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HARM REDUCTION: CONCEPTS, COMPASSION, AND CARE DELIVERY

MAKING RESEARCH RELEVANT

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None

Learning Objectives

1. Define harm reduction.

2. Explain how harm reduction fits into clinical care.

3. Identify a harm reduction practice you can use in your own work.

Joe

- 54-year-old male is seen in your office with type 2 diabetes (A1C = 12), elevated BP, and CAD.
- On chart review, you see that he frequently misses appointments with providers, the nurse, and the dietician.
- He continues to gain weight despite multiple referrals to exercise programs and encouragement for weight loss.
- His cholesterol is controlled with a statin.

Clinical Response

- What do you do?

  A. Tell Joe that unless he follows your recommendations and sees the dietician, loses weight, and reduces his A1C, you will have to discharge him from your care and discontinue his insulin, statin, and antihypertensives.

  B. Understand that his diabetes will never be controlled and decide to continue to be his provider but focus on other health conditions.

  C. Explore barriers, celebrate cholesterol control, and determine his care goals.

Mike

- Mike is a 54-year-old male with severe opioid use disorder and is receiving buprenorphine treatment.
- Urine toxicology screens are persistently positive for cocaine and buprenorphine and occasionally positive for benzodiazepines and heroin.
- He intermittently misses scheduled appointments and rarely sees the therapist as recommended.

Clinical Response

- What do you do?

  A. Tell Mike that unless he follows your recommendations, sees the therapist weekly, and stops using all non-prescribed substances, you will have to discharge him from care and stop prescribing buprenorphine.

  B. Understand that he will never achieve recovery, stop prescribing buprenorphine, and focus on other medical concerns.

  C. Explore barriers, celebrate continued engagement, identify his care goals, and discuss continued benzo, cocaine, and heroin use and how that use relates to his goals.

Why Do These Cases Feel So Different?

Defining Harm Reduction

What Is Harm Reduction?

There is no internationally agreed upon definition of harm reduction.

"Harm reduction refers to policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws. Harm reduction is grounded in justice and human rights—it focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support."

– *Harm Reduction International*

Source: https://www.hri.global/what-is-harm-reduction

Harm Reduction

- Patient-centered care:
  - Respect
  - Acceptance
  - Empowerment
  - Collaboration
  - Compassion
- Engagement is primary goal.
- No pre-defined outcomes.

“We're talking for the first time about affirming and even rejoicing in improvement—not perfection. Humans are really good at improvement. We are not so good at perfection.”

