Sawbones 359: Harm Reduction

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Intro (Clint McElroy): Sawbones is a show about medical history, and nothing the hosts say should be taken as medical advice or opinion. It's for fun. Can't you just have fun for an hour and not try to diagnose your mystery boil? We think you've earned it. Just sit back, relax and enjoy a moment of distraction from that weird growth. You're worth it.

[theme music plays]

Justin: Hello everybody, and welcome to *Sawbones*, a marital tour of misguided medicine. I'm your co-host, Justin McElroy.

Sydnee: And I'm Sydnee McElroy.

Justin: And I am so excited to be here with you, Syd, recording another great episode of *Sawbones*.

Sydnee: Me too, Justin. I'm excited to do this, I'm gonna kind of launch into our episode a little quicker than we normally do.

Justin: Okay.

Sydnee: Because it's an important one and there's a lot. It was one of those moments where I finished preparing the whole episode and then thought, "This should have been, like, a series." But, I think we'll look at this as like a general overview of the topic, and there are lots of other little alleys that I found that we can go down to explore more in-depth in the future.

But this is sort of a general overview of something that is really relevant to me, and to a lot of our community here where we live. But, I am certain there are other places all over the country who are dealing with this same struggle right now, that we are not alone in that, but I know it's very relevant right here.

Justin: Before you get into it, can you talk for just a couple minutes about why it's sort of like—your connection to it?

Sydnee: Well, first of all, what we're going to be talking about is harm reduction.

Justin: Okay.

Sydnee: And before I get into the episode, can I give a huge thank you to Luca, a listener who reached out to say that if I was going to do an episode like this, he is an expert and has a wealth of knowledge on the subject and would be happy to provide any support I needed and was just instrumental in the creation of this episode, so thank you, thank you, thank you, Luca. This episode of *Sawbones* would not exist without you.

Justin: Thanks, Luca!

Sydnee: So, thank you. Harm reduction is— first of all, do you know what it is, Justin?

Justin: I mean—

Sydnee: Before I launch into why—

Justin: You know I know what it is, but probably thinking of… it's like, needle exchange programs, right? Like—

Sydnee: That's what most people kind of think of, yes.

Justin: The less, uh… Is that term in distaste now? Is that a less—

Sydnee: What you just said, I'm glad that's what you said, because I think that's what most people envision. If they've heard it, that's what they envision is that concept, needle exchange. I would say that "exchange" is not the right word, but that's going to be part of the conversation, so that's fine.

We're gonna get into why that's not the best description. But I think a lot of people just envision some sort of place where you go and get clean needles.

Justin: Okay.

Sydnee: Right? That's the idea. The reason that harm reduction is so important to our community at this moment, is that we do have a harm reduction program in Huntington, and right now, the West Virginia state legislature has a lot of people, not all of the legislators, but a specific party and many of that party's members are quite invested in stopping harm reduction programs.

They have not introduced legislation to ban them, which has been attempted in the past, and there are states where you just can't do harm reduction. Period. At least when needles are involved. That has not been introduced, but to sort of regulate them out of existence if that makes sense.

We're going to put so many stipulations on the creation of these programs and involve so many people at different levels of government and within the community to sign off on them before they're allowed to exist, that we know will destroy all of the harm reduction programs in the state.

Now, at this moment as we're recording, some of the legislation has been watered down through tireless efforts of public health advocates in our community. Some of it has been watered down so that I don't think it will completely destroy all of the harm reduction programs in the state. But assuming it does pass, they will definitely be hampered, and probably therefore less effective, and certainly, some may close as a result of this.

And that, as a doctor, for me, is atrocious because as we're gonna talk about, harm reduction programs work. They save lives and they're evidence-based. They're good medicine, they're good science. They're the right thing to do scientifically, they're the right thing to do from a human perspective. And so, all of your arguments against it are usually based on a misunderstanding of what it is.

If you're in the medical field, you hear harm reduction and you immediately think of these programs, largely aimed at people who use injection drugs,

and were trying to use measures to avoid the negative consequences of using injection drugs. Things like blood-borne infections, like HIV or Hepatitis, an overdose, other sorts of infections that you can get from reusing needles that haven't been properly cleaned in between, that kind of thing.

Harm reduction programs are specifically aimed at mitigating those sorts of adverse effects. But you practice harm reduction in your daily life constantly.

Justin: Maybe you do. I live like I'm nine. Like Tim McGraw told me to. I'm out there every day, all risk, no reward.

Sydnee: Well, I don't think *that's* true.

Justin: Sorry, do you see this, uh, parachute that I dragged into the room that's still connected to my bag? I didn't even learn how to take it off, that's 'cause I don't— I'm all risk. I parachuted in here to record this episode.

