Advancing Health Equity with Harm Reduction Strategies

Cosponsored by Funders Concerned About AIDS

October 24, 2018 3:00 p.m. Eastern

Barbara DiPietro, National Health Care for the Homeless Council

Mishka Taylor, Virginia Commonwealth University

Kima Joy Taylor, Anka Consulting

ADVANCING HEALTH EQUITY WITH HARM REDUCTION STRATEGIES

DR. KIMÁ JOY TAYLOR, MD MPH
ANKA CONSULTING
kimataylor@ankaconsultingllc.com

THERE IS NO HEALTH EQUITY WITHOUT TALKING ABOUT HARM REDUCTION/SECONDARY PREVENTION

- What is harm reduction?
- What does it mean/what can it mean?
- What should it mean?
- How can funders engage?

HARM REDUCTION COALITION PRINCIPLES

- **Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.**
- Harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to meet drug users "where they're at," addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.
- However, HRC considers the following principles central to harm reduction practice.
- Accepts, for better and or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.

HARM REDUCTION COALITION PRINCIPLES

- Establishes quality of individual and community life and well-being–not necessarily cessation of all drug use–as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

ADVANCING HEALTH EQUITY WITH HARM REDUCTION STRATEGIES

Barbara DiPietro
Senior Director of Policy
October 24, 2018

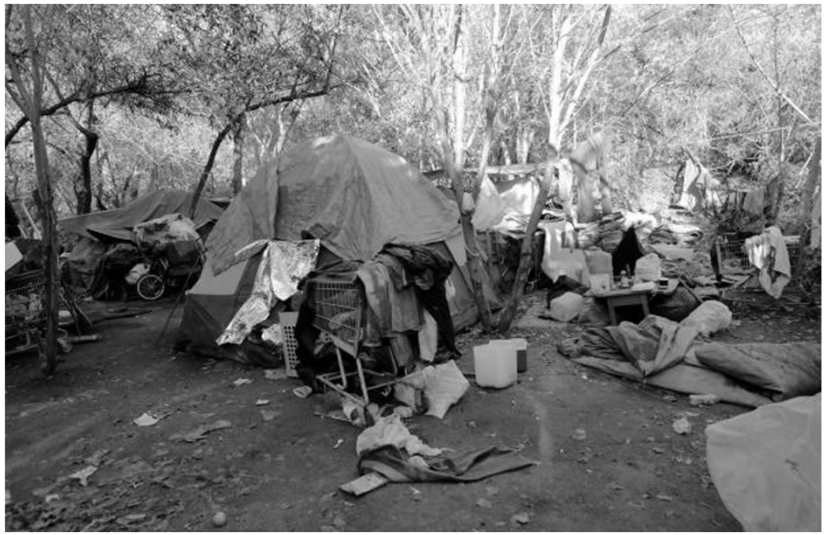
NATIONAL HEALTH CARE for the HOMELESS COUNCIL

HOMELESSNESS & BARRIERS TO CARE

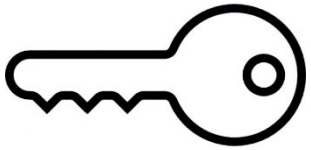
- **Prevalence:** 553,742 on any given night (1/3 on street) & 1.4 million over the course of the year using federally funded shelters
- **Health:** High rates of chronic disease, acute illnesses, addiction & mental health disorders, injuries, violence & trauma

Poor health ⟷ **Homelessness**

- **Barriers:** Health insurance/money, identification card, lack of housing, transportation, competition for basic needs, discrimination, fear/lack of trust, health conditions, uncertain where to go



‘HARM REDUCTION’ IS A FLEXIBLE TERM

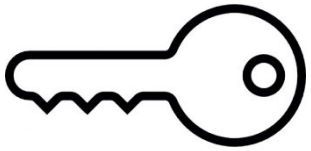


→ **As an Approach to Care**
- Low/no barrier access to services
- Adapted clinical plan
- No judgment

→ **As a Program**
- Needle exchange program
- Condom distribution
- Safe injection facilities (or some alternative)

→ **As Advocacy**
- Defending current programs & policies
- Changing inequitable & unjust policies

ROLE OF PHILANTHROPY COMMUNITY



→ **An Approach to Care**

- Workforce training in trauma, harm reduction, addiction as a disease & motivational interviewing
- Also: overcoming stigma, structural racism, bias in care, burnout prevention

