Harm Reduction: Expanding Competency

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Learning Objectives

- Waves of Opioid Epidemic historical perspective and current trends.
- Explore perceived conflicts and challenges related to implementing Harm Reduction in community.
- Defining Harm Reduction and exploring application in OUD treatment.
- Review established findings related to Harm Reduction initiatives.
- Helpers Oath examination of what being a helper obligates us of on the frontlines of Harm Reduction movement.
- Discussion of Challenges

Waves of Opioid Epidemic

Trajectory of Crisis

The *first wave* began with increased prescribing of opioids in the 1990s, with overdose deaths involving prescription opioids (natural and semi-synthetic opioids and methadone) increasing since at least 1999.

The *second wave* began around 2010-2012, with rapid increases in overdose deaths involving heroin. Crackdown on prescribing opioids began pushing many individuals physically dependent to the street for access. Failing to plan is planning to fail has never been so evident.

The *third wave* began around 2013, with significant increases in overdose deaths involving synthetic opioids, particularly those involving illicitly manufactured fentanyl. The market for illicitly manufactured fentanyl continues to change, and it can be found in combination with heroin and counterfeit pills.

The *fourth* wave is now currently being entered as polysubstance use related overdoses and deaths are skyrocketing. Accidental overdoses related to substance users unaware of laced illicit drugs (cocaine, methamphetamine, & xylazine). Nonexistent prediction of substance using experience with illicit drugs of any type.

Humanitarian Crisis

Over a million people have died since 1999

Opioids kill over 136 Americans each day

The national OD death rate increased 255.74% between 2000 and 2019.

The rate of OD deaths involving synthetic opioids increased at an annual rate of 580% over five years (2012-2017).

In 2017, opioid overdose was declared a national emergency in the United States.

Three million US citizens and 16 million individuals worldwide have had or currently suffer from opioid use disorder (OUD)

80-85% of opiate users relapse in abstinent-based treatment modalities

Data suggests that someone dies from overdose every 5 mins

Different Times

Traditionally

- Substance users could generally trust that illicit drugs were free from being laced
- Substance users could predict experience/tolerance
- Substance users were afforded prolonged windows of achieving motivation and increasing readiness to change (hitting bottom)
- Treatment approaches were rooted in abstinencebased models and "one size fits all" mentalities among professionals

Now

- Substance users have no idea whether illicit drugs are laced increasing risk. Probability implies certainty of toxicity
- Substance users can no longer predict experience tremendously increasing danger
- Substance users no longer have time to hit the "traditional bottom" once thought necessary
- Traditional abstinence-based approaches do not work for opiate population

Traditional Treatment for SUD Most SUD treatment in the U.S. characterized by the goal of abstinence from substance use.

12 step model/embedded culture

Majority of professionals believe abstinence is the only acceptable goal for recovery from SUD.

Abstinence rates were the primary outcome for determining SUD treatment effectiveness.

Wanting help is conflated with commitment to abstinence.

High threshold access

Archaic treatment approaches not aligned with emerging knowledge/research

Punitive measures for noncompliance - widespread practice of involuntary discharge

- Substance use disorders (SUD) are complex conditions that go far beyond mere use of substances.
- Trauma and SDOH significantly influence an individual's vulnerability to SUD and other
- Poverty and unemployment limit access to resources and create stressful existence
- Trauma, discrimination, and social isolation can lead to self medication substance abuse
- Adverse childhood experiences interfere with brain development producing diminished capacities for self regulation, difficulty with attention/focus, low self-esteem, impaired social skills, etc.
- SUD's exacerbate existing health disparities.
- Interventions must begin to factor in a wealth of critical factors to address unique needs related to economic status, education, employment, social connection, trauma, etc.

Social Determinants of Health & Trauma



- Around 2016, in response to rising rates of opioid use and overdose deaths, Congress created new opioid-specific grant programs to increase access to substance use disorder (SUD) treatment such as medication-assisted treatment (MAT) for opioid use disorder (OUD).
- The purposes of the grants were to increase access to treatment, decrease unmet treatment needs, and reduce overdose deaths through prevention, treatment, and recovery activities.
- Created necessary and important transition towards Harm Reduction services related to substance abuse throughout Shelby County community.

Help is on the way!!!

What is Harm Reduction???

