policymaking also may not be a priority. Hyshka et al. (this section) qualitatively studied the knowledge and awareness of harm reduction policies among policy actors, demonstrating ambivalence to harm reduction policymaking due to bureaucratic inefficiencies and inadequate resources. Governments and political environments also may not be enabling of policymaking related to the crisis. Hyshka et al. (this section) also note how the structure of some governments pose issues; multi-level support is needed in some countries, such as Canada, where a de-centralised system produces numerous levels of decision-making. In these systems, policymaking has been discretionary, authoritarian, and ad-hoc.

Many authors demonstrate that policy reform can be easily derailed or retracted within politicised policymaking contexts (Belackova et al., this section; Hyshka et al., this section; Strike & Watson, this section). Ad-hoc, grassroots interventions can be implemented relatively quickly by communities, but are vulnerable to political pushback (Strike & Watson, this section; Hyshka et al., this section). For instance, Strike and Watson (this section) note political interference of community-led overdose prevention sites in Canada where programming was stalled one year after opening and redesigned by the Ontario government who imposed greater restrictions and regulations.

Articles in this issue also highlighted some of the significant implementation difficulties harm reduction policies have faced including the importance of interpretation of policies in ways that the community understand (Hyshka et al., this section; Karamouzian et al., this section; Flemming et al., this section). A main barrier is that implementation is often left to lower-tier governments who may not have the resources to fund, plan and deliver interventions (Hyshka et al., this section; Strike & Watson, this section). The need for coordinated responses given these evident implementation challenges was underscored in the discussion by Karamouzian et al. (this section) who question if policies such as the Good Samaritan Laws have been effective in decoupling medical and criminal responses to drug use. They highlight the complexity and interconnectedness of policies, and urge us to move away from policymaking in silos.

Socio-structural determinants

Examining some of the main drivers of the crisis, Ciccarone (this section) disentangles the trajectory of several opioid crises throughout U.S. history to unpack the origins of the current epidemic. The unprecedented increase in the number of fatal and non-fatal opioid-related overdoses is attributed to a "triple wave epidemic" of overdose deaths from three sub-classes of opioids – prescription opioids, heroin, and synthetic opioids (mainly fentanyl and fentanyl analogues). In this examination, comprehending both the supply *and* demand of opioids, and the structures that sustain them, is underscored. For instance, on the supply-side, the prospect of impacting fentanyl importation into drug markets is minimal. On the demand side, there may be a growing acceptance for fentanyl (and fentanyl-adulterated and/or fentanyl-substituted heroin ('FASH')), complicating some of the demand-based harm reduction interventions, such as i-OAT. As well, restrictive policies regulating opioid prescriptions (the demand response) may have unintended consequences similar to prohibitionist drug policies, including diverting individuals to street-based opioid markets (also see Dassieu et al., this section). Collectively, Ciccarone's interrogation suggests that "unipolar" responses based on either supply or demand reduction separately do not sufficiently address the current crisis.

Alternatively, some scholars are turning their attention to addressing the socio-structural drivers of the crisis. As others have previously noted, "the structural and social determinants of health framework is widely understood to be critical in responding to public health challenges. Until we adopt this framework, we will continue to fail in our efforts to turn the tide of the opioid crisis" (Dasgupta, Beletsky, & Ciccarone, 2018, p. 182). The broader determinants of the overdose epidemic include a range of social, economic, political, and environmental factors (Rhodes, 2002). These include not only policies and laws, but resource availability, organisations, and environments that shape and influence behavior, as well as how institutions respond, govern, and enact policy. Strike and Watson (this section) underscore the importance of addressing intersecting influences of structural vulnerabilities and social determinants of health, including poverty, homelessness, trauma, and access to healthcare. Dassieu (this section) shows how policies often remain blind to and exacerbate inequities created by these systems, such as scarce resources for appropriate pain relief, employment, and access to healthcare. Structural interventions would seek to change the context that contributes to an individual's resilience, vulnerability, and risk by addressing these determinants. Shifting our focus to the structural determinants of health in responding to the opioid crisis may expand our understanding of harm reduction to widen its remit to the determinants of drug use harm which are rooted in structural inequities that shape our society.

An example of the importance of such factors is provided in Flemming et al.'s (this section) contribution which demonstrates the structural vulnerability and violence that people who use drugs face in housing. This research suggests that policies need to address human rights violations for structurally vulnerable populations who are subject to systemic oppression, and be mindful that such policies may reinforce and reproduce inequity and structural violence for an already marginalised population (Bourgois, 2003).

Stigma associated with substance use also remains a major, ongoing, and pervasive structural barrier that continues to be rife within institutions (Corrigan & Nieweglowski, 2018; Dasgupta et al., 2018). In the context of the opioid crisis, stigma has devastating consequences. For example, Dassieu et al. (this section) demonstrates how the labeling and stigmatisation of people who suffer from chronic non-cancer pain increases harm through individuals turning to street-based opioid markets. Addressing structural issues will require participation from the affected community whose experiences can speak to the underling influences and systems that impact their lives. Hyshka et al. (this section) found that harm reduction policy actors were especially supportive of policies related to the determinants of health.

Conclusion

While the opioid crisis has pushed harm reduction interventions to the forefront of the response, they are far from a panacea. On the one hand, the crisis has bolstered and solidified some governments commitment to harm reduction. On the other, it has exposed major gaps and suggests that we have not yet found a long-term solution. Clearly, not one intervention, policy, or approach to date has been a 'silver bullet' – complex problems require complex solutions.

We have reflected on four policy challenges related to harm reduction and the opioid crisis. The first is that many harm reduction programs are difficult to implement and struggle in a politically restrictive environment. The second is the lack of attention to the social determinants of health which underpin and drive the crisis. The third issue is that 'unipolar' responses are not effective. They are often uncoordinated, do not consider the social determinants, and other drivers (such as demand). The fourth challenge, with which we conclude, is an

absent discussion about whether harm reduction is indeed the only or preferred response. While it is impossible to know whether the trend line would have been even higher in the absence of harm reduction (although we suspect it would have), its scale-up has had little impact the current trend of overdose rates. In light of this, we question why there have not, to our knowledge, been any new harm reduction technologies – we are still working with models which already exist (for example safe consumption spaces, iOAT, naloxone). While scale-up has resulted in much important innovation in the shape and delivery of these interventions, no innovative or new approaches or strategies have emerged. The policy proposals to introduce a legal regulated supply of drugs that cause overdose are not new ideas either (and continue to fail to gain political and public support). We suggest that more innovative strategies need to come to the fore, which address both supply and demand side drivers. These interventions may come from different paradigms, and we need to think beyond harm reduction. This will also require enabling political environments that facilitate innovative and complex solutions. How much has the opioid crisis enabled a policy environment towards more structurally-oriented change? And, if the . crisis has opened opportunities for policy change, how are we going to use it?

Conflict of interest

We wish to confirm that there are no known conflicts of interest associated with this publication and there has been no significant financial support for this work that could have influenced its outcome.

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