Sydnee: Well, you know, you use that an example and this is kind of extreme, but, when you jump out of an airplane with a parachute, the reason you wear the parachute is to reduce the risk of harm from jumping out of an airplane.

Justin: They tricked me into wearing it. I wasn't going to do it.

Sydnee: This is sort of extreme, because most people, if they didn't have a parachute, just wouldn't jump out of a plane, right? Like, given the option.

Justin: Most people.

Sydnee: So let's use a more commonplace example. Do you drive a car or ride in a car? Have you been in a car that is moving?

Justin: Yeah, I've been in a car! You know I've been in a car.

Sydnee: Riding in cars, driving cars, is one of the most risky behaviors you can engage in, right?

Justin: Sure.

Sydnee: I mean, if you look statistically.

Justin: Yes.

Sydnee: Wrecks happen all the time.

Justin: Okay, good.

Sydnee: It is a risk you take.

Justin: Thanks, generalized anxiety disorder over here. Pile it on. Come on, Syd, what else you got?

Sydnee: My point is, you have the option of never being in a car. You could do that. It would probably greatly limit your quality of life.

Justin: Yeah. You couldn't go to Arby's... at all.

Sydnee: Yes, there are lots of things you can't do depending on where you live if you don't have a car. If you can't drive a car, not if you don't have a car; if you won't ride in one. Or a bus or any sort of moving vehicle, right?

Justin: Right.

Sydnee: So we do things to reduce the harm of that. We wear seatbelts. We have airbags. Cars are held to certain safety standards. We have traffic laws. We have all kinds of things in place.

Justin: We wear masks. Right?

Sydnee: Yes.

Justin: Similar idea.

Sydnee: Yes, wearing a mask is a way of—

Justin: That's more of a societal harm reduction, but sure.

Sydnee: Yeah. No, but wearing a mask is a way to mitigate a risk, 'cause you could just lock yourself in a closet for the duration of the pandemic, and that would be safer.

Sunscreen. You don't have to go out in the sun. You could just not go out in the sun, but you do and you wear sunscreen. Knee pads or helmets for our kids, like, riding bikes, playing sports. Every time a kid engages in one of those activities, there's a risk of harm, but we still let them. We have life jackets. These are all harm reduction. These are all things we do, right?

Justin: Right.

Sydnee: Even that—remember that weird stuff that you could drink before you got drunk so you wouldn't have a hangover? Do you remember that? That was advertised for a while on TV?

Justin: Beer. Do you mean beer?

Sydnee: No, the thing that you were supposed to take first, and then you wouldn't get a hangover.

Justin: Oh! Yeah, yeah, yeah. I forget the name of it. I don't—

Sydnee: I don't remember what it was. But, like, I don't think that—I mean, that didn't work. But, like, the point is it's the same thing. You could just not drink so much that you got hung over, but okay, instead I guess you're gonna use that.

Anyway, my point is, we all do things that reduce harm. And this is the same idea. That, you know, there are things we can do for people who use injection drugs, things they can do to reduce the risk of harm coming from it. There's also like, the larger issue, and we're gonna talk about this. The development of harm reduction has had sort of, like, two different phases.

There was the initial idea of, like, the individual human who uses injection drugs. How can we prevent harm from coming to them in the best way

possible? How can we reduce the risk, I should say, of harm coming to them.

But then, there was this sort of like, second wave of like, the public health benefit from this, right? Which is why you see a lot of harm reduction programs tied to health departments who are concerned, not just with your individual health and safety, but with the broader concept of the public health at large, right?

And I mean, this is a very valid thing, especially if you're talking to policymakers, you have to bring in all these points. You have to bring in all this evidence to the table as to why harm reduction is so important. Not just for the individual human but for the community at large. All of those things really speak to the people who get to write the laws, and the people who write the checks, because there's a money-saving argument here.

As a doctor, that's not really where my concern lies. My concern lies with the patient and the person, and I think a lot of people involved in harm reduction would argue passionately where it all comes from. The root has to be, "How can I help you, human?" [laughs] Preserve your dignity, your autonomy, your right to make decisions for yourself, but also reduce the harm that will come to you, you know, as much as possible.

Justin: Okay.

Sydnee: Does that make sense?

Justin: Yeah.

Sydnee: But both of these things come into play when we're trying to argue about how to maintain these programs. We're gonna start back—remember, we did a whole episode about the origin of the hypodermic needle?

Justin: Yeah.

Sydnee: Okay, and Christopher Wren got a dog high? Do you remember that? [laughs]

Justin: I—yeah.

Sydnee: Is that—I've read, was this the first injection drug use? I don't know.

Justin: Maybe?

Sydnee: The first time that somebody—I don't know. It wasn't long after we had, like, real, what we think of today as a hypodermic needle. There were lots of, from Christopher Wren, in between then and 1858.

