

Opioid Harm Reduction:

Lessons from Kensington, Philadelphia

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This paper will be using the National Institute of Health's definition of opioids: "Opioids are a class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone, hydrocodone, codeine, morphine and many others"

I. Introduction

The opioid epidemic has been a longstanding public health crisis in the United States for the past three decades. This epidemic has had catastrophic effects, from being a major source of substance-use deaths to driving the HIV/AIDS resurgence. In Pennsylvania, pockets of the state such as the Kensington neighborhood of Philadelphia are among the communities that have been devastated by the opioid epidemic. Patients suffering from opioid use disorder (OUD), a physical and psychological reliance on opioids, line the streets of Kensington, openly injecting heroin in the middle of residential neighborhoods. The amount of damage wrought by this epidemic is unimaginable; it has claimed thousands of lives, destroying entire families and communities along the way.

With no permanent curative solution in sight, Philadelphia turned to harm reduction, a body of practical principles and strategies to inform clinicians, policymakers and community members on how to reduce the negative consequences of opioid use. Philadelphia--and more generally Kensington's--experience with harm-reduction has exposed many harsh realities, namely that the opioid crisis cannot be wished away with plentiful spending and piecemeal interventions. While Naloxone distribution has brought many opioid patients back to life, it is only a short-term solution, and medication-assisted treatment (MAT), a core tenant of long-term rehabilitation, is not readily available to all who need it. Supervised injection sites (SIS) and needle exchanges have also been attempted, but they pose a cost to the general public and are prone to fall out of favor with local neighborhoods. In terms of intersectional harm-reduction, criminal justice reform and the destigmatization of drug use are the equitable way forward, yet these legal changes pose challenges of their own. It is clear that individual harm-reduction

techniques are insufficient to address the vast issues laid bare by the opioid crisis.

This paper intends to examine each harm-reduction technique critically, pointing out both the positives and negatives. Naloxone distribution, supervised injection sites, needle exchange centers, and medication-assisted treatment all have value in combating the opioid crisis; however, they also have limitations. Without a comprehensive community-oriented approach, including housing options, targeted nonviolent police intervention, and criminal justice reform, the opioid crisis will only grow. This is not a crisis confined to Kensington. It reaches deep into the heart of the U.S., cutting across racial and cultural lines. By sharing insights from one of the most hard-hit neighborhoods in the country, we hope to educate both the wider Philadelphia community as well as other communities about what can and should be done.

II. Background

The United States opioid crisis can be broken down into three major waves. Before the 1990's, opioids were considered to be potentially addictive enough that they were for the most part avoided by physicians. The first wave of the opioid crisis can be traced to the 1990s, when various pharmaceutical companies made false assurances to medical professionals and prescribers that patients wouldn't form an addiction towards prescription opioid drugs. Purdue Pharma led the way with their newly introduced Oxycontin in 1996. Purdue was notorious for its aggressive marketing and promotion of the drug; Oxycontin's sales went from \$48 million in 1996 to \$1.1 billion in 2000. To further grow their sales, Purdue Pharma and other pharmaceutical companies lobbied Congress for favorable regulations, enacted a lucrative physician-targeted bonus system which rewarded prescriptions, and even consulted the global management and consulting firm McKinsey & Company for marketing help. The drug's marketing success relied on one key misconception that physicians and other healthcare professionals were persuaded to believe: that the risk of addiction was "less

than one percent.”^{1,2,3} This belief resulted in sizable increase in the amount of opioid pain relievers prescribed to patients by healthcare professionals.^{4,5} That dramatic increase in prescriptions, in turn, led to an overall increase in opioid overdose deaths and marked the beginning of the crisis.⁶ Areas that saw an increase in opioid prescription saw an increase in opioid abuse as drug dispersion became a widespread issue. Patients who were prescribed opioids went on to distribute their excess supply to friends and other members of their household.



Figure 1: Death by opioid overdose statistic (CDC, 2021).⁷

The second wave of the opioid crisis was marked by the move from prescription opioids to heroin. When opioid use disorder was finally acknowledged as a public health crisis, officials quickly moved to reduce accessibility to the drug, shutting down the “Pill Mills” or profit-driven pharmacies that had been over-prescribing opioids, and introducing health policies that made it more difficult to acquire prescription opioids. This drastic reduction in supply paved the

¹ Forsythe, Michael, and Walt Bogdanich. “McKinsey Advised Purdue Pharma.”

² Van Zee, “The Promotion and Marketing of Oxycontin.”

³ DeWeerd, “Tracing the US Opioid Crisis to Its Roots.”

⁴ “What is the U.S. Opioid Epidemic?” U.S. Department of Health and Human Services.

⁵ “History of the Opioid Epidemic: How Did We Get Here?” National Capital Poison Center.

⁶ “Understanding the Epidemic,” CDC.

⁷ “Understanding the Epidemic,” CDC.

way for the introduction of heroin, a drug easier and cheaper to obtain. Unable to refill an opioid prescription at the pharmacy or a doctor's office, people who had developed an addiction turned to drug dealers for this low-grade but highly potent substitute. Heroin-related drug overdose deaths jumped 286% from 2002 to 2013. One report found that 80% of heroin users had been abusing prescription opioids prior to using heroin.⁸

The third wave of the opioid crisis was the introduction of the synthetic opioid fentanyl in 2013. This laboratory-formulated drug is significantly more powerful than standard opioids, approximately 50 to 100 times more potent than morphine. Synthetic opioids can be administered in a variety of ways: a shot, skin patch, even a lozenge. Very appealing to drug suppliers as a cheap addictive additive, fentanyl is often mixed in with other illicitly sold drugs such as methamphetamines, cocaine, and heroin. This drastically increases the chance for accidental or unknown overdose and makes it harder for those who respond to drug overdoses to determine which drug someone is overdosing on.⁹ The introduction of this lethal additive has seen overdose deaths skyrocket to unbelievable numbers with no signs of slowing down.

⁸ "History of the Opioid Epidemic: How Did We Get Here?," National Capital Poison Center.

⁹ National Institute on Drug Abuse, "Fentanyl DrugFacts."

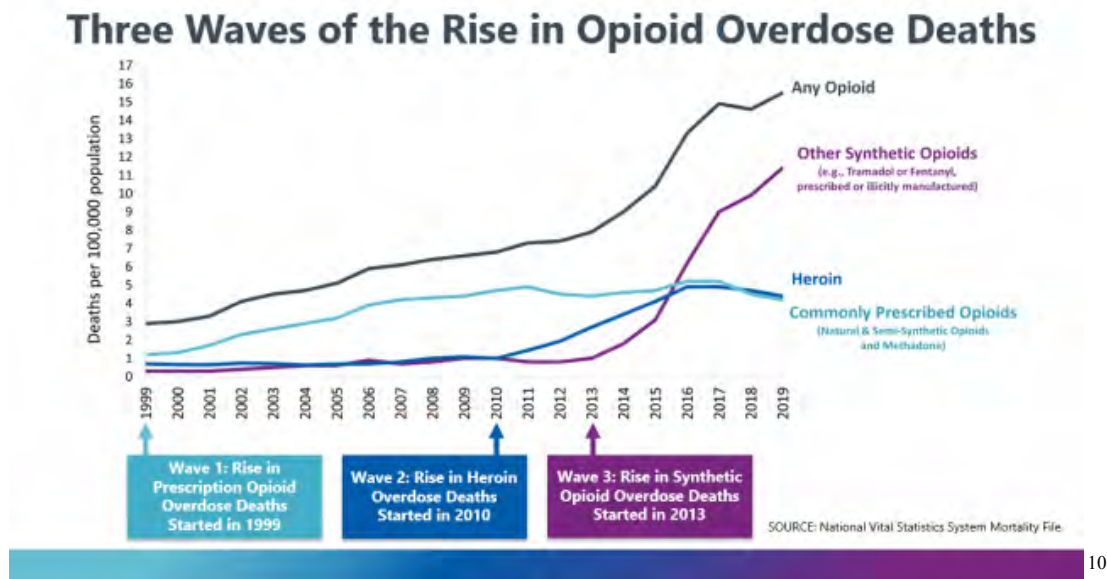


Figure 2: Graph detailing the three waves of opioid overdose deaths (CDC, 2021).

