

HARM REDUCTION

Honoring drug user autonomy,
improving health outcomes

NAMI Convention 2019
Meghan Hynes, MPH

basics of harm reduction

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

- ❖ 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

stigma

“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



Language Matters!

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)

Responses to Substance Use: Medication-Assisted Treatment (MAT)

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October 26th, 2019

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)**
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- **“Other psychoactive substances”**

MEDICATION FOR...

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- **Opioids**
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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*)

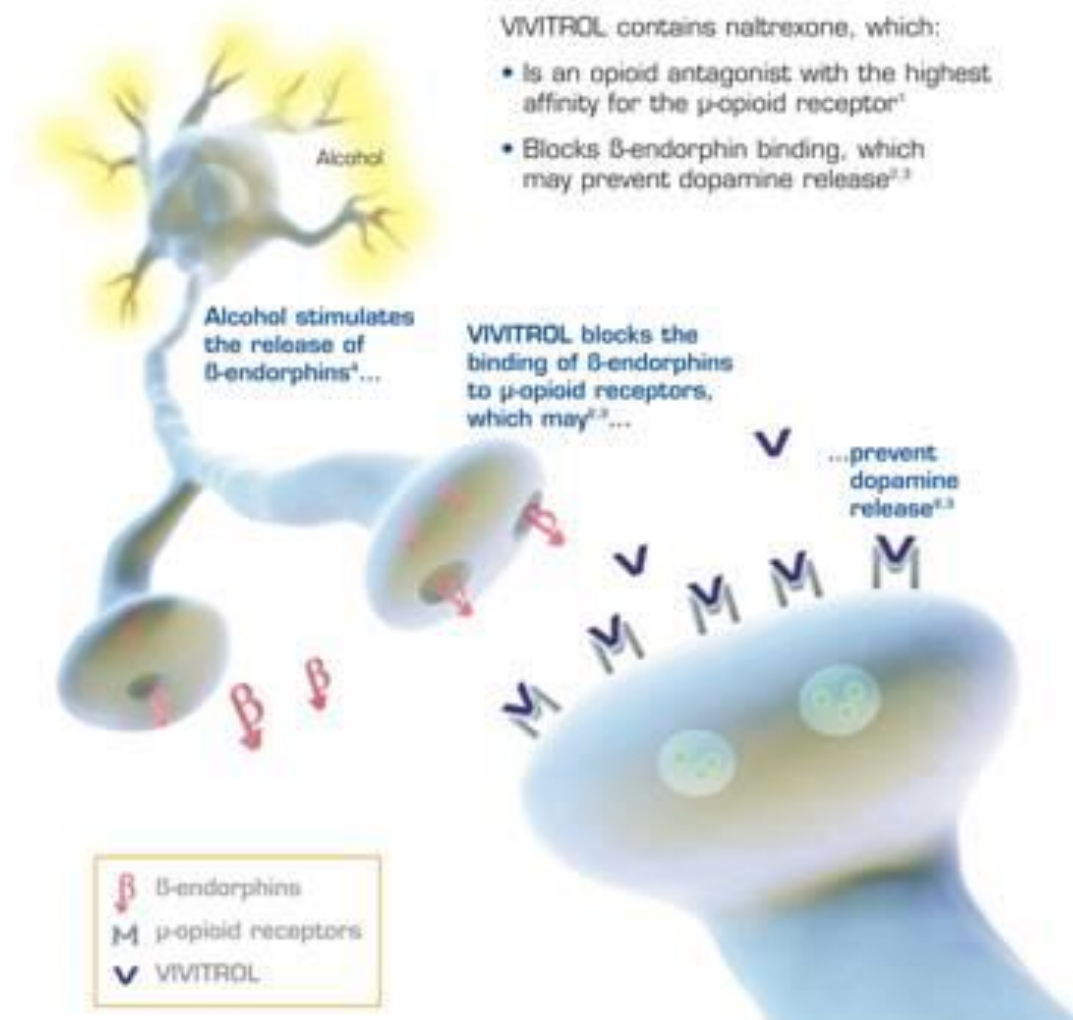
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NALTREXONE (VIVITROL)