There were a lot of other things introduced that were similar. But what we think of today as something to inject something, really came from around 1858. And soon after it was introduced, as we talked about in that episode, we started to have concerns about people using them and using psychoactive substances, things that can make you high, when they shouldn't. Or, you know, from the medical perspective, when it was unnecessary.

And there were already things, as early as the 1860s, you started to see concern about like, "Oh, well, not only I treated that person with morphine for a certain period of time, but now they seem to be continuing to use morphine. I haven't diagnosed them with anything." There was this concern arising. But then, there was also cases of, like, transmission of smallpox from reusing a needle. Tetanus, rusty syringes causing problems and infections.

So, like, all of this, as soon as the needle existed, harms that can come from the needle arose. And this is true for any new piece of technology. You find something. It's great, it works, and then you realize, like, "Oh. Oops." [laughs] "It does all this other stuff!" Fossil fuels, for instance.

Justin: Yeah.

Sydnee: "This is great! We have energy!"

Justin: "This is great! Look at this! I burned this rock! It's burning forever! I love it!"

Sydnee: "Oops!"

Justin: "Everybody come get these rocks!" [laughs]

Sydnee: And so then, you realize, like, "Oh, okay. There's some harm." So, like, this is not unique to the needle. Everything. You don't realize I think, until you put it out there, like, "Ooh. Okay. There's some stuff we didn't anticipate." And you gotta troubleshoot.

So, originally, using injection drugs was not illegal, right? You could use morphine or heroin, eventually, at home. Like, that's fine. There was no law against it. There were laws that were passed to try to limit the prescribing by doctors, initially. Like, they were kind of targeted on that end of it. Like, "Well, let's tax these things, let's regulate these things on the doctor end. On the prescriber, on the pharmacist end, on the people who are providing the substances. Let's try to control the supply on that end." But the drugs were not, like, criminalized, right?

Justin: Yeah.

Sydnee: Now, when you look into when did these things become criminalized, well, we're really talking about many things. It's tied to racism, cultural stigma, a fear—a racialized fear, very much tied to, "Let's make white people afraid of these drugs by associating these drugs with people who aren't white." That was very much sort of the origins of when all this stuff was criminalized.

In the early 1900s, the move to make opium, first, illegal was very much tied to prejudice against Chinese-Americans. And there were a lot of stories and like, this whole fear that all these white women, especially, were running away with and leaving their husbands for Chinese men because they had the opium.

And there was this whole big fear that, like, they're stealing white women. I mean, this story is so old in American history, like, you just hear it again and again, whatever race we want to demonize.

Justin: Yeah.

Sydnee: But there was this idea because so many women were prescribed Laudanum, opium, for, quote-unquote, "female troubles," that they were, many of them did develop an addiction to that substance, and so then would seek it out if they weren't getting it from a doctor. So they played upon those fears to, you know, make everybody afraid of Chinese-Americans and opium.

Then, they did the same thing with cocaine and Black Americans. There were many stories of, like, you get these wild ideas that cocaine gave Black men superhuman strength. And that's why—

Justin: That was a thing?

Sydnee: Yes. That's why we need to limit it, is because we're making Black men too strong with our cocaine and they can do anything. And again, tied to the fears of—I mean, what we're doing is weaponizing white women and their safety, at this point. And that's what all of this was about.

Marijuana was very much tied to Mexican-Americans. That's where that—I mean, all of these were very racist in their origin. "This is why these drugs are bad. Look at who they came from or who uses them." This was all this conversation when the Harrison Act was passed in 1914. And this addressed opiates, specifically. This is where this kind of starts, it addressed opiates specifically in a way that has ramifications to this day, okay?

So, in this milieu of all this, like, racist fear about drugs, the Harrison Act comes up and basically, opium at this point was considered an international problem. Everybody was freaking out, like, on an international level, "What are we going to do about opium? How do we stop it? How do we get everybody to stop using it?"

And so, there was this International Opium Commission in Shanghai in 1909. The U.S. of course sent delegates. And after that, they would play their part in, sort of, "How do *we* regulate it? Well, let's tax it. Let's make it harder to get opium to people." That was the idea of the Harrison Act and it got a lot of support because of all these stories that I just talked about.

But the thing about the Harrison Act, is that the way that it was worded, it didn't allow doctors to prescribe opiates, specifically, for addiction. And up until then, that was commonplace. Like, you might have someone who you treated with morphine for something painful. That painful condition resolved, they no longer had it, but the patient still came to you to get morphine, because at that point, it was addiction, you know?

Justin: Right.

Sydnee: And the doctor would prescribe it. That would be okay. That was an acceptable—"Well, we know the negative consequences of withdrawal, so we continue to prescribe it."