Kensington, a North Philadelphia neighborhood, is notorious for its place in the ongoing opioid epidemic. It has even been labeled the “Walmart of Heroin” for being the largest open-air heroin market on the East Coast.¹¹ Kensington was primarily a working-class area from the early 1700s all the way to the mid-1900s, undergoing many transformations in industries, including fishing and shipbuilding, steel and iron manufacturing, and textile manufacturing.^{12 13} The 1950s marked the rapid introduction of deindustrialization in Kensington, which led to a mass exodus of the white working-class population to the suburbs. Economically ravaged by deindustrialization and neglected by city and state politicians, Kensington became hospitable for drug dealing, with some of its African-American and Hispanic residents falling prey to the crack cocaine epidemic of the 1980s.

When the first wave of the opioid crisis occurred in the early 2000’s, Kensington was not severely affected. Most of the victims of opioid use disorder were at that time white and did not live in Kensington. However, during the second wave of the crisis, when access to prescription opioids was restricted by public health officials in an attempt to bring an end to it, those with

¹⁰ “Understanding the Epidemic,” CDC.

¹¹ Percy, “Trapped by the ‘Walmart of Heroin.’”

¹² Ushistory.org., “A Brief History of Philadelphia.”

¹³ “Kensington,” Workshop of the World- Philadelphia.

opioid addictions were driven to places where they could purchase illicit drugs. Thus they came to Kensington to buy heroin. Whereas Kensington had for about two decades dealt with what in retrospect appears to have been a manageable base of drug users and dealers of heroin, the second wave of the opioid crisis introduced masses of former prescription opioid users, who were coming from all over the U.S.. The arrival of fentanyl accelerated and intensified this problem. It did not take long for Kensington to acquire a national reputation as a hub for the most affordable and potent opioids. This neighborhood now suffers from a phenomenon called opioid tourism, with opioid users from all over the United States traveling there because of its national reputation for cheap drugs and police who do not enforce laws that would affect users.

In these last few years, Kensington has become nearly unlivable for many of its original inhabitants. Drug encampments pop up around the neighborhood, needles litter the sidewalks, and some street corners are rife with drug-related gun violence. At the same time, some parts of the neighborhood are undergoing gentrification and are heavily policed. Gentrification is further pushing and concentrating drug dealers and those with addiction in the lower-income neighborhoods of longstanding residents.¹⁴ This is causing considerable frustration among residents who see no way forward. The city's lack of leadership and concern for Kensington all but ensures that the opioid crisis will continue to plague Kensington for years to come.

III. Modes of Harm Reduction

“Harm reduction is a set of practical strategies and ideas aimed at reducing the 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.”

-National Harm Reduction Coalition¹⁵

The opioid crisis is not easily solvable. Every day hundreds of people across the United States suffer from OUD. The only way to overcome this addiction is a combined approach of rehabilitation, counseling and medication-assisted treatment; however not all those who suffer

¹⁴ Percy, “Trapped by the ‘Walmart of Heroin.’”

¹⁵ Harm Reduction Principles, National Harm Reduction Coalition.

from addiction want to stop or have access to the proper facilities even if they are determined to quit. In the meantime, those with addiction still deserve to live, and in full human dignity. In the absence of clear-cut solutions, public health departments must do everything they can to keep those with addiction alive long enough for them to access proper care. This is the definition of harm reduction, which comes in many forms. The most commonly recognized harm reduction strategies for opioid addiction include include needle exchanges, supervised injection sites, Naloxone/Narcan, medication-assisted treatment, the decriminalization and destigmatization of drug use, law-enforcement reform, increased access to mental health resources, encampment clearings, and affordable housing.

A. Public Health Harm Reduction

*Lesson 1: **Naloxone** prevents the death of those suffering from opioid use disorder. However, it does not heal drug addiction; it reverses the effects of an overdose. It cannot in itself end the opioid crisis.*

Naloxone (also known as Narcan) is a drug that can temporarily reverse opioid overdose when injected intramuscularly or with use of a nasal spray to prevent opioids from attaching to opioid receptors in the brain. Naloxone is considered a harm reduction strategy because it reduces the immediate dangers of an opioid overdose by preventing death. From July 2017 to April 2020, Philadelphia distributed nearly 150,000 doses of Naloxone to law enforcement agencies and community-based organisations.¹⁶ Philadelphia also adopted a free mailed program for the distribution of Naloxone during the height of the COVID-19 pandemic. This contributes to ending the crisis and eliminates barriers such as cost, proximity, and access.¹⁷

Kensington, as the heart of Philadelphia's overdose crisis, has a great need for Naloxone in their neighborhood. For example, Rosalind Pichardo, an outreach worker from Kensington,

¹⁶ French, Favaro, and Aronowitz, “Free mailed naloxone program.”

¹⁷ French, Favaro, and Aronowitz, “Free mailed naloxone program.”

has reversed 400 overdoses by her own count by delivering and administering it herself.¹⁸ In efforts to expand Naloxone use, a study recruited participants from Prevention Point Philadelphia in Kensington, a nonprofit public health organization providing harm reduction, to investigate user requirements for a smartphone application to coordinate layperson administration of Naloxone during an opioid overdose.¹⁹ The results of the study demonstrated the viability and usefulness of an app that enables laypersons to administer Naloxone. This application could be a critical part of the toolkit for combating the opioid crisis.

*Lesson 2: **Needle Exchange Centers** are successful and cost-effective in preventing outbreaks of HIV and reducing public health expenditures. However, discarded needles pose a significant health hazard to the community.*

If clean hypodermic needles are not readily available for those injecting heroin, those with addiction will share or re-use them, which leads to a high risk of infection for multiple blood-borne diseases, including HIV and hepatitis C. If needles are not available, in turn, desperate users will resort to buying or even stealing needles meant by insulin injection. Furthermore, used discarded needles become a public safety hazard when thrown on the streets or deposited in trash cans, where they easily pierce the trash bag and jab neighborhood volunteers doing clean-up as well as sanitation crews.

Thus needle exchange programs are a harm reduction strategy by providing clean hypodermic needles at little to no cost as well as collecting and safely disposing of used needles.

The main needle exchange in Kensington is Prevention Point's Syringe Services Program. Technically illegal in Pennsylvania, the needle exchange program has been allowed thanks to an executive order issued by Ed Rendell in 1992.²⁰ This Philadelphia needle exchange has averted 10,592 HIV diagnoses over 10 years (1993-2002).²¹ With program expenses of nearly \$400,000

¹⁸ Feldman, "One woman's mission."

¹⁹ Marcu et al., "Acceptability of smartphone applications."

²⁰ <https://www.phila.gov/ExecutiveOrders/Executive%20Orders/4-92.pdf>.

