HARM REDUCTION & THE OPIOID EPIDEMIC

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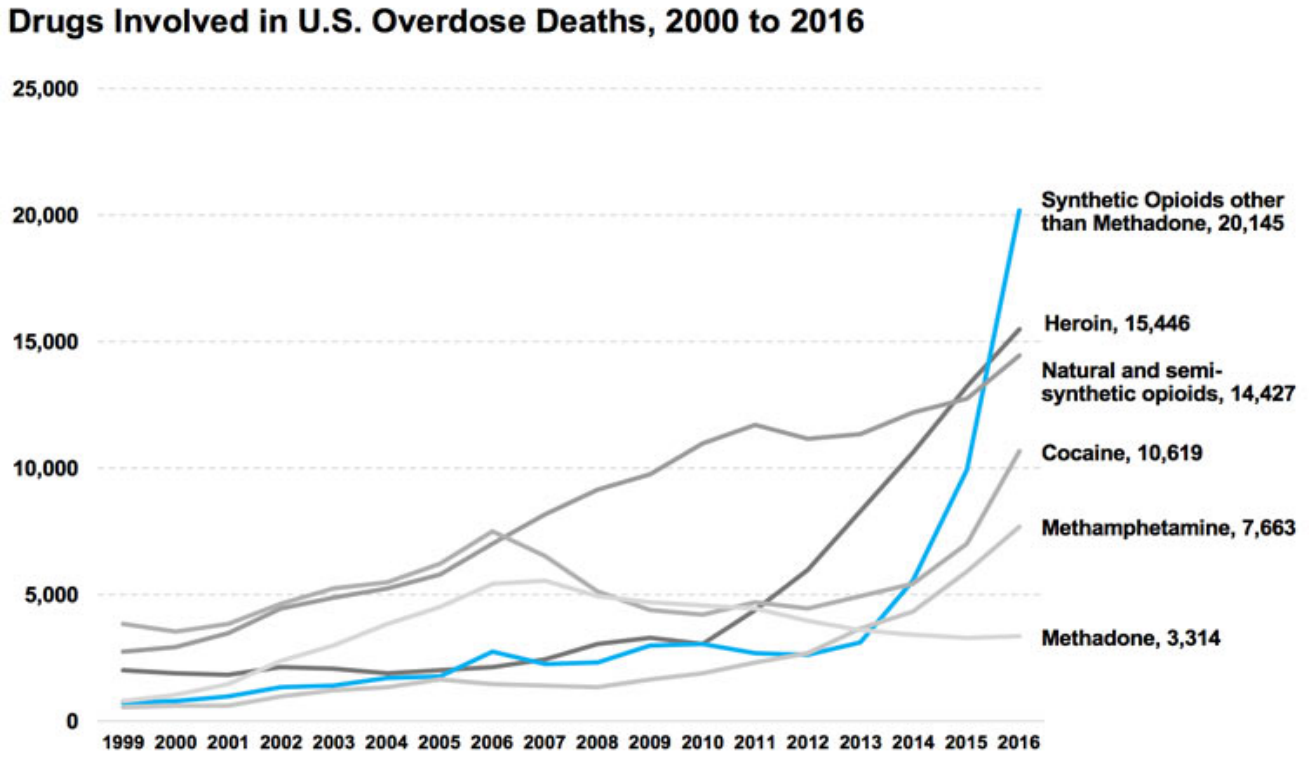
NO OVERDOSE BATON ROUGE

- Formed in late 2013
- Community education
- Naloxone distribution
- Syringe access
- Advocacy and policy