Justin: Okay.

Sydnee: The Harrison Act, the way it was worded, made it so that that was a criminal act. This is still the case outside of very well-regulated, very tightly controlled things like methadone and suboxone and things like that. I can't have someone come to me and say, "Listen, I was given Norco or Percocet or whatever for this, whatever, broken bone I had. The bone is healed. It's all better now, but I'm addicted to it now, and I would like you to keep prescribing it to me." I can't do that.

Justin: Is that—forgive my ignorance, you're deeper in this than I am. Is that a bad thing?

Sydnee: Well, here's what I would say, if we did—

Justin: 'Cause I know that doctors prescribe a lot of painkillers that people don't need for similar re—like, an addition is definitely a part of that. Like, is it a bad thing that they can't prescribe, like, injection drugs due to addiction?

Sydnee: Yeah, I would say that it is, as a blanket statement. I mean, I think there's a ton of nuance here. I don't think this is something you just say—

Justin: There's no room for that on *Sawbones*, Sydnee, I need a yes or a no, please.

Sydnee: You have to remove the moralistic part from it. And this is the same idea with things like methadone or suboxone. If taking this prevents all of the negative, all of the harm that can come from seeking to use substances in an illegal setting… if you can find a way to do that legally, we have plenty of scientific evidence that tells us the patient's quality of life and quantity of life is longer. That less harm comes to the patient in that scenario, so then why would it be bad?

Justin: I don't know, I'm just asking.

Sydnee: Because we're getting into areas where people feel like they have a strong moral grounding to make one argument or the other. And I think you have to remove it from the conversation. But anyway, this Harrison Act is really—

As we move forward, through the history of harm reduction in various parts of the world, this is a breaking point. And this is why the U.S. has been so far behind in so many ways, as an entity, the United States of America. Not specific people, because as always, grassroots activists step in when there is a void. But as a country from the top down, we have been behind for a very long time because, I mean, this is really where it starts. And we wouldn't catch up for quite a while, which I'm going to talk to you about.

Justin: Oh, okay, go ahead.

Sydnee: But first, we've got to go to the billing department.

Justin: Sydnee, let's go.

[ad break]

[Max Fun ad plays]

Justin: Alright, Sydnee, if I remember correctly, the U.S. was about to come roaring back and make up the lost ground to other nations and become a world leader in harm reduction, right?

Sydnee: No. We're not—no. None of that is true. I do wanna briefly tell you, in this same period of time as you look through like, all the way up until the 1960s, that was really—the idea that we should do literally anything about this, as like a concerted policy making government body thing… Again, I'm not talking about individuals. There were individuals who were trying to address these things all along, they just had like, no government support in doing so.

But it was really the '60s before we even start to catch up, and the '80s before anything big starts to happen, into the early '90s. Meanwhile, in other parts of the world, people *were* doing things. In the U.K., police officers recognized pretty early that arresting and putting people in jail for having drugs or using drugs didn't really help anyone. Like, "What are we even doing? What is the point?"

And so there was this concept of simple cautions, which is sort of a, like, shake your finger and say 'don't do that again' kind of thing, as opposed to like, developing this stigmatizing criminal record against somebody because they were caught with some drugs.

Justin: Yeah.

Sydnee: And as far back as 1926, you have doctors prescribing opiates for, I mean, the same way we would think of methadone or suboxone today for medical therapy.

Justin: In the U.K.

Sydnee: Yeah, in the U.K. with the Rolleston Report. And I mean, again, 1926, so all of this stuff that in the U.S. you couldn't do, they never stopped doing in the U.K. Another big step forward was in Merseyside, which is like

the county where—I say where Liverpool is, because… See, the thing about Americans is we don't really know geography, so you gotta give us something we can tie to like, a pop culture reference.

Justin: It's near Liverpool.

Sydnee: Liverpool. Like the Beatles.

Justin: It's where Liverpublians, like The Beatles.

Sydnee: Yeah, you know. The Beatles. Liverpool.

Justin: Where Pete Best is from!

Sydnee: [laughs] If you don't give us that—and that's true for our geography too, by the way. We don't know United States geography either.

Justin: Yeah. That's true.

Sydnee: [laughing] It's not a nationalist thing.

Justin: That's true.

Sydnee: Americans just don't know geography.

Justin: There's a lot of states in there, that if they started moving them tomorrow, I would have no idea.

Sydnee: Yeah.

Justin: The girls wanted to go to Omaha, Nebraska because that's where Jojo Siwa's from, and they've watched all these videos about the magical world of Omaha, Nebraska and they had this map and they wanted me to show them where Omaha, Nebraska was. And friends, I'm gonna tell you, it took a little bit of doing [laughing] to locate old Omaha, Nebraska on a map.