²¹ Allen et al, "Using Interrupted Time Series Analysis."

in 2011, the 1-year return on investment for Philadelphia needle exchange program amounted to \$182.5 M.²²



Figure 3: The Prevention Point Needle Exchange in Kensington²³

While needle exchanges are effective in curbing the spread of blood-borne pathogens, they have been far less successful in getting needles off the street. Executive Director of Prevention Point, Jose Benitez, is on record saying that in 2016 the program handed out 2.4 million needles but collected only 2.2 million used needles. More recently, Eva Gladstein, Deputy Managing Director of Health and Human Services for the City of Philadelphia, noted that in 2020, Prevention Point distributed 4,797,776 syringes in Kensington, but its collection rate was 87%, which means that 623,710 used syringes were left on the streets in that year alone.²⁴ Needle clean-ups are commonly organized by both the city and local volunteer organizations such as the Harrowgate Civic associations. However, as community activist Gilberto Gonzelez observes, needles continue to flood the neighborhood and pose a daily threat to Kensington residents, with needles strewn everywhere, from public parks to elementary school sidewalks. In an effort to boost official awareness of the situation, Kensington resident and community activist Shane

²² Allen et al, “Using Interrupted Time Series Analysis.”

²³ Prevention Point image courtesy of Joseph V. Labolito/Temple University.

²⁴ Tom Lineman, “Prevention Point distributed.”

Claiborne sent out jars of used needles to city officials to move them to act upon this dangerous situation.



Figure 4: Discarded needle debris on the ground in Kensington²⁵

Prevention Point’s inability to successfully address the problem of discarded used needles has caused parts of the community, especially those who live in Kensington, to question the effectiveness of the needle exchange programs themselves. Thus, while the success of these programs in curbing blood-borne pathogens is well-documented, the public can be resistant to them because of the less successful impact of this harm reduction strategy on fully eliminating discarded used needles from the streets.

*Lesson 3: **Supervised Injection Sites (SIS)** are essential in fighting the opioid pandemic. They provide spaces for users to safely inject drugs and serve as a means for health professionals to provide users with treatment, housing, and general medical care. However, for such sites to be effective, strong oversight and accountability measures must be in place and monitored. Equally important, the neighborhood must be aware and involved at all stages of development.*

²⁵ Image: Juniata News, “Prevention Point distributed.”

Supervised injection sites are medically supervised facilities designed to provide people with a hygienic environment at which they can consume illicit drugs intravenously. They are also an important means for health professionals to work with high-risk drug users, connecting them to addiction treatment and other health and social services. SIS programs in Europe span three decades and demonstrate the powerful impact of these sites, including reductions in syringe sharing and fatal overdoses but also a greater likelihood for those with addiction to pursue addiction treatment.²⁶

The original response to growing open drug scenes in Swiss and German cities was harsh crack-downs and drug-abstinence programs. The failure of that approach to reduce drug use led to local residents, public health authorities, and the police coming together and deciding on a more progressive plan involving SIS's. The new strategy focused on decriminalizing drug use and treating it like a medical condition as opposed to a jailable offense. The stated goal was thus to shrink the open-drug scenes and reduce the negative consequences that come with it such as the spread of blood-borne diseases and public disorder, and that SIS services should not be offered at open-drug scenes in fear of increasing their attraction. The original concern of the community was that these locations would drive drug use and only make the problem worse. The police likewise believed that such sites would become hubs of drug dealing and consumption.

After much planning and discussion, the SIS's were established on a short leash. Stakeholders closely monitored the situation and documented whether the right outcome had been achieved. The locations were partially seen as a way of eliminating the public disturbance/nuisance issue that comes with intravenous drug use, and this approach depended on making the use of these locations non-negotiable. Open-air drug use was decriminalized but not tolerated by the police. One thus had the right to inject heroin, but not the right to be a public nuisance in doing so. Evaluations of the SIS's demonstrated positive effects clear evidence of reductions in overdoses and public drug use as well as improvements in hygiene and access to healthcare.

²⁶ EMCDDA, *Drug consumption rooms: An overview of provision and evidence*.

Public perception of the SIS's also improved as the sites provided a preferable alternative to public drug use.²⁷

The first SIS to open in North America was in Vancouver, Canada in 2003. Despite legal battles, it has been effective in its stated goals: From 2003-2005, overdose deaths within 500 meters of the SIS decreased 35%, while decreasing only 9% in the remainder of the city. One overdose death per 1,137 users was prevented annually.²⁸ The number of intravenous drug users saw a similar decline over the span of four years.²⁹ Near one SIS, average monthly ambulance calls with Naxolone treatment for suspected opioid overdose decreased from 27 to 9, a relative risk reduction of 67%.³⁰

²⁷ Hedrich et al, "Drug consumption facilities in Europe and beyond."

²⁸ Marshall et al, "Reduction in overdose mortality."

²⁹ Sutherland & Kolber, "Does evidence support."

³⁰ Sutherland & Kolber, "Does evidence support."

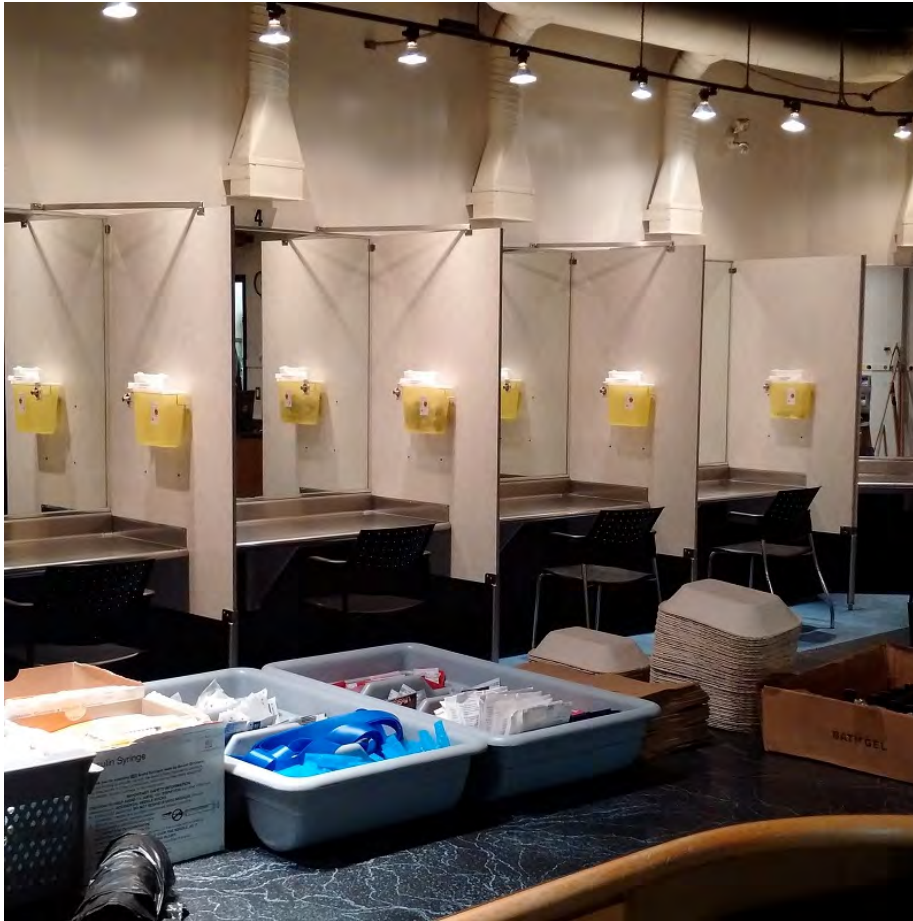


Figure 5: Vancouver Safety Injection site³¹

Despite such successes, SIS's have experienced some significant issues. In March 2020, a socio-economic review of supervised consumption sites in Alberta found multiple issues with the management of their SIS's. Recordkeeping was reportedly inconsistent and at times fraudulent, upper management refused to cooperate with the police, and community members were intimidated into silence if they raised any concerns.³² The review board also found that these sites had heavily favored harm-reduction and made few efforts to guide OUD patients to treatment or detoxification resources.³³ This theme of mismanagement spilled out into the surrounding area, with increases in opioid-related overdoses, opioid-related crime, and needle

³¹ Image courtesy of Vancouver Coastal Health

³² Alberta Health, "A Socio-Economic Review."