- 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)



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

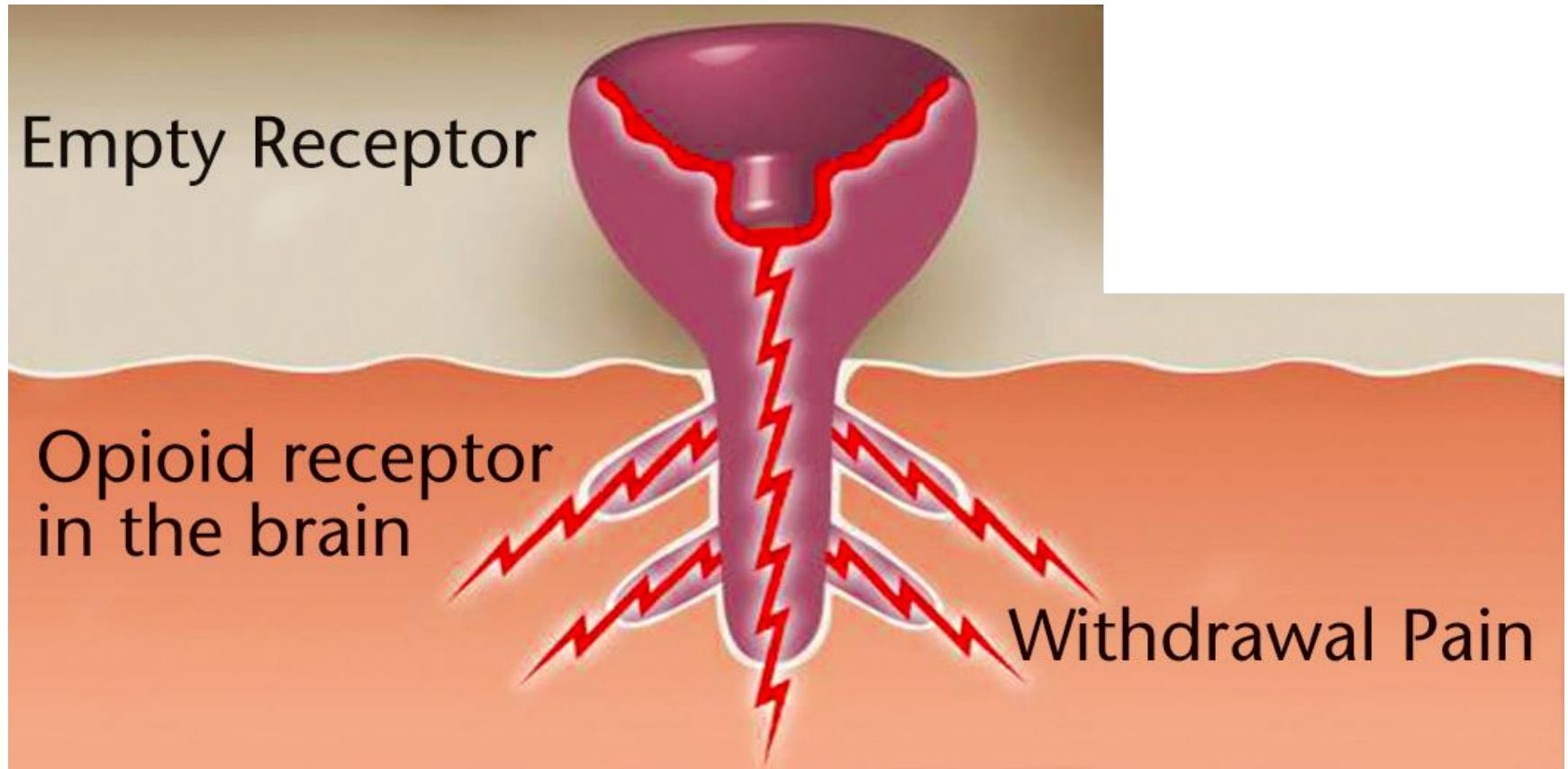
DISULFIRAM (ANTABUSE)