– Dan Bigg

Photo credit: Nigel Brunsdon; used with permission

Harm Reduction

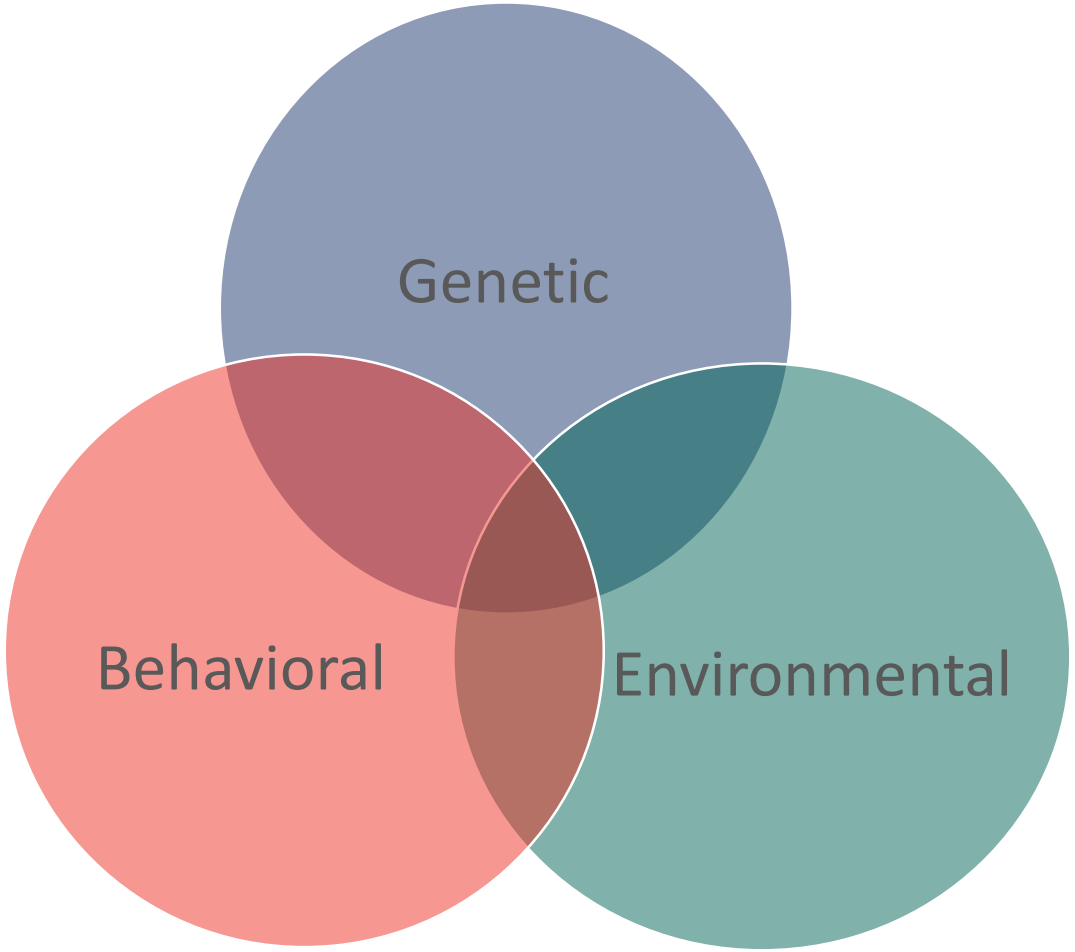
- Other examples of harm reduction interventions:
  - Seat belts
  - Epi pens
  - HPV vaccine
  - Condoms
  - Life jackets
- Harm reduction incorporates nearly everything we do as medical professionals.
  - Most patients do not follow our recommendations exactly as prescribed (therapy, medication adherence, exercise, mindfulness).

Substance Use Disorders

What Is Substance Use Disorder?

- Many people use drugs and alcohol, but not all of them develop substance or alcohol use disorder.
- Substance use disorder is not simply about the use of drugs; it is about the behaviors and symptoms related to the use of drugs.
- Many people get better without formal treatment.
  - Treatment shortens the time required to get better.
  - Treatment reduces negative outcomes along the way (HIV, mental illness, overdose death).

Who Develops Substance Use Disorders?



- Genetic component
- Environmental component
- Behavioral component
- Early exposures associated with increased risk
  - Adverse childhood experiences
  - Early exposure to drugs and alcohol

Source: McLellan, A. T., Starrels J. L., Tai, B., Gordon, A. J., Brown, R., Ghitza, U., . . . McNeely, J. (2014, January). Can substance use disorders be managed using the chronic care model? Review and recommendations from a NIDA consensus group. *Public Health Reviews, 35*(2).

Substance/Opioid Use Disorder Diagnosis

Diagnostic and Statistical Manual of Mental Disorders 5 Criteria	
1. More or longer than intended 2. Unable to cut back or control 3. Time dedicated to obtaining, using, recovering from	**Loss of control**
4. Physical or psychological consequences 5. Activities given up 6. Failure to fulfill major obligations (work, school, or home) 7. Continued use despite social or interpersonal problems caused or made worse 8. Recurrent use in hazardous situation	**Continued use despite consequences**
9. Craving, strong desire, or urge	**Craving or compulsion**
10. Tolerance (unless taken solely under appropriate medical supervision) 11. Withdrawal (unless taken solely under appropriate medical supervision)	

Severity is based on number of symptoms: **Mild** 2–3 symptoms, **Moderate** 4–5 symptoms, **Severe** ≥6 symptoms.

Source: American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Harm Reduction in Clinical Care

Continued drug use despite negative consequences is a symptom of addiction.

For no other condition do we discharge a patient who is showing symptoms of the condition for which they are seeking treatment.

Does Language Matter?