I'm not proud of that it took me a few. I had to point out some other interesting things on the way. "Ooh, there's the Grand Canyon, kids," while I

stalled for time, like, "it's gotta be on here somewhere, *please*, Omaha, please."

Sydnee: I always get mad when I see those maps that they're like, "Look, it's somebody from outside the U.S. who tried to fill in a map of all the states!" Do that to some of us. We can't do it either.

Justin: Yeah.

Sydnee: That's not fair.

Justin: Do, like, Europe. Just, like, the nations.

Sydnee: Well, yeah! Well, heck, yeah, we don't know the nations, but we don't know our states, and we live here.

Justin: France is a star, Italy's a boot, beyond that, the point is moot. That's my little pneumonic device I use for remembering [laughing] European nations.

Sydnee: Oh, I'm gonna get emails about that.

Justin: I just can't remember it all, folks! I'm sorry! This is self-critical, I'm not bragging.

Sydnee: Alright, well, I want to talk about how great this was in Liverpool.

Justin: Okay.

Sydnee: And Merseyside. So, there was a huge increase in heroin use in the 1980s, lots of places. But specifically, in Liverpool in this part of England. The local public health authorities were worried, as were a lot of activists in the community of people who use drugs, but also people who were worried about—everyone was worried about the same thing at this point: HIV.

Justin: Yeah.

Sydnee: The worry was, with more people using this heroin, are we gonna see an outbreak of HIV? So they developed what would eventually become known as the Mersey Model of harm reduction and is really a huge, sort of cornerstone.

Like, if you think about the things we do today that are harm reduction, a lot of the principles come from this. And the idea was, like… if we have all these activists within the drug-using population who are talking about what they see as the issues, the barriers, what they need, and then you combine that with like, public health officials, doctors, nurses, health care workers, which were always the hardest—especially the doctors, were some of the hardest people to engage in this process.

Along with the community at large and the police, and you can get everybody to buy in to sort of a non-judgmental set of goals. How can we address this issue, specifically about HIV, but the wider issue of people are using drugs? They're not gonna stop using drugs. So how can we reduce the harm to the people who use drugs, right?

Justin: Right.

Sydnee: So the focus was really on safe needle practices to prevent the spread of HIV. There were secondary goals, like, let's also offer methadone treatment if somebody wants to do that. Let's offer that at the same time. And there were things like, you *could* engage with programs to abstain from drugs completely, if that was your goal. All of that was offered, but that's not really the goal.

The goal is not, we will draw you in—and I think a lot of people get that impression, like the whole goal of a harm reduction program is to draw people in with needles that have already been cleaned, and so they can inject more safely. But once we get them there, we're going to convince them to stop using drugs.

That's not the goal of harm reduction. I'm not saying that that can't happen and certainly, it does, but that's not why it's there. It's there for the person who is using drugs to reduce the harm to themselves when they inject

drugs. That's what it's there for. And in this specific instance, HIV was the biggest thing they were focused on.

The barrier was low for entry, the staff were trained specifically in non-judgmental, which—gosh, if you think about, like, this is back in the 80s, and they're training people on a non-judgmental approach to people who use drugs… and we're still not there today?

Justin: That's light years ahead of us.

Sydnee: Yeah, in so many places. The result was that a lot more people came in to seek medical attention generally, who had not been to doctors in years because they were scared. They didn't want to go to doctors. They know what the doctors are gonna say.

Justin: "Stop doing drugs."

Sydnee: "Stop doing drugs. That's your problem." They're not gonna address any of it, they're just gonna tell them to stop. Which, by the way, when we're talking about abstaining from things as the only option, I think we have another great model for when you just tell people to abstain from something and don't give them any other information or education or help? How well does that work?

Justin: You know, it's funny, Syd, I joked about—not joked, but I mentioned masks earlier and it seems to me, and I don't want to get off too much on a tangent, so I'll try to be brief. But, listening to this, it seems to me that the best answer that the U.S. has been able to come up with for a very long time was embodied in the Just Say No campaign, right?

Sydnee: Exactly.

Justin: It's just say no, just don't do drugs. And it's like so pat. "Just don't do drugs. We don't have to do any of this other stuff. Just—"

Sydnee: "Just don't do drugs."

Justin: "Just don't do drugs." Except, which is obviously—there are huge problems with it—

Sydnee: Well, it failed, so...

Justin: Well, it failed, right? But if you want to see those exact problems personified, look at the lockdown. Look at the Coronavirus situation for the past year, right? We had an abstinence policy that would have worked. Like, the idea being, if everyone just didn't do anything at all, then this would go away, right? It would just be done with.