THE CURRENT STATE OF THE OPIOID EPIDEMIC

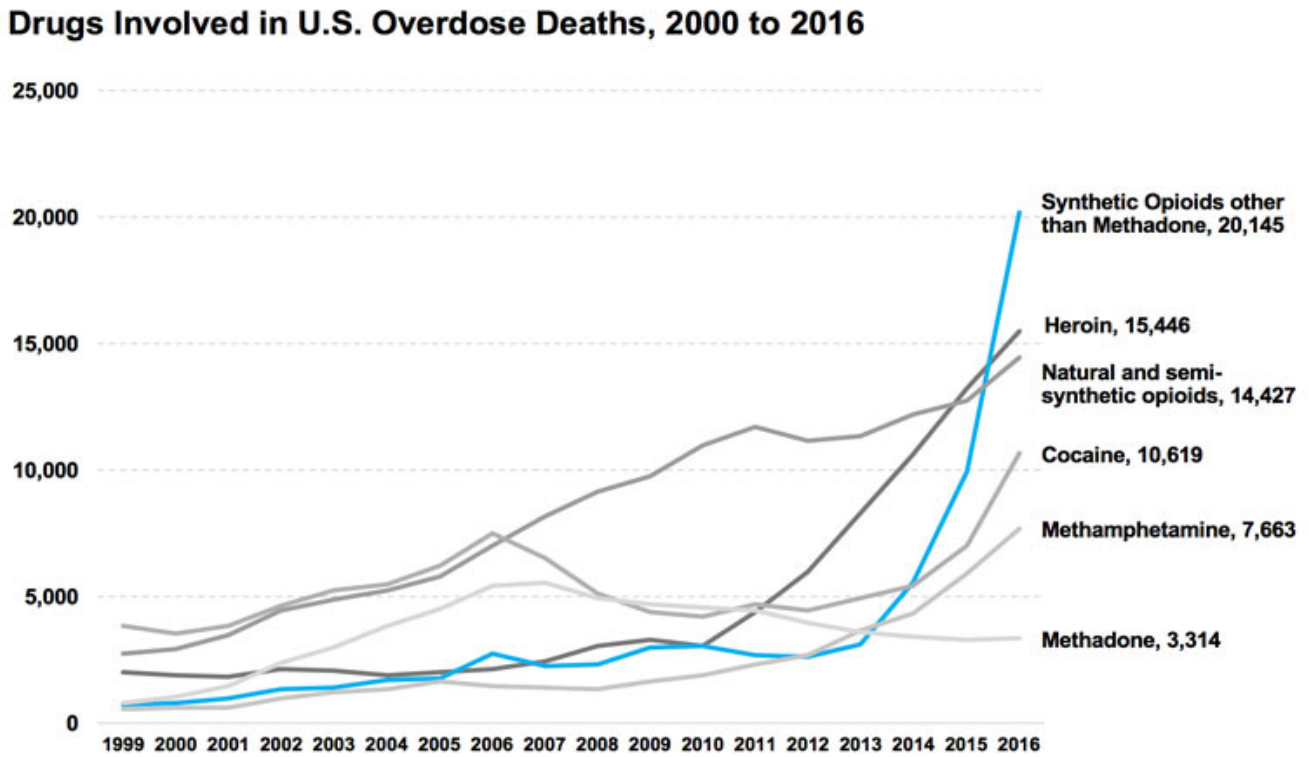
OVERDOSE DEATH TRENDS: THE CURRENT U.S. EPIDEMIC

- Overdose is the **leading cause of accidental death** in the U.S.
  - **5x higher** in 2016 than in 1999
- 2016: The number of overdose deaths surpassed the death toll from HIV at the peak of the HIV epidemic in 1995
  - >42,000 of the 53,000 OD deaths in 2016 involved



OVERDOSE DEATH TRENDS: THE CURRENT U.S. EPIDEMIC

- 2014-2015: Death rate from synthetic opioids (other than methadone) increased by 72.2%
- Increased presence of fentanyl in street drugs
- Heroin death rates also increased by 20.6%



FENTANYL

- Synthetic opioid that is **50x** more potent than heroin and **100x** more potent than morphine
- Illicitly manufactured fentanyl cut and mixed with other opioids has led to a dramatic increase in overdose deaths

OBSTACLES FACED BY DRUG USERS

- DRUG-RELATED STIGMA
- Risk of incarceration
- Barriers to employment, health care, housing, education and assistance
- Drug treatment: one-size-fits-all approach, moral over evidence-based

FEAR OF ARREST

- Only in about **half** of personal or witnessed overdose experiences did someone call 911 or seek medical assistance
- Fear of arrest cited as primary reason

WHAT IS HARM REDUCTION?

HARM REDUCTION = COMMON SENSE

- Pragmatic, evidence-based approach to dealing with substance use
- Aims to mitigate harmful consequences of drug use
- Respect and affirm dignity of people who use drugs
- “Meet people where they’re at”

HARM REDUCTION INTERVENTIONS

- Overdose prevention/naloxone distribution programs
- Syringe exchange programs
- Safe injection facilities
- Opioid replacement therapy
- Housing first

A BRIEF HISTORY OF HARM REDUCTION

- 1970s-1980s: Community responses to reducing transmission of HIV and Hepatitis
- 1980s: First syringe access programs
- 2000s: Buprenorphine and naltrexone prescribed for opioid dependence