- A randomized controlled trial was held with mental health professionals.
- Two groups were given same clinical scenario: one with a “substance abuser” and the other with a “person with substance use disorder.”
- Those in the “substance abuser” condition agreed more with the notion that the character was **personally culpable** and that **punitive measures should be taken**.
- DSM IV terms of “dependence” and “abuse” were changed to “use disorders” in transition to DSM 5.

Source: Kelly JF, Westerhoff CM. Int Journal of Drug Policy. 2010. 21:202-207.

Language Matters

Terms to Avoid Using	Terms to Use
Addict, junkie, drug abuser	Person who uses drugs or person with substance use disorder
Substance abuse	Substance use or Substance use disorder
Clean (drug test) Dirty (urine drug test)	Negative drug test Positive drug test
Drug habit	Substance use, substance use disorder
Staying clean	In recovery/in remission
Medication Assisted Treatment (MAT)	Medication for Addiction Treatment (MAT) Medication for Opioid Use Disorder (MOUD)

Source: https://www.addictionpolicy.org/blog/language-matters-infographic

Harm Reduction Tips for Clinicians

Know Local Resources and Laws

- Naloxone access for overdose prevention
  - http://pdaps.org/datasets/laws-regulating-administration-of-naloxone-1501695139
- Syringe service programs
  - https://www.nasen.org/map/
- Overdose prevention sites
  - Currently only available in Canada; none in the United States
- Area treatment providers (and which treatments they offer)
  - SAMHSA Treatment Finder (https://findtreatment.samhsa.gov/)

When Talking to Patients About Drug Use . . .

- Ask permission:
  - Is it okay if I ask some questions about your drug and alcohol use?
- Do not assume people want to stop use:
  - How do you feel about your drug/alcohol use?
  - How do you feel your drug/alcohol use is affecting your life right now?
- Ask questions about where they use drugs, with whom, what route:
  - When you use, are you usually with people or alone?
  - Where do you normally use drugs?
  - Do you usually inject or smoke or snort your drugs?

When Talking to Patients About Drug Use . . .

- Ask whether they want any resources (where to find sterile equipment, how to obtain naloxone, information on treatment):
  - Do you know where to get clean syringes and needles?
  - Do you have naloxone in case of an opioid overdose?
- Remember that many people already feel immense shame relative to their drug use:
  - I understand that you don't want to talk about this today. Just know that I'm here to support you if you change your mind or need help finding any resources to help you stay safe.
- If you do not understand something, it is okay to ask for clarification.

When Talking to Patients About Drug Use . . .

- Principles of motivational interviewing apply:
  - Ask open ended questions.
  - Affirm patient's goals and progress made. ("This week was really hard and you still decided to come back in. You're really persistent!")
  - Avoid praise or "I" statements.
  - Offer reflections based on what the patient shares (avoid interpretations that are judgements).
  - Offer information, but avoid lecturing. ("Is it okay if I share some resources on safer injection practices?")

Specific Tips for Patients Using Drugs

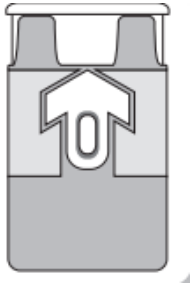
- Try not to use drugs alone (or have someone check on you).
- Leave the door unlocked or slightly open.
- Develop an overdose response plan with friends or others who use drugs.
- Try not to mix drugs (benzodiazepines, alcohol, opioids, and other downers significantly increase risk of overdose and death).
- Do a “test shot.”
- Try not to share syringes, needles, or equipment (spoons, straws, pipes).
- Carry naloxone and make sure others know how to use it!