→ **A Program**

- Targeted funding for gaps in services not covered by public grants or health insurance (e.g., dental, hygiene kits, etc.)
- Capital funding for new space to deliver care (housing & services)

→ **As Advocacy**

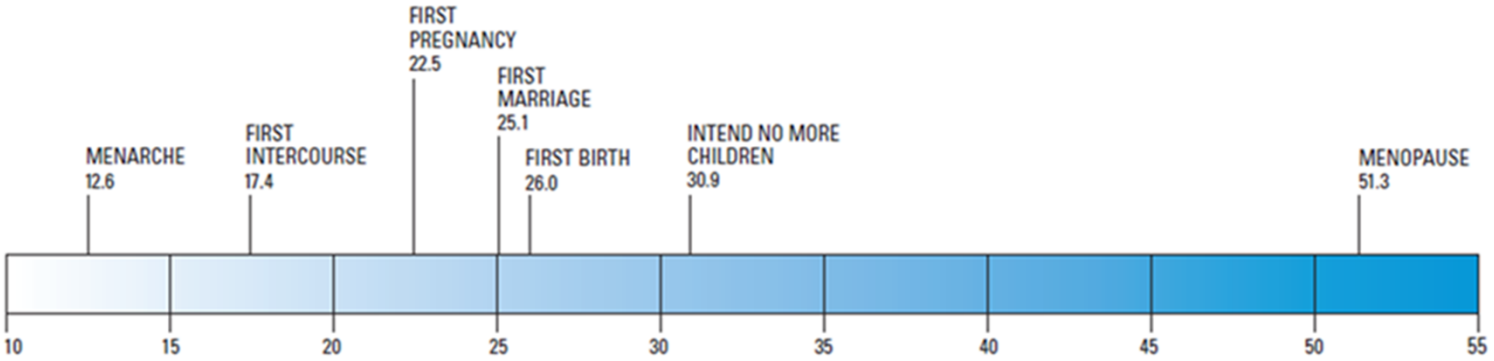
- Support grassroots advocacy organizations for direct organizing & education of policymakers
- Support training events that help service providers build organizing & advocacy skills

What Harm Reduction Looks Like: Gender and Behavioral Health

Mishka Terplan MD MPH FACOG DFASAM
Professor Departments OBGYN & Psychiatry
Virginia Commonwealth University

FIGURE 1.1

The typical woman spends five years pregnant, postpartum or trying to get pregnant and 30 years trying to avoid pregnancy.



Median age at which event occurs*

Note *Age by which half of women have experienced event.
Source Reference 6.

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Contraceptive use and method choice among women with opioid and other substance use disorders: A systematic review

Mishka Terplan [a,b,*], Dennis J. Hand [c,d], Melissa Hutchinson [a,b], Elizabeth Salisbury-Afshar [a,b], Sarah H. Heil [c,d,e]

[a] Behavioral Health System Baltimore, Baltimore, MD 21201, United States
[b] Department of Epidemiology and Public Health, University of Maryland, Baltimore, MD 21201, United States
[c] Vermont Center on Behavior and Health, University of Vermont, Burlington, VT 05401, United States
[d] Department of Psychiatry, University of Vermont, Burlington, VT 05401, United States
[e] Department of Psychology, University of Vermont, Burlington, VT 05401, United States