- 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

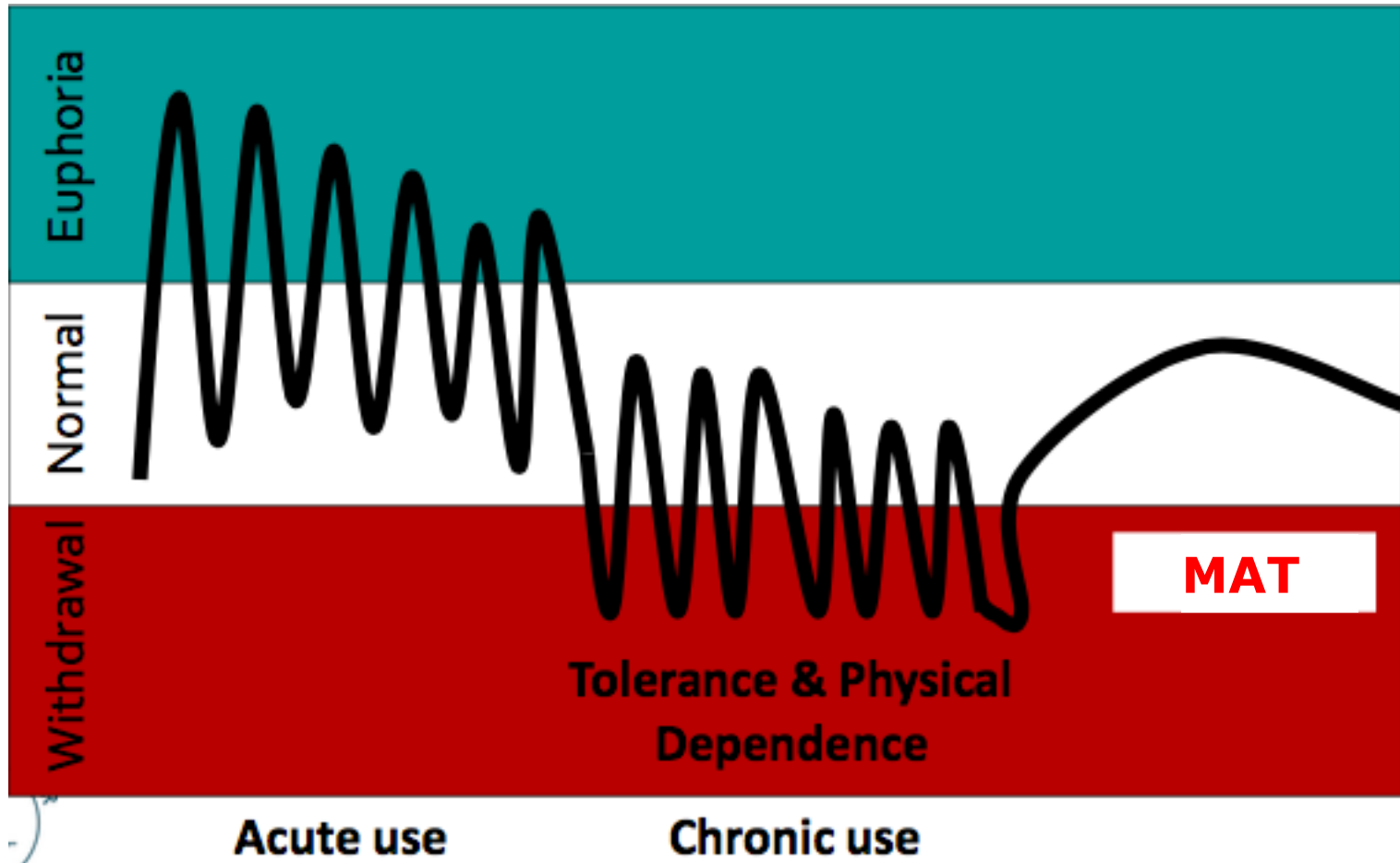