³³ Alberta Health, "A Socio-Economic Review."

litter all increasing in the immediate vicinity following the opening of the sites.³⁴

Inadequate oversight, lack of accountability, and a lack of standard operating procedures were the most common problems identified by the review committee. Combined with the upper management's refusal to cooperate with the police, higher health authorities, and the local community, these failings negated the positive effects generated by the Alberta SIS's.

While the issues that plague the Alberta SIS's are uncommon, the possibility of mismanagement is not to be discounted. Overall assessments of the SIS's in Canada remain positive. When implemented properly, these sites greatly benefit the communities they serve, which is why they are backed by the medical community.³⁵

Despite their successful implementation elsewhere, SIS programs have yet to make it to the United States. SafeHouse, the nonprofit behind Philadelphia's proposed supervised injection facility, has faced stiff opposition from the local community. Their site was originally supposed to open at Constitution Health Plaza in South Philadelphia, but the announcement of these plans was met with outrage from the residents of the area, who had not been informed of the plans. South Philadelphia residents were under the impression that the SIS would be opening in Kensington where the opioid epidemic is most pressing, rather than in their neighborhood. They were concerned that such a facility would attract drug dealers and crime to the nearby daycares and schools, including some located in the same building as the proposed SIS. Jose Benitez, the president of Safehouse, is also the CEO of Prevention Point. Prevention Point's failure to keep needles from littering the streets did not inspire confidence in their ability to manage the proposed SIS. In response to intense community opposition, including rallies and confrontations with Safehouse board members, the owner of Constitution Health Plaza canceled the lease for the facility, forcing Safehouse to look elsewhere.

³⁴ Alberta Health, "A Socio-Economic Review."

³⁵ The Ontario HIV Treatment Network, "A Review of Structural, Process, and Outcome Measures."

The fight against Safehouse has continued long after they canceled plans for their original site in South Philly. The idea of opening an SIS in Kensington has also been met with disapproval from the locals.

SIS's appear to have little support from the residents of Kensington. Failures on the part of activist groups and Philadelphia city government to solve the opioid crisis make any proposed harm-reduction sites a hard pill to swallow, especially one that serves as a designated place to inject heroin. Residents point, for example, to Conwell Middle School in Kensington, which was forced to go into lockdown five times in one academic year because of drug-related gun battles right outside the school. Drug use is sufficiently normalized that it is a daily occurrence for parents to pass by someone actively injecting heroin in the street as they walk their kids to school.³⁶ The continued failings of both city and activist-led initiatives to stem the growth of the drug epidemic in Kensington has diminished community trust and made residents less receptive to proposals for new methods. In the words of Kensington longstanding resident and activist, Gilberto Gonzalez: "The city has not been able to manage the encampments. . . How are they going to manage an injection site? I have no confidence in the city anymore, and they're condescending to us when we complain."³⁷

Families of the victims of opioid use disorder are supporters of SIS; for the most part, such families do not live in Kensington.³⁸ Neighborhood leaders, along with many longtime residents and business owners, are generally opposed to the idea. One resident compared the idea of opening an SIS in Kensington to "holding an AA meeting in a bar."³⁹ The overall concern is that an SIS will attract more dealers and more violence. These residents of Kensington are neither selfish nor cruel for having such reservations. They too want to help the people suffering from opioid addiction, but fear that doing so will continue to be at the expense of their own livelihood, safety, and well-being.

³⁶Gonzalez "This crisis affects the quality of life."

³⁷ Polaneckzy, "Kensington resident: 'There's been a disaster here.'"

³⁸ Wolfram, "Safehouse vows to take more community input."

³⁹ Jones, "You wouldn't hold an AA meeting in a bar."

This divide between the proponents of SIS's and the people who will bear the consequences of SIS's must be bridged. That will only occur if the residents of Kensington are treated as stakeholders rather than bystanders in the matter. Their livelihoods and living standards are just as important as the needs of OUD patients, and should not be ignored. The City of Philadelphia as well as the proponents of Safehouse must earn the trust of the Kensington community with demonstrated commitment to accountability and strong oversight and rigorous outside monitoring. Any attempt to push through the SIS without community trust will see mass protests and stiff opposition.

*Lesson 4: Despite being the gold standard of OUD therapy, **Medication-Assisted Treatment** possesses many barriers to access primarily due to a lack of informed practitioners.*

Among the clinically prominent therapies for OUD is Medication-Assisted Treatment (MAT).⁴⁰ MAT is conducted through having individuals with OUD regularly take one or a combination of three FDA-approved opioid agonist drugs, methadone (Methadose), buprenorphine (Suboxone), and naltrexone under clinical oversight.⁴¹ The World Health Organization reports that by quelling withdrawal symptoms through a variety of physiological pathways, these drugs reduce the likelihood of relapse from opioid withdrawal, and consequently the threat of overdose-related death that often occurs during initial relapse.⁴² Review papers of research comparing the effectiveness of MAT reveal that both methadone as well as buprenorphine are effective at treating OUD, with some study cohorts having success rates as high as 90%.⁴³ Additionally, MAT may reduce risk posed by conditions that commonly co-occur among those with OUD.⁴⁴ For instance, HIV positive individuals with OUD adhered to their antiviral medications at greater rates when undergoing MAT.⁴⁵

⁴⁰ Carroll et al., "Evidence-Based Strategies for Preventing Opioid Overdose."

⁴¹ NIDA, "How Do Medications to Treat Opioid Use Disorder Work?"

⁴² NIDA, "How Do Medications to Treat Opioid Use Disorder Work?"

⁴³ Mattick et al., "Methadone Maintenance Therapy versus No Opioid Replacement Therapy for Opioid Dependence."

⁴⁴ Carroll et al., "Evidence-Based Strategies for Preventing Opioid Overdose."

⁴⁵ Carroll et al., "Evidence-Based Strategies for Preventing Opioid Overdose."

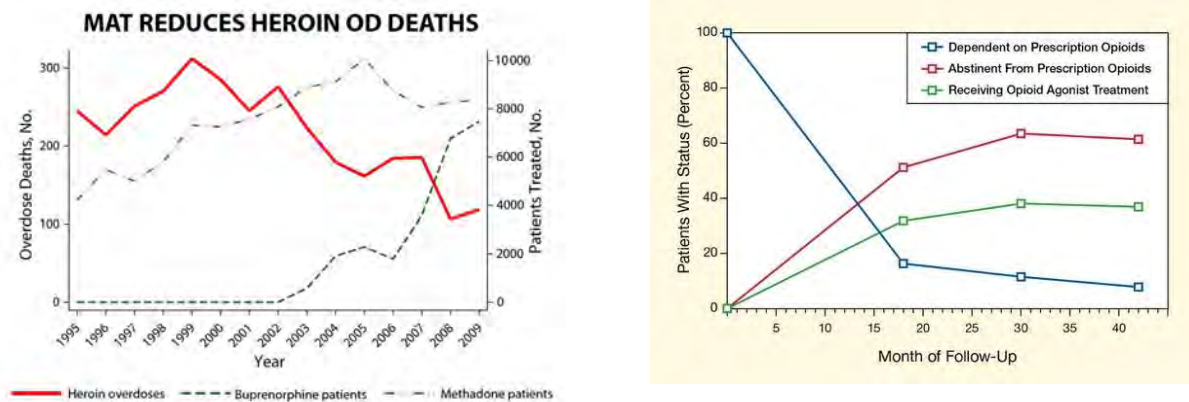


Figure 6: MAT regime reduces the likelihood of overdose and substance dependence at overtime.⁴⁶

Given their strong influence on opioid tolerance, MAT medications are solely provided in combination with Cognitive-Behavioral Therapy (CBT), which includes regular counseling and other forms of social support.⁴⁷ Since MAT typically requires daily engagement with a practitioner in order to receive medication and counseling it is challenging to maintain a continuum of care for those undergoing treatment.⁴⁸ For instance, patients may find themselves balancing their professional and personal commitments with frequent commutes to treatment sites, which are typically only open during standard working hours.⁴⁹

Moreover, certification and additional board requirements limit wider MAT access and general awareness of its existence in the medical community.⁵⁰ For instance, a practitioner without board-certified specialty training in neurology or psychiatry who wants to offer Suboxone would instead need to complete certification requirements administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), which mandates a 100 patient annual treatment limit for their first two years post-certification.⁵¹ For that reason,

⁴⁶ NIDA, “Effective Treatments for Opioid Addiction.”

