HARM REDUCTION & TREATMENT

Devin Reaves MSW
The mission of PAHRC is to promote the health, dignity, and human rights of individuals who use drugs and communities impacted by drug use. Recognizing that social inequity, criminalization, and stigma silence those affected most, we advocate for policies that improve the quality of life for people who use drugs, people in recovery, and their communities.
OVERVIEW

- A Snapshot of the epidemic in the Keystone State
- The System We Have is Not Working
- Harm Reduction A 4 Part Plan
- Action Plan
Learning Objectives

- Describe the risk of lethal overdose for clients during and following treatment
- Describe strategies to reduce overdose risk in the client's post-treatment
- Create an action plan to provide to their agencies well so to reduce clients' risk of lethal overdose post-treatment.
PENNSYLVANIA HAS THE 4TH HIGHEST RATE of drug overdose deaths in the USA.
WHAT IS THE PROBLEM?

- Data from the DEAs 2016 Overdose Analysis shows:
  - 2016 an estimated 4,642 people died of a drug-related overdose
  - 2016 rate of drug-related overdose deaths increased from 26.7 per 100,000 to 36.5 per 100,000
  - An opioid was present in 85% of drug-related overdose deaths
  - 2016 – 380% increase of fentanyl within toxicology reports ages 15-24
  - 2016 – 970% increase of heroin within toxicology reports ages 25-34
  - Rural counties witnessed a 42% increase in drug-related overdose deaths
  - Urban counties witnessed a 34% increase in drug-related overdose deaths
THE PROBLEM

HEROIN OVERDOSE PER 100,000

Fulton: 33.60
Allegheny: 26.9
Westmoreland: 25.7
Washington: 22.6
Beaver: 21.7
THE #1 CONTRIBUTOR

MOST PREVELANT DRUGS IN TOXICOLOGY REPORT

- Fentanyl: 25%
- Heroin: 12%
- Benzodiazepine: 13%
- Cocaine: 22%
- Opioids: 16%
- Ethanol: 9%
- Other Illicit: 3%
THE SYSTEM WE HAVE IS NOT WORKING

But what do we do?
NEED A CHANGE IN GOAL
WHAT IF THE GOAL WAS NO DEATH?
OR LESS DEATHS.
When drugs such as heroin are used repeatedly over time, tolerance may develop. Tolerance occurs when the person no longer responds to the drug in the way that person initially responded. Stated another way, it takes a higher dose of the drug to achieve the same level of response achieved initially.

For example, in the case of heroin or morphine, tolerance develops rapidly to the analgesic effects of the drug. [The development of tolerance is not addiction, although many drugs that produce tolerance also have addictive potential.] Tolerance to drugs can be produced by several different mechanisms, but in the case of opioids, tolerance develops at the level of the cellular targets. When morphine binds to opiate receptors, it triggers the inhibition of an enzyme (adenylate cyclase) that orchestrates several chemicals in the cell to maintain the firing of impulses. After repeated activation of the opiate receptor by opioids, the enzyme adapts so that the opioid can no longer cause changes in cell firing. Thus, the effect of a given dose of opioid is diminished.
Cycles of opioid abstinence and use, or even a single episode of use following a period of abstinence, can put an individual at high risk due to reduced tolerance.

Medically supervised withdrawal procedures (detox) often include the use of comfort medications, like benzodiazepines, that are sedating and increase overdose risk.

The period immediately following discharge from treatment is one of high overdose risk. Opioid tolerance is decreased, at the same time level of support is decreased and access to substances may increase. One instance of use - a lapse or “slip” - can be potentially fatal when tolerance is low.

Opioid agonist (methadone & buprenorphine) assisted treatment has a demonstrated high rate of success in reducing illicit opioid use, criminal activity, HIV transmission, and overdose among opioid addicted clients. However, the half-life is highly variable and risk of over sedation and overdose increases during changes in dosing (such as during methadone induction or discharge) or when combining with other sedating substances e.g. benzodiazepines or alcohol.
HARM REDUCTION: A 4 PART PLAN
WHAT DOES HARM REDUCTION MEAN TO YOU?
Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.
WHAT IS HARM REDUCTION?

- Reduce harms associated with drug use
- At the core of the harm reduction is the belief that the development of a substance use disorder does not negate the basic and human rights of substance users.
- Meeting people where they are at – Acknowledging the rights of substance users to determine when and how they enter recovery.
  - In the mean time? : Harm Reduction focuses on advocating for policies and interventions that keep people safe and alive until they are ready to begin their path to recovery
- Social justice movement –The Harm Reduction Movement recognizes that substance users needs are diverse and advocates for policies, resources, and interventions that can meet the diverse needs of substance users and their community.
STEP 1: SCREENING
Pre admission
In Treatment
Discharge
EXPANDED ACCESS TO NALOXONE
A PLAN TO AVOID OVERDOSE

- How can clients mitigate risk of overdose?
  - Stop using
  - Engage in treatment
  - Know your tolerance
  - If relapse, start low and go slow
  - Avoid mixing substances
  - Use when others are around
  - Keep a kit where you use
  - Train your network to call for help, rescue breathe, and administer naloxone
  - Encourage your network to get a naloxone rescue kit

- Tailor this plan to the client’s situation
CLINICAL CHANGES
HR Approach to addiction treatment: provides access to psychosocial services (i.e. therapy) and client-driven case management even if the individual is still an active substance user

- Psychosocial approaches that can be used in harm reduction settings:
  - Motivational Interviewing
  - Harm Reduction therapy

