HARM REDUCTION
Honoring drug user autonomy, improving health outcomes

NAMI Convention 2019
Meghan Hynes, MPH
basics of harm reduction

- Safer sex supplies
- Sterile injection equipment
- Naloxone
- Safer smoking and sniffing kits
- Medication Assisted Treatment
- Reduction in Use
- Drug Testing
- Housing First
- Low Threshold Drop-in Centers
- Supervised Consumption Sites
- Sobriety

meet people where they are

addiction is a health issue, not a criminal one

drug users need support, not stigma

there's more than one path to recovery

there's no recovery from a fatal overdose

the opposite of addiction is connection

not everyone is ready to stop using drugs

we can prevent death by overdose
“Drug users are often stereotyped as ignorant of the message of abstinence. But they are extremely aware of it. Drug users are closed out of most services, hunted by police and publicly derided by politicians, preachers, teachers, children and practically everyone else, including other drug users. It is undeniable that chronic drug use has many harms, and abstinence is a goal that many drug users strive for. A participant’s life may be devastated by drug use, but an outreach worker has to consider that the participant may know this already, and carry shame for it. Most of the participants I know have been in and out of treatment and recovery more than once, and already have very strong feelings of shame about the problems their drug use creates for themselves and their families.”

– Donald Grove, ACT UP
strategies for providers

Communicate honestly
Ask open-ended questions. Be honest and direct. It’s okay to ask questions and express concerns when legitimate and based on a person’s actions.

Maintain a position of non-judgment
The safer people feel in disclosing risky behaviors, the more likely they are to keep lines of communication open. Making assumptions makes…

Validate
There are many reasons why people use drugs. Often they are a tool to manage trauma, violence, health inequities or underlying behavioral health concerns. Acknowledge this, and build off prior success.

Leave your own agenda at the door
Use motivational interviewing techniques to discover and amplify what a person wants to work on and where they are at in the process. Remember, people are perceptive and they have likely been through this process before.

Create safe spaces to talk about drugs
People rarely get to explore the aspects of their use. It is important to acknowledge reasons why people DO use drugs. Can also help to find alternatives to substance use.

Unconditional Positive Regard
The more that a person’s self-determination is supported; the higher the chances they will engage in socially constructive behavior AND be empowered to make healthy changes.

Give appropriate, preferably ‘warm’ referrals when possible
Patient-centered, Efficient and Coordinated, Accessible, Safe and Confidential, Effective/competent (Patient EASE)
WHAT IS MAT?

- “Medication-Assisted Treatment”
- “Medication for Addiction Treatment”
- Gold-standard, evidence-based treatment for Substance Use Disorders
- Umbrella term for all FDA-approved treatment options
SUBSTANCE USE DISORDERS

- Alcohol
- Opioids
- Cannabis
- Sedatives/anxiolytics (Benzos-Klonopin, Xanax, Ativan)
- Stimulants (amphetamines, cocaine, meth)
- Hallucinogens (LSD, PCP, ketamine, MDMA)
- Tobacco/nicotine
- Inhalants
- “Other psychoactive substances”
SUD WITH NO MAT OPTIONS

- Alcohol
- Opioids
- Cannabis
- Sedatives/anxiolytics (Benzos-Klonopin, Xanax, Ativan)
- Stimulants (amphetamines, cocaine, meth)
- Hallucinogens (LSD, PCP, ketamine, MDMA)
- Tobacco/nicotine
- Inhalants
- “Other psychoactive substances”
MEDICATION FOR...

- Alcohol
- Opioids
- Cannabis
- Sedatives/anxiolytics (Benzos-Klonopin, Xanax, Ativan)
- Stimulants (amphetamines, cocaine, meth)
- Hallucinogens (LSD, PCP, ketamine, MDMA)
- Tobacco/nicotine
- Inhalants
- “Other psychoactive substances”
TREATMENT OPTIONS: ALCOHOL

- First-line:
  - Naltrexone (*Vivitrol*)
  - Acamprosate (*Campral*)
- Second-line:
  - Disulfiram (*Antabuse*)
TREATMENT OPTIONS: OPIOIDS

- Agonist-based
  - Methadone
  - Buprenorphine (*Suboxone*)
- Antagonist-based
  - Naltrexone (*Vivitrol*)
TREATMENT OPTIONS: TOBACCO

- Nicotine Replacement Therapy (NRT)
  - Long-acting: transdermal patch
  - Short-acting: gum, lozenge, inhaler
- Varenicline (Chantix)
- Bupropion (Wellbutrin)
TREATMENT OPTIONS: ALCOHOL

- First-line:
  - Naltrexone (*Vivitrol*)
  - Acamprosate (*Campral*)

- Second-line:
  - Disulfiram (*Antabuse*)
NALTREXONE (VIVITROL)

- Used for Alcohol and/or Opioids
- Blocks brain receptors, diminishes dopamine release when alcohol is consumed
- Evidence shows reduction in # of heavy drinking days
- Orally: one pill daily
- Injectable: one injection intramuscularly every 28-30 days
NALTREXONE (VIVITROL)

VIVITROL contains naltrexone, which:
- Is an opioid antagonist with the highest affinity for the μ-opioid receptor
- Blocks β-endorphin binding, which may prevent dopamine release

Alcohol stimulates the release of β-endorphins...