Except, we're a functioning people and we're living being, and people are going to go do things because they're human beings. So what steps can we take to make that safer because we're going to take that step? That's just what we are, I mean, we're animals, right? Like, we can't—there's not a cut and dry, just don't do it.

You can reinforce that, you can teach it, you can preach it, but it's not a one-size-fits-all, it's not gonna fix the problem.

Sydnee: Exactly.

Justin: We realized that with Coronavirus.

Sydnee: Yes.

Justin: We realized, "how do we make this safer, because we can't lock people in their homes for a year?" Like, we realized that, and it's the exact same—but that policy, like, and that's supposed to work for somebody that's literally addicted. I mean, is like, chemically addicted, unlike going outside and doing stuff. Like, this is chemically addictive and your solution is just like, abstinence. It doesn't make any sense.

Sydnee: And to carry the metaphor even further, a lot of the argument was, "Yeah, but maybe you won't get Coronavirus if you don't do these things, but what about people's mental health?" That was a lot of—which was valid, I'm not disagreeing. That was a valid concern, a lot of people's mental health suffered because they had to, you know, not do any of the

things that they do on a daily basis. So a lot of people suffered for that reason.

In that same way, if your only answer to someone who uses drugs is "don't use drugs," and then either they do or they don't know how to cope. Maybe they were self-medicating and maybe they need some other sort of substance. You're not addressing any of the other things that that, like, "I have dictated to you this is best for you, now either do it or if you don't, it's not my problem."

Justin: Or the income disparity in economic situations that make it so that it doesn't seem like there's another worthwhile outside of drugs, that this is the best thing you have going.

Sydnee: And this approach—the other thing about all this is it doesn't just sound better, like, from a human perspective. What they found from doing things this way, is that people came in and sought care for all kinds of things that they had not sought care for for a long time.

The medical community learned a lot more by engaging with people who use injection drugs, as opposed to just telling them to stop and alienating them. We learned more about how to better care for people. They learned more, the people who actually use drugs, learned more about how to do it in a way that reduces harm to themselves. So everybody learned about—from interacting, it was a good thing.

No HIV outbreak occurred, which is, I mean, a substantial plus. And some people maybe chose to start methadone, some people maybe did abstain from drugs. That was again, not the primary goal. But a lot of people got better medical care, avoided an acute risk to their life at that moment, so maybe saved their life. And then also, were able to prevent negative health consequences from happening.

This also led to, uh, especially a lot of police buy-in. Because the law enforcement saw that it worked, that it was good, and supported it. And they said, "We don't want to go back to the way things were. We don't want to go back to arresting people because we found them with some heroin. Like, because it didn't do anything. Nobody was—the person wasn't

benefitted, society didn't benefit, I didn't benefit as the police officer that had to do it. Nobody benefitted from any of this."

And this that they're doing, this Mersey Model, is actually beneficial. We see—and so because of all that buy-in, it was really interesting. I guess the Thatcher administration was very pro-this. Like, very much promoted it. I don't know enough about British politics, I've discovered, because Thatcher was like, I guess, a proponent of this and the Local Labor party was very much against it. So I don't think I really understand British politics in the ‘80s. [laughs] Sorry.

The Netherlands also contributed to this, even in the ‘70s. They had people forming what they call Junkie Bonden, which translates to Junkie Unions. So, people who use injection drugs, forming these sort of groups to advocate for themselves, to share knowledge, to basically demand that, you know, "We don't want these negative health consequences to come to us, and there are ways that we could do this if you allow us to, that will keep us safer."

And by, like, demand—they even stormed a methadone clinic in the early ‘80s. But by demanding these things for themselves and then finally working with people who would listen to them, they did the same thing. Like, needle services, methadone, police and public buy-in, all of that stuff was happening. While meanwhile, in the U.S., it was the ‘60s, until you could even use methadone treatment.

I mean, it really—and even then, it was not widespread. In 1988, law was passed that federal funds could not be used for any sort of syringe service program. That actually lasted 'till 2009.

Justin: [scoffs]

Sydnee: So, like, the federal government not only isn't promoting this stuff...

Justin: They can't—

Sydnee: ... specifically, you can't use federal money to do this stuff, even as the U.K. and the Netherlands and other countries all over the world were

expanding these services, providing more of them, because they saw it work. Because the evidence kept mounting that it worked.

In the U.S., it was up to—and this is true, you know, a lot of this runs kind of concurrent with HIV activists. And there was overlap, certainly, in these communities of people who were saying, in the ‘80s, "This infection is spreading and there are things we could be doing that are happening throughout the world to limit the spread among people who use injection drugs, and we're not doing any of it."

Justin: Yeah.