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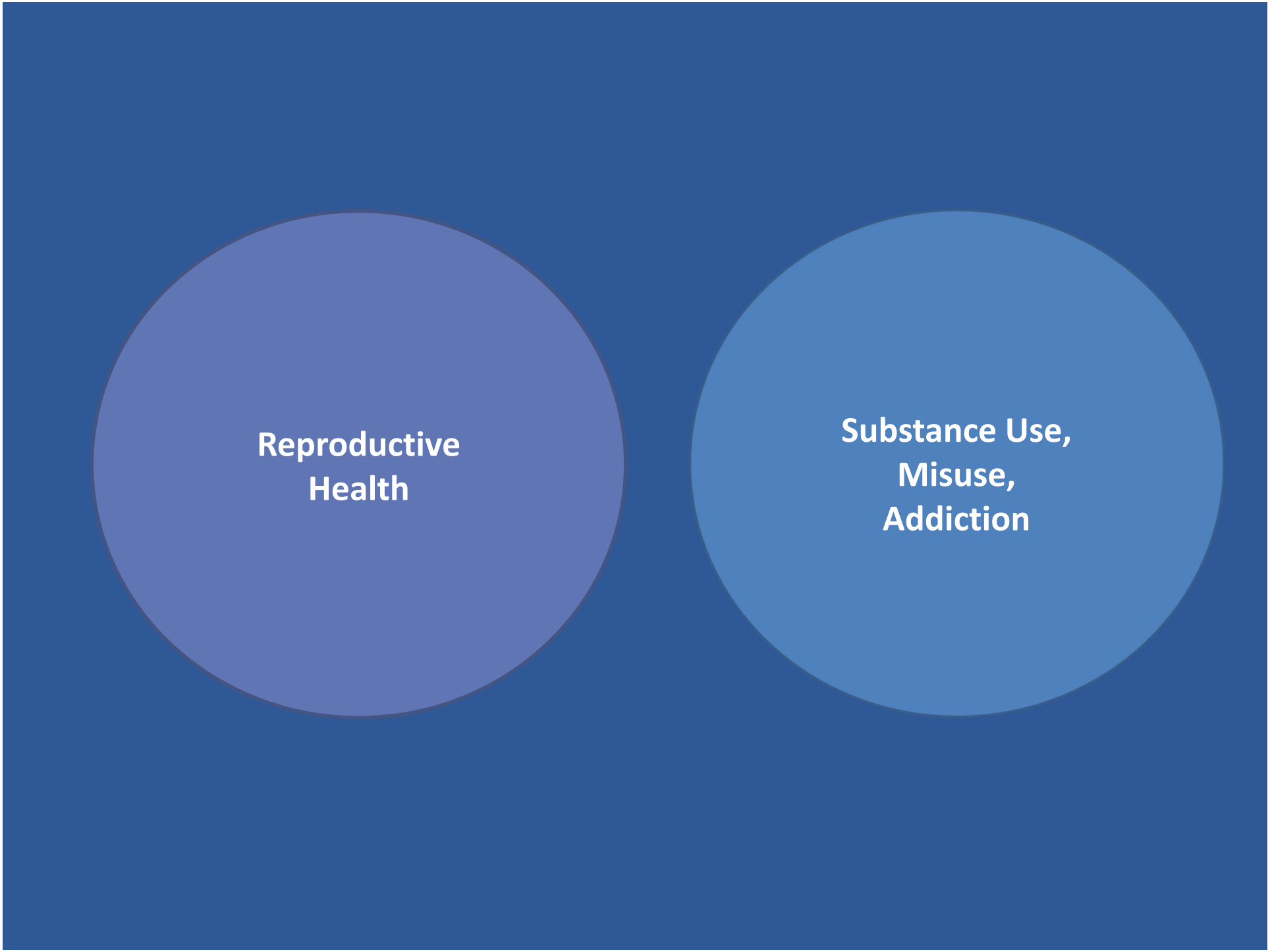
ABSTRACT