⁴⁷ Mattick et al., “Methadone Maintenance Therapy versus No Opioid Replacement Therapy for Opioid Dependence.”

⁴⁸ Carroll et al., “Evidence-Based Strategies for Preventing Opioid Overdose.”

⁴⁹ Carroll et al., “Evidence-Based Strategies for Preventing Opioid Overdose.”

⁵⁰ SAMHSA, “Medication-Assisted Treatment (MAT).”

⁵¹ SAMHSA, “Medication-Assisted Treatment (MAT).”

Philadelphia has aimed to increase the number of providers certified to practice MAT, setting a strategic goal of increasing the number of certified physicians by 42% through 2021.⁵² Requiring medical schools in Philadelphia, and more broadly nationwide, to include SAMHSA's MAT curricula within their education so that graduates are automatically certified, as the Warren Alpert School of Medicine at Brown University has recently done, is another way to expand the number of physicians capable of providing more comprehensive care to those with OUD.^{53 54}

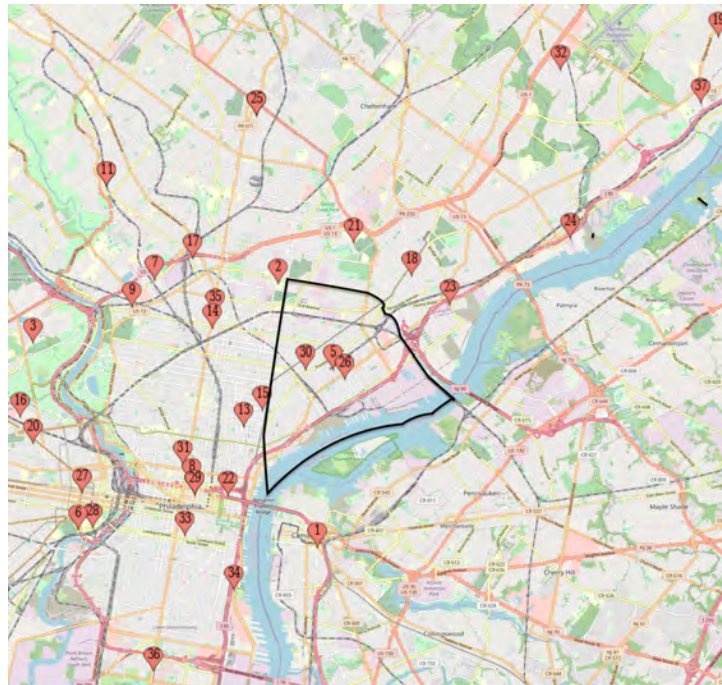


Figure 7: Map of in-network MAT providers for Community Behavioral Health (CBH), which manages behavioral health services for Philadelphia residents who are uninsured or enrolled in Medicaid.⁵⁵ Kensington/Frankford are outlined in black.⁵⁶

Currently, methadone and buprenorphine treatment programs are concentrated in West Philadelphia within academic or federally administered medical centers such as the VA hospital

⁵² Opioid Response Unit, Philadelphia Opioid Response 2021 Action Plan.

⁵³ Murphy, "At Brown, Syllabus Covers Treating Opioid-Use Disorder."

⁵⁴ Wallace et al., "Developing an Opioid Curriculum for Medical Students: A Consensus Report from a National Symposium."

⁵⁵ Philadelphia Department Of Behavioral Health And Intellectual Disability Services, Fall 2018 Fact Sheet 2A.

⁵⁶ Schoenberg Center for Center for Electronic Text & Image, Philadelphia Neighborhoods.

as 79% of Philadelphia’s currently certified MAT providers are based in these settings.⁵⁷ As figure 7 displays, of CBH’s thirty-seven in-network MAT providers, only three are located within the Kensington/Frankford locale.⁵⁸ With Kensington being widely considered the epicenter of Philadelphia’s opioid crisis it begs the question of whether there are sufficient channels to obtain MAT among those who may benefit from it the most.⁵⁹

Understanding reception to MAT at a community-based level is essential for shaping potential efforts to expand its accessibility in places like Kensington. Given the incidence of methadone dependence, some members of Kensington have called into question MAT’s effectiveness in ending drug dependence, and have also expressed concerns over the risks posed by having substance users gathering around MAT facilities.⁶⁰ Concerns that MAT may only be a temporary solution rather than a real remedy are not entirely unfounded as researchers identified a subset of substance users in Pennsylvania who used buprenorphine maintenance therapy (BMT) simply when heroin was not immediately available, rather than a desire for long-term recovery.⁶¹ Additionally, advocates in favor of MAT in Kensington have highlighted vulnerabilities in the lack of widespread coverage for medication, which can result in a disruptive and ultimately failed treatment regime for individuals in recovery.⁶²

B. Interconnected Framework for Harm Reduction (Implicit)

Lesson 5: The stigmatization of Opioid Use Disorder reduces access to care for those affected. The public, policymakers, and healthcare providers must be educated about how OUD is a mental illness and why person-first language is critical.

Despite the understanding of OUD as a mental illness, many people still attribute opioid use and medication-centered recovery to a character weakness or a willful choice.⁶³ This

⁵⁷ Opioid Response Unit, Philadelphia Opioid Response 2021 Action Plan.

⁵⁸ Philadelphia Department Of Behavioral Health And Intellectual Disability Services, Fall 2018 Fact Sheet 2A.

⁵⁹ Opioid Response Unit, Philadelphia Opioid Response 2021 Action Plan.

⁶⁰ Whelan, “This addiction treatment medicine is often sold on the streets — and may be preventing overdoses.”

⁶¹ McLean, “‘They’re making it so hard for people to get help.’ Motivations for non-prescribed buprenorphine use in a time of treatment expansion.”

⁶² Whelan, “This addiction treatment medicine is often sold on the streets — and may be preventing overdoses.”

⁶³ Olsen and Sharfstein, “Confronting the Stigma of Opioid Use Disorder—and Its Treatment.”

misconception leads to stigma with far-reaching implications for access to care. Public stigma, or the negative attitudes of the general public, leads to social exclusion of those with OUD and reduces the likelihood that they will receive psychological treatment.⁶⁴ For instance, many still believe that recovery means using willpower to practice abstinence from all opioids. Thus, taking medications such as methadone and buprenorphine is seen as a moral failing. This misconception can play a role in communities' decision to oppose medication-assisted treatment services located in their neighborhoods.⁶⁵ Even some substance-use support groups, such as Narcotics Anonymous, have historically excluded people taking methadone or buprenorphine from participation, seeing medication-centered recovery as contradictory to their philosophies. As a result, many people managing their OUD with medications may fear being ostracized if they mention their medication use in support groups.⁶⁶

Public stigma is also an issue within the healthcare system. The majority of primary-care providers (PCPs) believe that addiction to opioids are the fault of the individual, that people with OUD are more dangerous than the general population, and that employers should deny employment to those experiencing drug addiction.⁶⁷ These stigmatizing attitudes make it less likely that healthcare providers will prescribe medication to treat OUD, refer patients to other clinicians for OUD medication, deliver guideline-concordant OUD treatment, and encourage patient engagement throughout treatment.⁶⁸ Health insurers have also made access to treatment more difficult by creating arbitrary limits on how long people can receive medication-based treatment.⁶⁹

Public stigma can produce self-stigma, which is when individuals internalize the prejudice and discrimination they experience and apply it to themselves. The effects of self-stigma include lowered self-esteem, decreased faith in one's own abilities, and psychologically harmful feelings of shame and embarrassment. These negative feelings can lead to what Corrigan refers to as the "why try" effect, which is when a person questions why they

⁶⁴ Cooper et al., "Perceived Stigma and Social Support in Treatment for Pharmaceutical Opioid Dependence."