Sydnee: And so, like, activists are the ones who started any sort of movement in this area in the U.S. In San Francisco, you have the DOPE Project that started in the early ‘90s. All of this started in the early ‘90s, this is wild. This is within our lifetime that all of this finally started happening.

It started happening in the early 90s where they would do HIV testing and try to provide needles to people who use injection drugs, try to go meet people where they are, try to go find, you know, people who use drugs. Find sex workers to encourage people to get tested and to, you know, get clean needles and all that kind of stuff.

In Chicago, the Chicago Recovery Alliance did the same sort of work, but they also included in that, at the time, the only place you could get naloxone, Narcan, which reverses an overdose. You know, we use that to save someone's life acutely in an overdose situation to opiates. At that point, you could only get it in a hospital. There was no option to, like, carry it with you and save someone's life out on the street.

Justin: Wow.

Sydnee: So, they partnered with people in the health care community who had access to it and got it. Which is, a lot of this work has to be done outside the bounds of what is currently legal, because the law is lagging behind… uh, well, I would say lots of things. The science.

Justin: Science.

Sydnee: The human rights, the autonomy of an individual. So they did what they had to do, and they passed out naloxone and developed, like, a buyer's club so you could ship supplies all over the U.S. to other programs, help develop programs in places like New Orleans.

All of these things were happening by activists. By people, largely people in the community who were using injection drugs, who were advocating for themselves and fighting for themselves to prevent themselves from getting HIV and other blood-borne pathogens, but at the time, HIV was the biggest concern.

And all the other things that can happen if you're using a needle that has not properly been cleaned or using a technique. Some health care professionals eventually started listening, academics started listening, and like, the science follows this. As these programs were developed by people in the community who knew what was necessary, you start to see the studies, the support that show that it works.

That time and again, this is how we reduce the spread of HIV. This is how we reduce the spread of Hepatitis. This is how we prevent overdose. This is how we prevent other sorts of—I mean, we're not even getting into infections. If you use a needle that hasn't properly been cleaned or you don't prep the site properly, where you're going to inject, or the stuff you're going to inject. All of these things can lead to bacterial infections in the bloodstream, and horribly negative health outcomes.

All of that can be, to a great extent, prevented if you know how to do it safely.

Justin: Mm-hmm.

Sydnee: And that knowledge started to spread as well, especially if you look to Canada. They started the first, like—I mean, we don't have them here in West Virginia, but in Canada, they started these safe injection sites where you could actually go and inject drugs with people there, you know, to give you knowledge if you needed to know how to do it safely, and to make sure that an overdose didn't occur, and that kind of thing.

And, again, the U.S. has just still been in disarray. I mean, some things are better, you know, things like naloxone, but overall, even as all these other countries have this huge, coordinated, top-down sorts of efforts… I say top-down, they started from the bottom up. They all started grassroots, but now the government is involved.

In the U.S., it really depends on where you live and the same thing happens over and over again. So, you have a community like ours that has a, I would say, syringe service program. I wouldn't say syringe exchange. Or needle service program, I wouldn't say needle exchange. Because what we have found, again and again, is that at these programs—

So, to get into them, one of the things you can do is bring needles back that have been used and get needles that are unused, right? Simple enough. What we found is if we put this restriction on, that it's a one-to-one, "You bring us one needle, we'll give you one needle." If it's that kind of literal exchange, which is where the word "exchange" comes into play, they're not as effective.

Justin: Mm-hmm.

Sydnee: It's just not. It does nothing to decrease needle litter, which is usually the big problem on, like, a community level, people are really concerned about dirty needles in the streets. It does nothing to reduce that, and it increases the likelihood that people will still be sharing needles.

Justin: So what do you do?

Sydnee: You just give them needles.

Justin: Oh, okay.

Sydnee: And there's more than that, though. And that's the other thing—

Justin: Wouldn't it—if you're giving people needles, wouldn't that increase the likelihood of litter?

Sydnee: It doesn't.

Justin: Why?

Sydnee: Because they can still—it's still a safe place for you to dispose of used needles.

Justin: Yeah, I guess that's true.

Sydnee: And then people do! People— Because they're humans. Because that's the other thing, this isn't—the "othering" has to stop. Because these are people who use injection drugs. Just because I don't use injection drugs, doesn't mean I make every single decision that would be risk-free for my life. I drink alcohol. That is not a risk-free decision.

Using heroin is not a risk-free decision either, but when I use alcohol, if I drink too much and I go to the hospital, I don't get arrested. I don't get a criminal record because I became so intoxicated that I had to go and get IV fluids or anything, you know? I mean, like, none of that—

Justin: And that's weekly.

Sydnee: Not that that hasn't happened. [laughs] But my point is— I mean you get my point. Like, we approach it entirely differently and the roots of that are, I mean. They're racist and they're a way of—

Justin: Classist, for sure.