Opioid Overdose Response and Naloxone Distribution

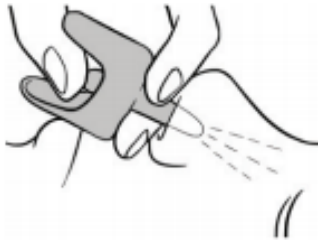
- No increase in drug use; increase in drug treatment
  - Seal et al. *J Urban Health*. 2005;82:303–311
  - Galea et al. *Addict Behav*. 2006;31:907–912
  - Wagner et al. *Int J Drug Policy*. 2010;21:186–193
  - Doe-Simkins et al. *BMC Public Health*. 2014;14:297
- Cost effective
  - Coffin & Sullivan. *Ann Intern Med*. 2013;158:1–9
- Reduction in overdose deaths
  - Walley et al. *BMJ*. 2013;346:f174
- Should center around people who use drugs
  - Rowe et al. *Addiction*. 2015;1301–1310

Overdose Response and Naloxone Distribution

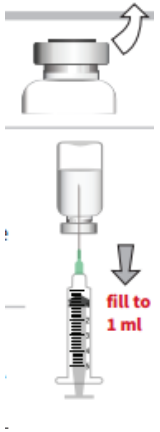
- Many U.S. states allow:
  - Providers to prescribe to a layperson (with criminal and civil immunities).
  - Pharmacists to dispense through standing order.



Auto-injector



Intra-nasal



Intra-muscular

Permission to use images of medications received from San Francisco Department of Public Health.

In Case of Overdose:

1 CHECK RESPONSIVENESS
LOOK FOR ANY OF THE FOLLOWING:

- No response even if you shake them or say their name
- Breathing slows or stops
- Lips and fingernails turn blue or gray
- Skin gets pale or clammy

2 CALL 911 & GIVE NALOXONE
IF THEY ARE NOT BREATHING

IF NO REACTION IN 3 MINUTES, GIVE SECOND NALOXONE DOSE

3 DO RESCUE BREATHING AND/OR CHEST COMPRESSIONS
FOLLOW 911 DISPATCHER INSTRUCTIONS

LET 911 DISPATCHER KNOW HOW MUCH NALOXONE YOU HAVE GIVEN THEM

STAY WITH PERSON UNTIL HELP ARRIVES.

Illinois has a Good Samaritan Law with certain protections for those calling 911. Learn more at **overcomeopioids.org/respond**

How To Give Naloxone:

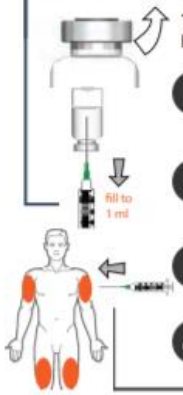
There are 3 common naloxone products. Follow the instructions for the type you have.

Nasal Spray

This nasal spray needs no assembly and can be sprayed up one nostril by pushing the plunger.

If no reaction in 3 minutes, give second dose.

Injectable Naloxone

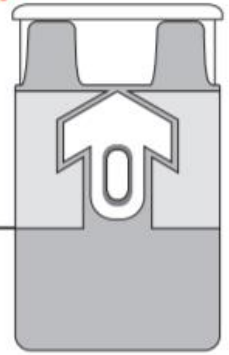


This requires assembly. Follow the instructions below.

1. Remove cap from naloxone vial and uncover the needle.
2. Insert needle through rubber plug with vial upside down. Pull back on plunger and take up 1 ml.
3. Inject 1 ml of naloxone into an upper arm or thigh muscle.
4. If no reaction in 3 minutes, give second dose.

Auto-Injector

The naloxone auto-injector needs no assembly and can be injected into the outer thigh, even through clothing. It contains a speaker that provides step-by-step instructions.



How To Get More Naloxone:

Find a nearby Chicago Recovery Alliance (CRA) location where you can be trained and get an injectable naloxone kit for free! For a list of locations and times visit **www.anypositivechange.org**

Ask your local pharmacist for naloxone (pharmacists who have completed training can dispense naloxone without a prescription). Depending on your insurance, there may be a cost.

Ask your healthcare provider for a prescription for naloxone that you can fill in a pharmacy.

https://overcomeopioids.org/free-resources

Key Takeaways

- Harm reduction is patient-centered care and uses motivational interviewing principles.
- Harm reduction fits in clinical care settings.
- Drug use despite negative consequences is a symptom of the disease of addiction.
- As medical providers, our first goal should be to do no harm. This includes the way we talk to, and about, our patients.
  - Language matters!
- In addition to treating substance use disorders clinically, there are other tools we can use to reduce risk and improve health.

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THANK YOU