VIVITROL blocks the binding of β-endorphins to μ-opioid receptors, which may prevent dopamine release...

ACAMPROSATE (CAMPRAL)

• Reduces cravings for alcohol
• Ideally started following period of abstinence, but not required
• Evidence shows improvement in abstinence rates
• Taken orally, 2 tabs 3x/day
DISULFIRAM (ANTABUSE)

- Blocks breakdown of alcohol in body, build-up of acetaldehyde
  - Nausea, vomiting, headache, flushing, dizziness, sweating, chest pain
- Cannot be started within 12 hours of any alcohol use
- Taken orally, one pill daily
TREATMENT OPTIONS: OPIOIDS

- Agonist-based
  - Methadone
  - Buprenorphine (Suboxone)
- Antagonist-based
  - Naltrexone (Vivitrol)
HOW OPIOIDS WORK

Empty Receptor

Opioid receptor in the brain

Withdrawal Pain

GOAL OF MAT

Euphoria
Normal
Withdrawal
Tolerance & Physical Dependence
Acute use
Chronic use

MAT
FULL AGONIST OPIOIDS

Perfect fit – Maximum opioid effect.

No Withdrawal Pain

Euphoric opioid effect
METHADONE

- Full agonist opioid
- Reduces opioid cravings/withdrawals
- Only prescribed in specific clinics
- Need to return to clinic daily initially, can eventually receive “take-homes”
- Taken orally, liquid form, doses range
PARTIAL AGONIST OPIOIDS

Imperfect fit – Limited opioid effect
BUPRENORPHINE (SUBOXONE)

• Partial agonist opioid
• Reduces cravings/withdrawals
• Only prescribed by waivered providers
• Taken orally (sublingual films/tabs) or via monthly injection (Sublocade)
• Combined with antagonist (naloxone) to deter misuse
• Need to be in active opioid withdrawal before starting
NALTREXONE (VIVITROL)

• Antagonist – full blocker
• Prevents other opioids from reaching brain receptors
• Must wait 7 days after any opioid use before starting treatment
• Increased risk with relapse – lower opioid tolerance, higher risk of OD
BUPRENOORPINE WAIVER

• Buprenorphine requires providers complete waiver training before prescribing
  • 8 hours (MD/DO) and 24 hours (NP/PA)
• Limits set on # of patients in care
• France case study
  • Waiver requirement lifted → 10x more pts Rxed MAT → fatal OD down 79% in 3 years
• Mainstreaming Addiction Treatment Act of 2019 introduced in House on 5/2/19
TREATMENT OPTIONS: TOBACCO

- Nicotine Replacement Therapy (NRT)
  - Long-acting: transdermal patch
  - Short-acting: gum, lozenge, inhaler
- Varenicline (*Chantix*)
- Bupropion (*Wellbutrin*)
NICOTINE REPLACEMENT THERAPY

- Available in various forms
  - Patch, gum, lozenge, inhaler
- Recommended: combination of long/short-acting forms
- Well-tolerated, minimal side effects
VARENICLINE (CHANTIX)

• Blocks nicotine from binding to receptors, reduces rewards of smoking
• Potential side effects: nausea, insomnia, vivid dreams
• Evidence: shown to be more effective than other treatment options
• Taken orally, one tablet twice daily
BUPROPION (WELLBUTRIN)

- Developed as an antidepressant, but also used for smoking cessation, ADHD
- Reduces cravings, withdrawals
- Well-tolerated, but can have side effects
- Taken orally, one tab twice daily
- Used cautiously if:
  - History of seizures, depression, bipolar
TREATMENT OUTCOMES

- Extended periods of sobriety
- Increased engagement with BH
- Decreased risks when transitioning from detox/rehab, incarceration, or any period of full abstinence
- Utilization of harm reduction resources
- Detection of co-occurring infections (Hep C, HIV)
- Opportunities to decrease transmission (i.e. PrEP)
- Improved treatment outcomes of other conditions
- Decreased rates of criminal activity
REPLACING ONE ADDICTION WITH ANOTHER?

- Important to recognize ways that Opioid Addiction is unique
  - Fatality
  - Risks of relapse
  - Proven benefits of reducing:
    - Cravings and withdrawal symptoms
    - Transmission of infectious disease
    - Criminal activity
  - Proven to improve treatment success and general quality of life
QUESTIONS?