⁶⁵ Olsen and Sharfstein, "Confronting."

⁶⁶ Olsen and Sharfstein, "Confronting."

⁶⁷ Stone et al., "The Role of Stigma in U.S. Primary Care Physicians' Treatment of Opioid Use Disorder."

⁶⁸ Stone et al., "The Role of Stigma."

⁶⁹ Olsen and Sharfstein, "Confronting."

should try to live and work independently if they are not valued.⁷⁰ The feelings of helplessness that arise from self-stigma deter individuals from seeking out treatment and support. For those who are in drug treatment, self-stigma is linked with higher rates of relapse.⁷¹

Language is one factor that reflects and perpetuates the stigma around medication-centered OUD treatment. Assigning judgmental and emotionally charged terms to opioid recovery increases stigma around treatment.⁷² “Detoxification” is used to describe tapering off of methadone or buprenorphine as though they are poisonous toxins, and “drug-free” therapy is used as though people in medication-assisted treatment are not in recovery. Individuals are also often labeled as either “clean” or “dirty” based on whether or not they demonstrate OUD symptoms. Replacing terms such as “abuser,” “addict,” and “junkie” with person-first language such as “people affected with OUD” helps to shift blame away from the individual and foster empathy for the struggles of addiction.⁷³ Medical practitioners, in addition to using nonjudgmental and person-first language, should also receive bias training. Their training should include education about both the nature of OUD and the appropriate ways to address this disorder in a healthcare setting.

*Lesson 6: Individuals with **other mental disorders and illnesses** are more vulnerable to developing OUD. Prevention and treatment must cater to the unique needs of those with comorbid mental health issues.*

Individuals with co-morbid, or co-occurring, mental disorders and illnesses are often at higher risk of developing OUD. For example, a person with mood and anxiety disorders is more likely to develop an OUD than someone without these disorders who is prescribed an opioid.⁷⁴ This correlation exists in part because individuals with co-morbid mental illnesses often self-medicate with opioids to temporarily alleviate their symptoms. However, prolonged opioid use can eventually exacerbate symptoms such as social isolation, sadness, and hopelessness. This

⁷⁰ Norms et al., *Understanding Stigma of Mental and Substance Use Disorders*.

⁷¹ Cooper et al.

⁷² Olsen and Sharfstein, “Confronting the Stigma of Opioid Use Disorder—and Its Treatment.”

⁷³ Stone et al., “The Role of Stigma in U.S. Primary Care Physicians’ Treatment of Opioid Use Disorder.”

⁷⁴ Martins et al., “Mood/Anxiety Disorders and Their Association with Non-Medical Prescription Opioid Use and Prescription Opioid Use Disorder.”

phenomenon particularly impacts individuals with mood or anxiety disorders who do not have health insurance to cover effective mental health treatments.

Individuals with attention-deficit hyperactive disorder (ADHD) are also at higher risk of developing OUD due to impaired executive functions such as decision-making and impulse control. In fact, ADHD is present in nearly one out of every four patients with a substance use disorder.⁷⁵ Patients with both disorders become addicted at a younger age and have higher rates of hospitalization and relapse than substance-use disorder patients without ADHD.⁷⁶ It is critical that OUD interventions address the unique challenges that individuals with mental disorders and illnesses face. Treatment should first focus on managing addiction to reduce active opioid use and then provide evidence-based psychotherapies that have been found to change behavior, such as Cognitive-Behavioral Therapy (CBT).⁷⁷ More research needs to be done on which specific types of therapy are most effective for certain mental health co-morbidities.

*Lesson 7: **Criminal penalties** do not reduce opioid use nor aid the end of the opioid crisis. Law enforcement must work with the community and public health officials to assist and treat community members with OUD.*

Criminal penalties for simple possession do not reduce addiction. A study by The Pew Charitable Trusts examined data from federal and state law enforcement, corrections, and health agencies and performed an analysis which found no statistically significant relationship between state drug imprisonment rates and the three indicators of state drug problems: self-reported drug use, drug overdose deaths, and drug arrests.⁷⁸ Enforcing harsher penalties also hurts individuals, families and communities by creating criminal records that often prevent offenders from obtaining work, housing or professional licensure.⁷⁹

⁷⁵ van Emmerik-van Oortmerssen et al., “Prevalence of Attention-Deficit Hyperactivity Disorder in Substance Use Disorder Patients.”

⁷⁶ van Emmerik-van Oortmerssen et al.

⁷⁷ Zulauf et al., “The Complicated Relationship Between Attention Deficit/Hyperactivity Disorder and Substance Use Disorders.”

⁷⁸ The Pew Charitable Trusts. “Imprisonment Does Not Drug Problems.”

⁷⁹ “Addressing Opioid Addiction.”

Criminalizing opioid possession also deepens the racial divide that shapes the war on drugs. While the bulk of OUD residents in Kensington and worldwide are white, this war relies on a reciprocal relationship between the criminalization of blackness and the decriminalization of whiteness.⁸⁰ Black people are arrested more frequently and punished more severely than white people for drug crimes, while drug use within the two racial groups is roughly the same.⁸¹ The stark difference in criminal penalties by race are prominently seen when comparing the criminalization response from the crack/cocaine epidemic of the 1980s which affected mainly Black and Brown people to the opioid epidemic which affects mainly white people.⁸²

With evidence from The Pew Charitable Trust study and the deepening racial divide that pairs with imprisonment in the United States, it is important that policymakers pursue alternative strategies. Clinical practitioners, public health researchers, and criminal justice officials have been taking different forms to advocate for the diversion of arrestees into mental health and addiction treatment services rather than incarceration. Philadelphia has attempted multidisciplinary methods to address the opioid epidemic through law enforcement. Harm reduction within the criminal justice field is characterized by minimizing the recruitment of new drug users through low-level policing, encouraging existing drug users to retire and enter treatment programs, and employing community-based corrections to reduce the use of custody and promote rehabilitation.⁸³ Philadelphia employed a pilot program called Police-Assisted Diversion (PAD) in 2019 for low-level, non-violent drug offenses.⁸⁴ With this diversion program, police in the 24th District in Kensington have referred some offenders of minor drug-related offenses to social workers instead of charging them for a crime.

PAD is free to the participant, the services are voluntary, and it refers people in Kensington who struggle with opioid addiction to the necessary health and social services they need. It is limited in that those with histories of violence or people open cases against them are not eligible. As well, participants can only be diverted twice with the third infraction involving

⁸⁰Lassiter, “Impossible Criminals.”

⁸¹ “Crack vs. Heroin Project.”

⁸² Netherland and Helena, “The War on Drugs.”

⁸³ “Police Assisted Diversion.”

⁸⁴ Pearson, “Drugs and Criminal Justice.”

criminal charges.⁸⁵ Additionally, most of the participants came through social referrals so the program needs to expand to reach people with OUD who do not have such resources.