Harm Reduction Defined

- Harm Reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use and other high-risk behaviors (National Harm Reduction Coalition, 2023).
- Harm reduction is an evidence-based approach that is critical to engaging with people who use drugs and equipping them with life-saving tools and information to create positive change in their lives and potentially save their lives (SAMHSA, 2023).
- Harm reduction is a practical and transformative approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower people who use drugs (and their families) with the choice to live healthy, self-directed, and purpose-filled lives (Recovery Research Institute).
 - Harm reduction emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission; improve physical, mental, and social wellbeing; and offer low barrier options for accessing health care services, including substance use and mental health disorder treatment.

Examples of Harm Reduction

EXAMPLES OF HARM REDUCTION IN OTHER AREAS





SUN SCREEN

SEAT BELTS





BIRTH CONTROL CIGARETTE FILTERS Evidence of HR Interventions

Does it really work???

- School based programs harm reduction methods proven to be more effective at reducing substance use in the short-term than abstinence-based programs.
- College Students dozens of controlled studies conclude harm reduction has long term benefits among alcohol-using college students (even those who met criteria for SUD). Pragmatic goals and nonjudgmental attitudes.
- Workplace Programs brief interventions proven to decrease drinking, reduce consequences, and improve attitudes towards changing use.
- Housing First Initiative established findings related to noncontingent housing decreased drinking, less intoxication, and avoided monthly medical/social services costs.
- Syringe Services Programs effective in reducing transmission of hepatitis/HIV/other infectious disease, increase likelihood – 5x more likely to enter treatment and 3.5x more likely to stop injecting drugs, does not increase illegal drug use and/or crime.

Examples of services available to prevent substance use related harms

- Condom Distribution/Safe Sex Education
- HIV testing/Access to PrEP medication
- Hepatitis prevention/testing/access to treatment
- Substance abuse prevention efforts
- Overdose Prevention Education/Naloxone (also known as Narcan)
- Fentanyl Test Strips
- Syringe Services Programs
- Medication-Assisted Treatment

Examples of Harm Reduction Services Established challenges negotiating demands of highly structured programs

Unmet needs

Skill deficits

Low retention rates

Lack of environmental supports

Controversial Views

Paradigm Shift

Operating in "shades of gray"

Opponents of harm reduction

Stigma in recovery communities

Challenges to Implementing Harm Reduction

MAT Stigma



1

Humanism

- Value, care, respect, and dignity for patients as people
- Acknowledging non-blaming reasons for behavior
- Genuine connection/understanding

Principals of Harm Reduction

2

Pragmatism

- None of us are capable of perfection
- Practical solutions
- Usefulness/Effectiveness

4

Autonomy

- Client is agent of change
- Patient driven care
- Shared decision making
- Reciprocal learning

3

Individualism

- People are unique (needs/strengths)
- Wide spectrum of harm and receptivity (no answer for all)
- Individualized care

5

Incrementalism

- Redefining success and how we measure change
- Celebrate small victories
- Understanding and planning for backwards movement

Harm Reduction Treatment

- Therapeutic Alliance meeting people where they are involves providing space for individualized goals related to substance use, presuming vulnerability/trauma prevalence, and preparing professionally.
- Corrective Emotional Experiences being able to truly accept someone unconditionally is where self-hate, guilt, and shame begin to heal gradually. Must remain accepting, respectful, and calm.
- Teaching Self-Regulation Strengthen ability to sit with difficult feelings/thoughts.
- Assessing Risk Ongoing collaborative conversations/ analysis of events, feelings, thoughts, urges, and choices.
- Affirming Ambivalence Accept that a part of them doesn't want to change which is completely normal. Drug use has a function.
- Setting Positive Change Goals Incremental progress builds momentum for long term success.

Myths of MAT

Trading Addictions

- MAT bridges biological and behavioral components of addiction.
- Goals are stabilization of brain chemistry, treat withdrawals/cravings, & avoid euphoria

Hinders Recovery Process

- MAT is proven to assist in improving quality of life, level of personal functioning, and ability to handle stress.
- Creates stabilization and space to work on other aspects of recovery.

Abstinence is Better

- 85% of individuals suffering from OUD relapse in abstinence-based modalities.
- MAT is the first line; gold standard for treating OUD due to its undeniable effectiveness

TN SOR Program

TN State Opioid Response (2018-2021)

Hub and Spoke system founded on the necessity of meaningful collaboration – four regional hubs across the state of TN Upper East, East, Middle, and West TN (30 providers).

Client population - 5,154 unduplicated clients

Key goal of TN SOR was to increase opioid treatment availability by expanding access to MAT and recovery support services for individuals diagnosed with OUD.