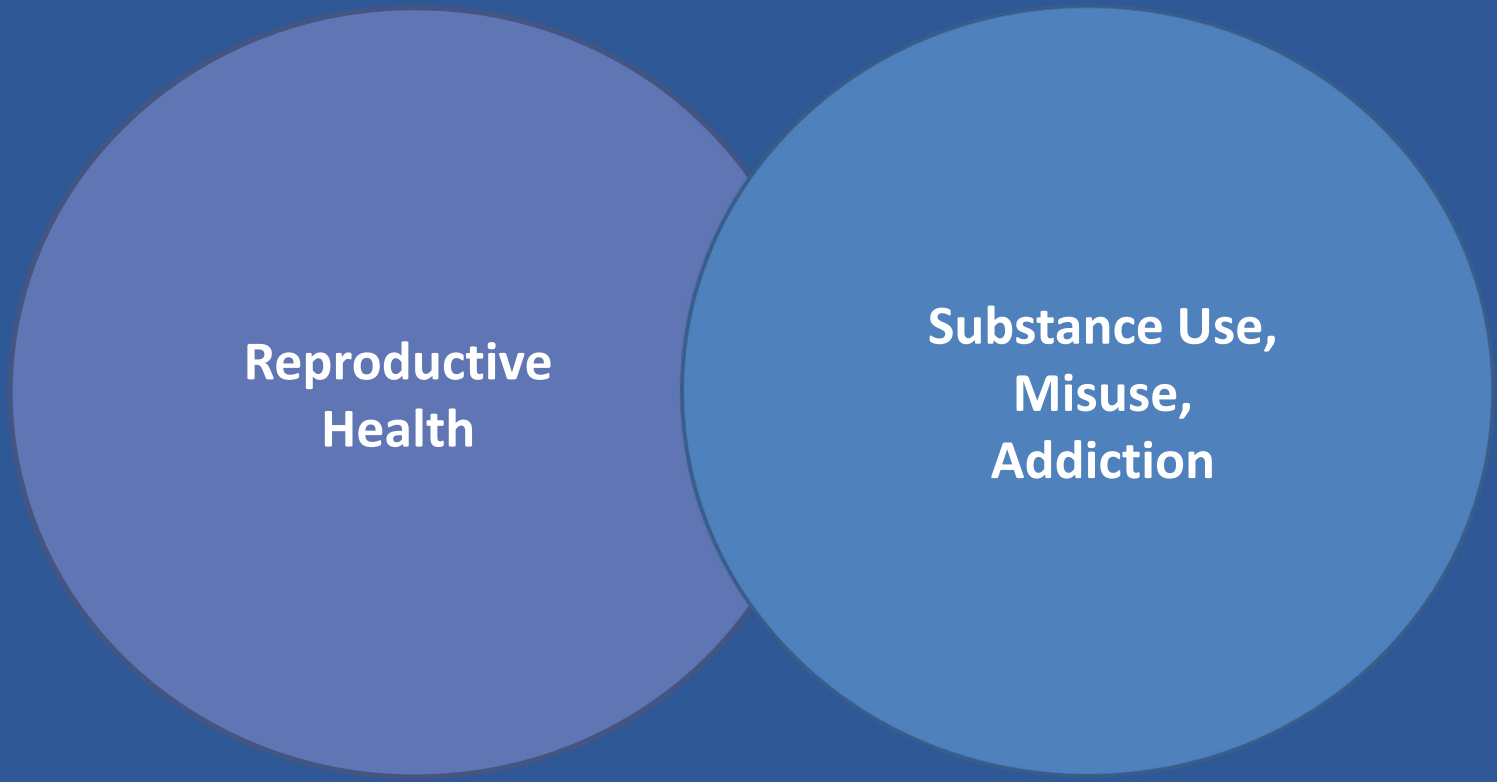
Aim. To systematically review the literature on contraceptive use by women with opioid and other substance use disorders in order to estimate overall contraceptive use and to examine method choice given the alarmingly high rate of unintended pregnancy in this population.

Method. Pubmed (1948–2014) and PsycINFO (1806–2014) databases were searched for peer-reviewed journal articles using a systematic search strategy. Only articles published in English and reporting contraceptive use within samples of women with opioid and other substance use disorders were eligible for inclusion.

Results. Out of 580 abstracts reviewed, 105 articles were given a full-text review, and 24 studies met the inclusion criteria. The majority (51%) of women in these studies reported using opioids, with much smaller percentages reporting alcohol and cocaine use. Across studies, contraceptive prevalence ranged widely, from 6%–77%, with a median of 55%. Results from a small subset of studies (N = 6) suggest that women with opioid and other substance use disorders used contraception less often than non-drug-using comparison populations (56% vs. 81%, respectively). Regarding method choice, condoms were the most prevalent method, accounting for a median of 62% of contraceptives used, while use of more effective methods, especially implants and intrauterine devices (IUDs), was far less prevalent (%).

Conclusions. Women with opioid and other substance use disorders have an unmet need for contraception, especially for the most effective methods. Offering contraception services in conjunction with substance use treatment and promoting use of more effective methods could help meet this need and reduce unintended pregnancy in this population.


Reproductive Health
Substance Use, Misuse, Addiction


Reproductive Health
Substance Use, Misuse, Addiction

Contraception and Clean Needles: Feasibility of Combining Mobile Reproductive Health and Needle Exchange Services for Female I

| Eva Moore, MD, MSPH, Jennifer Han, ScM, Christine Serio-Chapman, BS, Cynth

Study	3 month continuation	12 month continuation
Martin et al	36%	9%
General population	41%	36-69%
Low-income urban minority women seeking FP services	49-64%	23-29%
Minority adolescents with public assistance	71%	12-27%

Injectable Contraceptiv Female Exotic Dancers Seel Health S

Caitlin E. Martin, MD, MPH
Jennifer J. Han, ScM
Chris Serio-Chapman, BS
Patrick Chaulk, MD
Mishka Terplan, MD, MPH

Abstract: **Objectives.** We describe depot ation patterns among female exotic da mobile syringe exchange. **Methods.** Clie August 2012 were identified retrospectiv continuation. Client characteristics were nine clients were identified; 72% were A At three months, 36% of the study samp likely to be White (p=0.01) and receive continuation probability was 0.09. Consi tinuation proportions were higher (46% of female exotic dancers may favor DMP reproductive health services into public needs of this high-risk population.