While decriminalization programs like PAD do not encourage or spur opioid use, there is concern that single state drug decriminalization efforts have contributed to bringing about opioid tourism. In certain areas of Kensington, open-air drug use is de facto decriminalized as, according to interviews conducted with multiple community activists, the police only respond to complaints of it in gentrified neighborhoods. This pick and choose approach to crime has made Kensington a prime location for out-of-state opioid tourists whose home states impose harsh sentences on heroin possession. This negative consequence of decriminalization could be offset if neighboring states coordinated their decriminalization efforts. This would eliminate most, if not all incentive for OUD victims to come to Kensington.

The decriminalization approach is rightly oriented towards social justice, but the wider implications of such a policy should be heavily considered before implementation. Overall, more collaboration is needed between public health, law enforcement, and social services to create solutions that could pivotally alter the systems which perpetuate this opioid crisis. These efforts should also incorporate the policies of neighboring states as well as the federal government.

⁸⁵ Wolfram, “Help Instead of Criminal Charges.”



Figure 8: Philadelphia Police Department members engaged in a community cleanup⁸⁶

*Lesson 8: OUD disproportionately affects **justice-involved populations**. Correctional facilities should offer treatment and linkage to care following release for those with OUD.*

Individuals who are or have been incarcerated are disproportionately impacted by both opioid use and overdose deaths. In fact, an estimated 50% of incarcerated people meet the criteria for an OUD diagnosis.⁸⁷ In the first two weeks following release, formerly incarcerated individuals are 129 times more likely to die of drug overdose compared to the general public.⁸⁸ These drug overdoses mostly occur while using opioids.⁸⁹

This disparity in overdose deaths is caused primarily by opioid tolerance and lack of continuity of care following release. Opioid tolerance is a reduced responsiveness to opioids with regular use that creates a need for higher doses to achieve the same initial effect. Opioid tolerance decreases significantly during incarceration because correctional facilities force individuals to discontinue opioid use. Not only does this forced break lower the tolerance of incarcerated individuals, but also takes place in an unfamiliar environment. Many recently released people are not aware that drug tolerance lowers when taken in new locations where the

⁸⁶ “Police Assisted Diversion.”

⁸⁷ Chandler, Fletcher, and Volkow, “Treating Drug Abuse and Addiction in the Criminal Justice System.”

⁸⁸ Binswanger et al., “Release from Prison — A High Risk of Death for Former Inmates.”

⁸⁹ Pizzicato et al., “Beyond the Walls.”

environmental cues associated with drug use are absent.⁹⁰ Thus, individuals who take their usual dose somewhere where they have not used before are likelier to overdose. Lowered tolerance following release makes it likelier that recently released individuals will suffer from fatal complications. To make matters worse, methadone maintenance therapy is often taken away at the time of incarceration, which increases individuals' risk of drug relapse, overdose, and recidivism, or reoffense, following release. Lack of social support and continuity of care following release also contributes to high rates of overdose deaths. Although treatment during and after incarceration has been shown to significantly reduce drug use and drug-related crime, less than 20% of inmates with drug abuse or dependence receive formal treatment.⁹¹ Even if a correctional institution does provide treatment, continuity of treatment post-incarceration is often non-existent.

In addition to the general problems with forced methadone withdrawal, it is important to note that incarceration-related opioid deaths have a far greater impact on racial and ethnic minority communities such as Kensington. Black men are six times more likely to be incarcerated in state or federal prisons than white men, despite similar rates of crime between racial groups.⁹² Thus, Black men are more likely than white men to experience the forced methadone withdrawal policies of correctional facilities. For most individuals, those with and without prior treatment alike, methadone withdrawal symptoms are considered worse than opioid withdrawal. As a result, forced methadone policies increase the reluctance of individuals with OUD in the community, especially Black men, to enter methadone maintenance therapy.⁹³ The fear of withdrawing from methadone during incarceration is a greater deterrent to treatment than the fear of withdrawing from opioids is a motivator for treatment.

Another factor to consider with OUD is that, while prisons, which offer long-term facilities, are able to provide some degree of healthcare, jails are locally operated and short-term. Since jails are short-term, they rapidly cycle through individuals in a way that presents a unique

⁹⁰ Gerevich et al., "A Case Report."

⁹¹ Chandler, Fletcher, and Volkow, "Treating Drug Abuse and Addiction in the Criminal Justice System."

⁹² Hetey and Eberhardt, "The Numbers Don't Speak for Themselves."

⁹³ Fu et al., "Forced Withdrawal from Methadone Maintenance Therapy in Criminal Justice Settings."

barrier for OUD treatment. In the Philadelphia Department of Prisons, a study found that the risk of overdose death was especially high for those incarcerated between 31 days to 6 months⁹⁴. This finding indicates that even those who are incarcerated in jails for relatively short periods, compared to those in prisons, are at risk of losing tolerance for opioids and overdosing. In turn, since jails have less government funding and rapidly cycle individuals in and out, they are more limited in their ability to provide treatment on the inside for at-risk individuals.

In order to address OUD among people who experience incarceration, we can look to the example set by the Rhode Island Department of Corrections (RIDOC). In 2016, they became the first state correctional system to initiate a program that screened all individuals for OUD, to offer treatment with methadone, buprenorphine, and naltrexone for those medically eligible, and to provide linkage to care in the community after release.⁹⁵ Within the first year of this program's implementation, there was a 12% drop in statewide overdose deaths and a 61% drop in post-incarceration overdose deaths.⁹⁶ By following RIDOC's example, other correctional facilities can reduce the alarmingly high rates of opioid deaths among those incarcerated.

Lesson 9: The provision of stable housing combined with the disruption of open-drug scenes is essential in combating the opioid epidemic. While the city of Philadelphia has made some efforts to provide housing and clears encampments from time to time, there is neither sufficient housing nor an overarching strategy behind these actions, effectively negating them both.

Homelessness goes hand in hand with opioid addiction. The destructive nature of addiction can cause job loss, financial problems, and the deterioration of personal relationships, all of which culminate in homelessness. This is the case in Kensington where, based on a study conducted in January 2021, 57% of the OUD community were found to be homeless.⁹⁷ Conversely, addiction can also be a result of homelessness. Despair from having to live on the street can cause people to turn to hard drugs such as heroin. No matter how someone ends up

⁹⁴ Pizzicato et al., "Beyond the Walls."

⁹⁵ Clarke et al., "The First Comprehensive Program for Opioid Use Disorder in a US Statewide Correctional System."

⁹⁶ Clarke et al., "The First Comprehensive Program."

⁹⁷ Cecile et al. "HIV Infection and Depression Among Opiate Users."

homeless with OUD, the lack of a permanent residence can act as a significant barrier to accessing care and actually recovering from addiction. These barriers include social isolation, lack of mobility or transportation, and complex treatment needs for co-occurring conditions.

Homelessness increases the morbidity and mortality of substance use disorders, making housing a key form of harm-reduction.⁹⁸ Housing is within the same linear path of those who suffer from an opioid addiction, and in order for a person to reach the next step of becoming clean, free and independent of addiction, they must first have the basic necessities to fall back on. When OUD patients are left out in the streets, they are at higher risk for wound infection, street violence, and social alienation, all of which reduce the chances of them accessing and successfully completing MAT and other long-term rehabilitation services. This assessment is backed by many studies that show that treatment approaches that incorporate housing provide better health outcomes than usual care for people who are homeless.⁹⁹ Moreover, it has also been demonstrated that with increased connections to housing, homeless patients become as statistically likely as stably housed patients to successfully complete MAT.¹⁰⁰

While the city has made attempts to provide affordable or even free housing to the OUD suffering homeless, it is not at all sufficient and this failure is readily apparent in Kensington. Since February 2020, more than 59,000 names remain on the waiting list for the Philadelphia Housing Authority's affordable housing with the majority of the city's homelessness rates stemming from Kensington.¹⁰¹ As of June 2021, there are still hundreds of the neighborhood's residents living in tents and makeshift structures on the sidewalks, under bridges, and even in public parks.