Medications – Buprenorphine, Methadone, and Naltrexone.

Various recovery support services such as case management, recovery housing, transportation, recovery skills, and relapse prevention were made readily accessible to client population.

TN SOR clients were required to complete intake, 6-month follow up, and discharge assessments.

Outcome Measures – Abstinence, Justice Involvement, Employment/Education, Social Connectedness, Health & Social Consequences, & Housing Stability,

- Target enrollments were exceeded consistently
- Relatively high retention rates
- Abstinence: 3,448 individuals had achieved abstinence at time of discharge (82% change)
- Criminal Justice Involvement: 5,081 had no criminal justice involvement in past 30 days (2.7% change)
- Employment/Education: 2,061 were either employed or enrolled in school (47% change)
- Social Connectedness: 4,751 individuals considered themselves socially connected (6% change)
- Health and Social Consequences: 3,808 clients had not experience physical, social, or emotional consequences related to substance use (75% change).
- Housing Stability: 1,618 individuals had a permanent place to live (-14.5% change)

Evidence of Change

Nora Volkow M.D.

Director of the National Institute on Drug Abuse

"Treatment programs for substance use disorders" inherited a dichotomous working definition of recovery from the 12-step world of past generations, where being completely "drug free" was not merely the gold standard but the only standard. Short of which an addicted individual was regarded as having failed or not considered to be "recovering". Yet evidence indicates that abstinence is not the only clinically relevant outcome for every individual and that alternative endpoints can contribute to recovery even when abstinence is not completely achieved."

- Era of demonization/witchcraft (1400's-1600's)
- Asylums periods of isolation (1700's)
- Prohibition (1920's) Banning substances
- Lobotomy surgically cutting connections between prefrontal cortex and frontal lobes (won Nobel Prize in Physiology and Medicine 1949)
- War on Drugs (1980's-1990's) criminalization of substance use/users

History

lesson

- Narco Farms/Lexington Cure/Free treatment allowed research on human subjects.
- Mental health issues and substance abuse were treated exclusively instead of simultaneously
- Failure to acknowledge and address trauma in treatment
- System of scapegoating and victim blaming

Helper's Oath

To, above all. do no harm

- To create safe spaces of belonging and support listening to spoken and unspoken struggle
- To avoid blame and acknowledge endless causation
- To promote self-determination and foster belief in other's ability to not only figure things out, but radically transform their existence.
- To maintain patience, empathy, and flexibility throughout people's everlasting transitions.
- To honor uniqueness and diversity by welcoming differences.
- To courageously confront existing deficits and systemic flaws negatively impacting the lives of real people.
- To maintain integrity and commit to enhanced standards of care.
- To detest complacency and challenge "status quo" syndrome.

Heroes Needed

No hero starts with an awareness of what they'll become, but simply emerges from a refusal of ignoring need, and a courage to act on the behalf of something or someone other than themselves...

What could you become in this obvious time of need if you simply became unwilling to accept the way that things are and realized your power of doing something to make it better?



2019 NSDUH Annual national report. CBHSQ Data. (n.d.).

http://www.samhsa.gov/data/report/2019-nsduh-annual-national-report

Logan, D. E., & Marlatt, G. A. (2010, February). *Harm reduction therapy: A practice-friendly review of Research*. Journal of clinical psychology. <u>https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3928290/</u>

Mancini, M. A., Linhorst, D. M., Broderick, F., & Bayliff, S. (2008). *Challenges to Implementing the Harm Reduction Approach*. Challenges to Implementing the Harm Reduction Approach.

https://www.researchgate.net/publication/233355156 Challenges to Implementing t he Harm Reduction Approach

Paquette, C. E., Daughters, S. B., & Witkiewitz, K. (2022, February). *Expanding the continuum of substance use disorder treatment: Nonabstinence approaches*. Clinical psychology review. <u>https://pubmed.ncbi.nlm.nih.gov/34864497/</u>

Tatarsky, A. (2022, October 25). *The Challenge of Harm Reduction*. Psychotherapy Networker. <u>https://www.psychotherapynetworker.org/article/challenge-harm-reduction/</u>

Volkow, N. D. (2020, February 1). *Personalizing the Treatment of Substance Use Disorders*. American Journal of Psychiatry. <u>https://aip.psychiatryonline.org/doi/10.1176/appi.aip.2019.19121284</u>

References