$85 programmatic cost per client, including clinician costs and supplies

25–29	18 (26%)	9 (36%)	9 (20%)	
≥30	8 (11%)	4 (16%)	4 (9%)	
Race				
African American	49 (72%)	13 (52%)	36 (83%)	.01
White	18 (27%)	11 (44%)	7 (17%)	
Other	1 (1%)	1 (4%)	0	
Residence				.45
Baltimore City	42 (61%)	14 (56%)	28 (64%)	
Other Maryland County	25 (36%)	11 (44%)	14 (32%)	
Out of state	2 (3%)	0	2 (4%)	
Syringe exchange client				
Yes	6 (9%)	3 (12%)	3 (7%)	.67
No	63 (91%)	22 (88%)	41 (93%)	
Received other services[a]				
Yes	30 (43%)	17 (68%)	13 (30%)	<.01
No	39 (57%)	8 (32%)	31 (70%)	
Contraceptive use at first visit				
Yes	4 (7%)	2 (9%)	2 (5%)	.63
No	56 (93%)	21 (91%)	35 (95%)	

[a]Defined as those returning within 10–14 weeks from last injection.

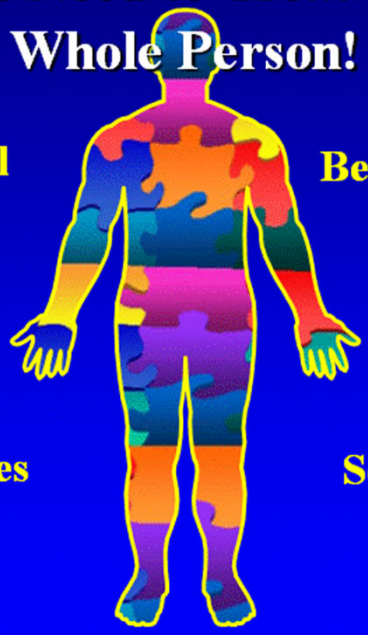
Parity and Integration

Treating a Biobehavioral Disorder Must Go Beyond Just Fixing the Chemistry

We Need to Treat the Whole Person!

Pharmacological Treatments (Medications)

Behavioral Therapies



Medical Services

Social Services

In Social Context

NIDA

What if the “Whole Person” is a Woman?

Prevalence of reproductive health hits in specific web search engines

	Reproductive Health	Sexual Health	Contraception	HIV	Pregnancy
NIDA	21	22	17	c. 125,000	c. 19,800
SAMHSA	55	29	43	3910	1350
ASAM	6	3	7	179	121

Prevalence of addiction search term hits

	Addiction	Substance Use
ACOG	177	135
AAFP	640	277
AAP	140	293

April 2017

What Harm Reduction Means To Me

- “Meeting people where they are at”
- Assumes Autonomy and Liberty
- Realistic and Person-Centered
- Examples: Condoms, Seat Belts, Defibrillators, Naloxone, Syringe Exchange, Contraception, Prenatal Care ….

How do we address inequities in reproductive health for women with addiction? Conclusions

- Reproductive Health = Human Right
  - Right to determine whether and when to become pregnant
- Reproductive/Sexual Health:
  - Essential domains of wellness and recovery
- Family Planning needs to be integrated into addiction treatment
- By providing comprehensive services – move towards actualizing gender equality and addressing injustices

Thank You

- Mishka Terplan
- @do_less_harm
- shka.Terplan@vcuhealth.org

Harm Reduction is:

Evidence-Based

And

Person-Centered

- Evidence-Based
  - Science, Epidemiology, Public Health
  - Measurable and meaningful outcomes
  - Level of the population
- Person-Centered
  - Individual belief and values
  - Ethical and humanistic: Grounded in human rights (autonomy)
  - “Art” of medicine = asking and listening

GRANT MAKERS IN HEALTH

Questions?

Please type your question into the Chat Box or press
*6 to unmute your phone line and ask a question

- More webinars on this topic?
- New topics you want to tackle or learn more about?
- Innovative work that you want to share?
- A question you want to pose to your colleagues?

Contact us at bh@gih.org