Despite the lack of housing availability, the city has continued to dismantle and clean out encampments of the homeless opioid users throughout the city. The clearing out of encampments can be a harm-reduction technique. However, Philadelphia's approach was lacking in multiple

⁹⁸ Aldridge et al., "Morbidity and Mortality in Homeless Individuals."

⁹⁹ Hwang et al., "Interventions to Improve the Health of the Homeless."

¹⁰⁰ Alford et al., "Treating Homeless Opioid Dependent Patients."

¹⁰¹ Valania, Jonathan, "The Opioid Crisis Is Worsening Homelessness."

aspects.¹⁰² In theory, the encampments, which act as open-air drug scenes, are cleared by the police and sanitation departments while social workers guide the camp residents to treatment and housing. The problem with Philadelphia's approach is that they break up encampments without providing housing for those whom they displace.

Dispersal combined with housing is an approach used in multiple European cities with reasonable success.¹⁰³ In contrast, Philadelphia only dismantles the encampments in Kensington when the neighborhood protests become too loud to ignore, and they fail to find adequate housing and treatment options for the camp residents. The police who lead the clearings just push out the inhabitants who then must set up new encampments elsewhere in the area. In addition, from what community activists have said, social workers who are supposed to guide the OUD patients to treatment and housing are overwhelmed, which makes consistent long-term interaction difficult. This lack of strategic, thoughtful, prepared effort leads to insufficient, inhumane, and ineffective policy, negating any positive effects of the clearing strategy.¹⁰⁴

Affordable housing, treatment and guidance, and encampment clearings are key to dealing with homeless OUD populations. Housing availability heavily increases the viability of treatment options while camp clearings keep open-drug scenes small and manageable. Housing needs to be both

plentiful and easy to access for any clearing activities to be effective. Any shortcomings in the planning and coordination of these two harm-reduction techniques will inevitably cause them to both fail and have a negative impact on all concerned, including the community as a whole.

*Lesson 10: Harm reduction programs must approach this crisis **comprehensively and through community-led engagement**. Piecemeal efforts result in amplified drawbacks, such as opioid tourists, discarded needles, and homeless encampments.*

¹⁰² Clausen et al., "Open Drug Scenes: Responses of Five European Cities"

¹⁰³ Clausen et al., "Open Drug Scenes: Responses of Five European Cities"

¹⁰⁴ Britt Carpenter Addiction, Humanizing. "Showing Our Love Shared." Humanizing AddictionTM.

Harm-reduction techniques must be considered as part of a holistic framework to combat addiction and the problems associated with it. The stated purpose of harm reduction is to keep addicted people alive and healthy long enough for them to access treatment, but in absence of coherent, sustainable treatment options and law enforcement, individual types of harm reduction programs operating autonomously can create an inviting environment that normalizes the use of hard drugs.

For example, despite all the attempts made to combat the opioid crisis in Kensington, the population of heavy drug users patients has only grown.¹⁰⁵ More OUD patients are appearing in Kensington, and their mortality rate is rising.¹⁰⁶ Opioid tourists are driving in from as far as Texas, and they are setting up camp in Kensington public parks.¹⁰⁷ The number of people who need treatment for OUD continues to increase while options for these people continue to face roadblocks.¹⁰⁸ Philadelphia Housing activist Dr. Bill McKinney attests to the fact that the housing supply for vulnerable populations cannot keep pace with the number of people streaming into the area in search of cheap heroin and a comfortable environment to consume it in. De facto decriminalization of drug possession and lax clearing efforts have essentially made Kensington a prime vacation destination for suburban out of state opioid users fleeing states with harsher enforcement.

Indeed Kensington serves as the ideal environment to use opioids: the needles are clean, the drugs are cheap, the police won't arrest you, and the encampments are not regularly disturbed. Rather than tackling the root of the problem with a comprehensive approach, the city has found itself shifting around resources to accommodate rather than guide those with addiction to obtain effective treatment. According to Dr. McKinney, one Kensington public park has 12 sanitation workers whose sole responsibility is to clean the trash piles and needles left behind by opioid users. On the other hand, a social worker who can actually help guide people to long-term treatment only comes in once a week for a few hours. Unfortunately, such a harm-reduction approach contributes very little to the solving the opioid crisis. Philadelphia's base of users is enormous, and these almost futile, short-term gestures do little to

¹⁰⁵ Percy, "Trapped by the 'Walmart of Heroin.'"

¹⁰⁶ Patel and Rishworth, "Opioid Overdoses Have Spiked during the Pandemic."

¹⁰⁷ Percy, "Trapped by the 'Walmart of Heroin.'"

¹⁰⁸ Carroll et al., "Evidence-Based Strategies for Preventing Opioid Overdose."

address this crisis.

While resources and efforts have been marshalled to tackle the crisis in Kensington, no meaningful progress has been made. A lack of consensus in city government as well as a lack of comprehensive planning has been the Achilles heel of harm-reduction in this neighborhood.¹⁰⁹ Without community engagement, comprehensive planning, cooperation and consensus among the various city agencies and politicians, and extensive, cohesive harm-reduction implementation, the crisis will only continue to intensify.

IV. Conclusion

The overarching lessons from Kensington, Philadelphia on how to employ harm reduction methods in your community are as follows:

Lesson 1: Naloxone is a harm reduction strategy that prevents the death of those suffering from opioid use disorder so that they can be treated. However, Naloxone is not a stand-alone solution. It does not heal drug addiction; it merely reverses the effects of an overdose.

Lesson 2: Needle Exchange Centers are successful and cost-effective in preventing outbreaks of HIV and reducing public health expenditures. However, discarded needles continue to pose a significant health hazard to the community.

Lesson 3: Supervised Injection Sites are essential in curbing the opioid pandemic. They provide spaces for users to safely inject drugs while also giving them access to counseling, treatment, housing, and general medical care. While demonstrating a strong record of success, there have been instances of mismanaged sites and lack of community engagement in their development. Thus SIS's must have strong community involvement, oversight and accountability.

¹⁰⁹ McKinney, "History is repeating in Kensington."

Lesson 4: Despite being a gold standard of OUD therapy, Medication-Assisted Treatment poses challenges due to a lack of informed, certified practitioners to staff them. Medical schools should require this training.

Lesson 5: Stigmatizing those with opioid addiction interferes with successful treatment and access to care. The public, policymakers, and healthcare providers must be educated about how OUD is a mental illness and why person-first language is critical.

Lesson 6: Individuals with other mental health issues and cognitive disabilities such as ADHD are more vulnerable to developing OUD. Prevention and treatment must be sensitive to the unique needs of those with co-morbid mental health issues.

Lesson 7: Criminal penalties do not reduce opioid use nor aid the end of the opioid crisis. Law enforcement must work with the community and public health officials to assist and treat their OUD Residents.

Lesson 8: OUD disproportionately affects people who experience incarceration. Correctional facilities should offer treatment and linkage to care following release for those with OUD.

Lesson 9: Destroying encampments is only effective if accompanied by stable housing and treatment. While the city of Philadelphia has made some efforts to provide housing and regularly clears encampments, there is neither sufficient housing nor an overarching strategy behind these actions, potentially doing more harm to the OUDs and the community as a whole.

Lesson 10: Harm reduction programs must approach this crisis comprehensively and through community-led engagement. Piecemeal, incoherent efforts amplify the problem, resulting in opioid tourists, discarded needles, and homeless encampments.

We hope these lessons serve as a guide when making decisions about how your city, neighborhood, or community should respond to their own opioid crisis. Please consider the strengths, weaknesses, limitations, and successes of these harm reduction strategies employed in Philadelphia and the hotspot neighborhood of Kensington to make the best decisions for both OUD-suffering populations and the community at large.

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