HISTORICAL CHALLENGES

- Opposition from federal government
- Many people condemned the use of certain drugs associated with stigmatized minority groups
- Policy and science favored abstinence as the only effective solution
- Researchers viewed as a disease; general public viewed as a moral failing

HARM REDUCTION TODAY

- Over 300 syringe service programs in 39 states in the U.S., Washington D.C. and Puerto Rico
- Many offer services including condom distribution, treatment referrals, counseling and testing for HIV and Hepatitis, overdose education and naloxone distribution
- HR strategies now expanding to other healthcare settings

HARM REDUCTION CHALLENGES TODAY

- Many people in rural and suburban areas lack access to harm reduction programs
- Can collect data on distribution of supplies but documenting overdose reversals is difficult
- Government grants fund naloxone distribution for emergency responders but not laypeople

KEY CONCEPTS OF HARM REDUCTION

RESPECT & DIGNITY

- Drug use is not wrong or immoral
- People who use drugs are more than their drug use
- Listen to and affirm the person’s feelings and experiences
- Build relationships and trust

PRAGMATISM

- Drug use results from individual and environmental circumstances
- Drug use can meet important needs
- Strive to understand why this person uses and what they get out of using
- Avoid unrealistic expectations—no one has “perfect” health behaviors

DRUG USE ≠ HARM

- Harm is relative, and not all use is chaotic
- Drug user has an intimate, complex relationship with drug(s), may involve both benefits and risks
- Focus on negative consequences of use rather than assuming that all use is harmful
- Deconstruct the person’s drug use—determine what they find problematic

AUTONOMY

- Listen to the person’s needs
- Value the person’s expertise and life experience
- Involve the person in decision-making, goal-setting and treatment plan
- Self-efficacy inspires motivation, leading to growth and change

INDIVIDUALIZED TREATMENT PLANS

- Offer a range of options to ensure best outcomes
- Abstinence is one of many possible goals
- Work together to come up with a tailored plan based on their strengths and abilities
- Help motivate the person to make progress toward the goals you set together

ANY POSITIVE CHANGE

- Prioritize improvement of quality of life rather than cessation of all drug use
- Incremental change is better than no change at all
- Measure progress in health, social and economic outcomes rather than changes in use

ACCEPTANCE

- Backtracking is part of the process
- Do not punish or reject for not achieving goals
- Use positive reinforcement, focus on what the person is doing well
- Avoid judgment or condemnation
- There should be no requirements for treatment

SUMMARY OF PRINCIPLES

- Drug abuse is a **health** concern, not a legal or moral issue
- Not all drug use is abuse
- People use drugs for specific reasons
- Drug use occurs on a continuum from mild to severe—harm is relative
- Incremental change is normal and motivation is fluid

HARM REDUCTION PRACTICES

KEY SYSTEMATIC DIFFERENCES

	TRADITIONAL MEDICAL MODEL	HARM REDUCTION MODEL
STRUCTURAL PHILOSOPHY	Hierarchical chain of command with provider as expert	Inclusion; community decision-making; process
SYSTEM DESIGN	Provider designates procedures for care	Low threshold for care access; focus on reciprocal learning; patient-driven care
PROVIDER PERSPECTIVE ON APPROACH TO CARE	Expert knowledge	Continuously question assumptions; avoid judgment; be attentive to patient needs
PROVIDER ROLE	Prescribe treatment; seek compliance and adherence	Collaborative decision-making; patient education
USER ROLE	Accept and comply with treatment recommendations	Understand options, active involvement in care choices, strive for incremental changes to reduce harms
LOCUS OF CONTROL	Physician-centered	User-centered

HOW MEDICAL PROFESSIONALS CAN PRACTICE HARM REDUCTION

- Encourage people to take small steps forward to reduce the harmful effects of drug use, particularly overdose, HIV, hepatitis C and other blood-borne infections
- Make support and compassionate care accessible
- Listen in order to build trust and look for teachable moments
- Share medical knowledge, skills, and items people can use on their own or when they are helping others

HOW MEDICAL PROFESSIONALS CAN PRACTICE HARM REDUCTION

- Help people make small changes that have tangible results
- Learn as much as possible about people’s decision-making and life circumstances and support the whole person
- Consider the root causes of people’s health issues
- Focus on the person instead of the behavior and point out what they are doing well
- Refer people to community resources

OTHER RECOMMENDATIONS

- Provide staff with educational sessions and training workshops in harm reduction and overdose prevention
- Use motivational interviewing techniques with clients
- Ensure agency is equipped to provide trauma-informed care

QUESTIONS?

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