HARM REDUCTION APPROACH
NEW TREATMENT MODALITIES

Harm Reduction and Motivational Interviewing
HARM REDUCTION THERAPY (HRT)

- HRT: an approach that is founded in the acceptance that each individual requires person-centric services or care
  - Person-centric services/care:
    - Encourages each individual to make their own decision about goals for therapy and treatment
  - HRT: can help to reach substance users who have been labeled “untreatable”
    - This is due to the fact that HRT is rooted in one of the core principles of harm reduction:
      - “Meeting individual substance users where they are at”
    - HRT groups: have different goals from the traditional forms of substance use treatment groups
      - HRT group members are encouraged to determine for him or herself what they need most
      - HRT groups accept their members diversity of drug use patterns, goals, and progress toward change
MEDICATION ASSISTED TREATMENT (MAT)

• MAT: special type of harm reduction that involves meeting substance users “where they are at”. Medications are primarily used to treat substance use disorders related to opioids and alcohol.
  
  • Methadone: It is one of the oldest medications to treat opioid addiction and is a full opioid agonist, which means it fully activates opioid receptors to suppress withdrawal, block the effects of other opioids, and reduce craving. This medication must be taken every day and, because it has a high potential for abuse, it is only available through licensed opioid treatment programs.

  • Buprenorphine: This medication is a partial opioid agonist approved by the FDA in 2002. It has a lower risk of abuse, dependence, and side effects compared with methadone. It can be prescribed by a certified physician, thus eliminating the need to visit specialized treatment clinics. Buprenorphine often is offered as a combination medication with naloxone, which reduces its potential for abuse.

  • Naltrexone: This is used for the treatment of opioid dependence and alcohol use disorders. As an opioid antagonist, naltrexone blocks the effects of opioids and has demonstrated effectiveness in reducing alcohol consumption, the effects of alcohol, and cravings for alcohol. Because patient compliance can be an issue with naltrexone, the FDA has approved Vivitrol, an injectable form of naltrexone that is administered monthly.
In 2004 the city of Philadelphia began bridging the divide between harm reduction and AART in hopes of encouraging dialogue and coalition building between the two groups.

Four areas in which the integration of harm reduction and AART philosophies could lead to the transformation of Philadelphia's behavioral health care system:

- Assertive outreach and low-threshold service access points
- Recovery-oriented methadone maintenance
- Needle and syringe exchange programs that include the goals and principles of harm reduction and recovery
- Housing services that provide resources for wet, damp, and dry housing.
Listed below are 10 beliefs shared by supporters of AART and harm reduction that have assisted in bridging the divide between the two groups:

- Harm reduction-oriented services can preserve life during periods of active drug use and reduce the burdens of self, family, and community brought into a subsequent recovery process.

- Both AART and harm reduction programs have the responsibility of enhancing coping methods and increasing social supports as alcohol or drug use decelerates or ceases. Such supports are critical to prevent inadvertent harm resulting from the service intervention.

- Integrated AART and harm reduction principles and practice provide a way to reach, engage, and supportive positive change across the arenas of drug use, addiction, and recovery.

- AART and harm reduction represent not opposing strategies but approaches to reaching different populations and reaching the same individuals at various stages of their alcohol or drug use, addiction, recovery careers.

- Integrated AART and harm reduction principles and practices are particularly important for addressing multiple, severe, complex, and chronic problems that are often intergenerational.

- Shifts in drug choice and changes in the frequency, methods of administration, and contexts use can be viewed within an “all or none” view of addiction recovery or viewed as incremental experiments in problem resolution that constitute an important “recovery priming” process.
Resistance and ambivalence are a natural—not pathological—response to internal and external pressure to change deeply engrained behaviors.

Resistance and ambivalence are reduced when people have real choices and are empowered to choose.

Recovery can be achieved with or without medication support— including recovery from opioid addiction with or without methadone or buprenorphine.

Defining recovery as contingent upon cessation of medications such as methadone or buprenorphine flies in the face of scientific evidence and clinical experience and creates a “hierarchy of worthiness” that feeds stigma and discrimination against people in medication-assisted recovery.

**SHARED BELIEFS (CONTINUED)**
THE SOLUTIONS

Bringing this to your treatment setting
DEVELOPING AN ACTION PLAN
WHAT IS AN ACTION PLAN?

- It makes the vision concrete.
- It shows how you will implement strategies to attain your objectives.
WHY DEVELOP AN ACTION PLAN?

- To lend credibility plan for change.
- Don't overlook details.
- For feasibility.
- For efficiency.
- For accountability.
TIPS FOR PLANNING MEETINGS

- Be inclusive.
- Create a safe, comfortable environment.
- Prepare for possible conflict.
- Be efficient.
- Record what happens.
- Communicate the products of planning.
- Support and encourage group members.
WHO TO CONVENE FOR YOUR PLANNING GROUP

- Influential people from parts of your program including the community.
- People directly involved in the problem or issue.
- Members of grassroots organizations.
PREPARING AN ACTION PLAN

- Convene a planning group.
- Develop an action plan with action steps for all proposed changes.
- Review completed plan.
- Follow through.
- Keep everyone informed.
- Keep track of what (and how well) you’ve done.
- Celebrate accomplishments.
CONTENTS OF THE ACTION PLAN

- What action or change will occur?
- Who will carry it out?
- By when (for how long)?
- What resources are needed?
- Communication (who should know what?)
THANK YOU FOR BEING PART OF THE SOLUTION
QUESTIONS?

- Devin Reaves MSW
- 215-316-1118
- Devin@paharmreduction.org