Sydnee: They're classist, they're a way of systemically controlling human behavior that doesn't work, and just criminalizes people that won't do the things that we've decided arbitrarily that they have to do or what risks they can or can't take.

But what they've found is that, uh, in places where they have—and these are some really important things to debunk, a place that has a harm reduction program, a syringe service program, statistically has less needle litter than a place that doesn't, assuming the both have people who use injection drugs in the area.

So, it does not increase needle litter; in fact, it probably decreases it. When you just give out needles and it's low barrier, you have less sharing of needles in the community, which means you have less likelihood that people are gonna get things like HIV or Hepatitis.

The other thing is, people need more than just a needle. In order to use injection drugs, you need sterile water a lot of the time, you need some sort of cotton or filter or something like that, you need a cooker, you need rubber ties, you need alcohol swabs. All of those things, all that equipment that can reduce the harm to the person who's using drugs and help them use it properly, all of those things can be available under these programs, which again, reduces the risk to the person who's going to use the drugs.

You can also get naloxone, Narcan. That's huge. We know one of the best ways we can prevent overdose deaths is by giving naloxone to people who are either using injection drugs or are with people who are using injection drugs, so that they can be there. We teach them the signs of an overdose so they can recognize it and respond immediately with the Narcan that hopefully we've provided them with, or to call emergency services as needed.

All of that training, plus you can get HIV testing, you can Hepatitis testing. They do other sort of medical services. I mean, every harm reduction program is different. Some of them are like a building, some of them are a van that travels around. They're all different sorts of models. Some of them hand out condoms and do, like, safe sex education, that kind of stuff.

Some of them do target more, like, sex workers, while others cater more to people who are experiencing homelessness, you know? I mean, like, they're all a little bit different and cater to the needs of that area. But they also allow people to exchange information.

I'm reading a handbook right now on how to properly use injection drugs, not necessarily in preparation for myself, but because that's useful for me to know as a medical professional. Here are all the things that the people who are the experts, who have been using drugs, tell me are the safe things and the things to learn. And things I can counsel people.

It also helps to—things like, when fentanyl hit the streets. Fentanyl, which is a much stronger opiate, which has caused a lot of overdose deaths. When fentanyl started appearing out there in the community, the people who use injection drugs knew something was off before. They knew that—that wealth of information exists in the people who are experts on it, the people who use injection drugs.

And it takes a while for the rest of us in the medical profession to, like... we're lagging behind, and that causes unnecessary deaths. So like, that sort of information—and it's also just, a harm reduction program puts people in a community together who right now, our society tends to forcibly separate.

Justin: Mm-hmm.

Sydnee: Right?

Justin: Yeah.

Sydnee: And doing that is really important for people who do want to seek out methadone or suboxone or abstain. This is the bridge for those people. Now that's not the goal, that can't be the goal. They don't work if that's the goal. That's been shown time and again.

I mean, you can have that there as part of it, but the goal has to be that you deserve to make the decisions for you in a safe way, in a healthy way, and I am going to do my best to provide that for you. And whatever else happens next, we have that available. But the goal is, I'm going to provide you with what you need to reduce the harm to you in this very specific situation.

It's pragmatic, it focuses on the individual, on stopping harm. Again, there are all these other community, public benefits from it. I mean, you can—people will tell you the dollar amounts that are saved by programs like this, and that's all well and good. I mean, that's true and again, if you're gonna lobby somebody to protect a harm reduction program, I think knowing that information is vital. But just as a human, this is how we save lives. This is how we promote health. This is preventive. This is preventive medicine.

Justin: Well, here's hoping the rest of the nation can catch up.

Sydnee: [chuckles]

Justin: I mean, I think the dialogue has to change before any of the policies can. I mean, I think reinforcing that people who use drugs are people, um, and reminding people of that is a good first step, because I feel like until politicians can get to that point, it's harder to make these other things happen.

Sydnee: Well, I just certainly hope—there are a lot of models for harm reduction throughout our lives, and there are a lot of great models for harm reduction in this specific arena all over the world, and the U.S. is behind.

Justin: Thank you so much for listening to our show *Sawbones*. Reminder, we got a book. It's called *The Sawbones Book*, cleverly enough. You can find it wherever fine books are sold. We got a new paperback edition that came out last year. There's an audiobook version of that, too, if that's your… if that's you're thing.

And thanks to The Taxpayers, for the use of their song *Medicines* as the intro and outro of our program. Thank you to you. That's right, you, pointing at yourself, for listening. We sure appreciate it. And that is gonna do it for us. So, until next time, my name is Justin McElroy.

Sydnee: I'm Sydnee McElroy.

Justin: And as always, don't drill a hole in your head!

[theme music plays]