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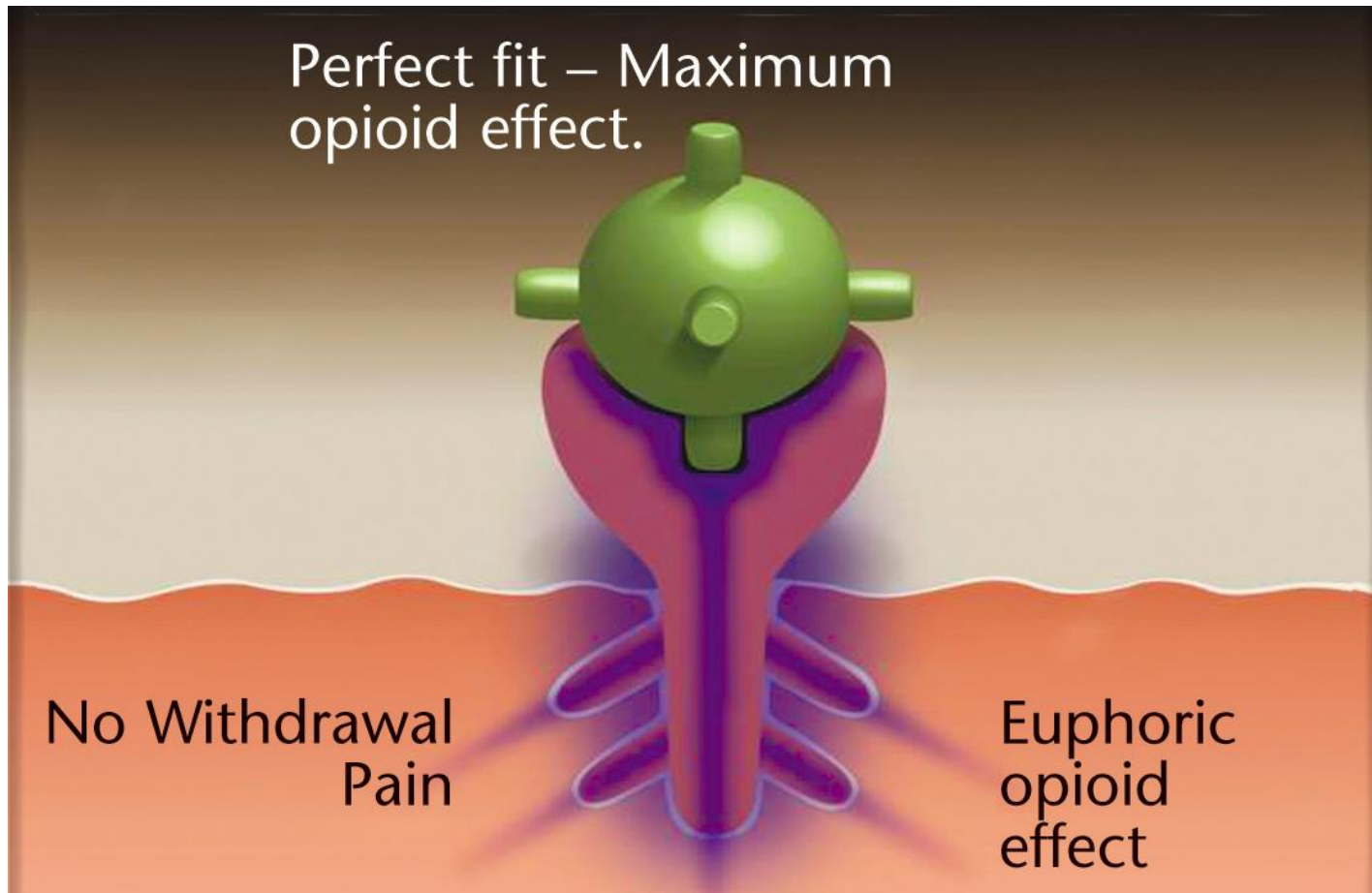
HOW OPIOIDS WORK



GOAL OF MAT



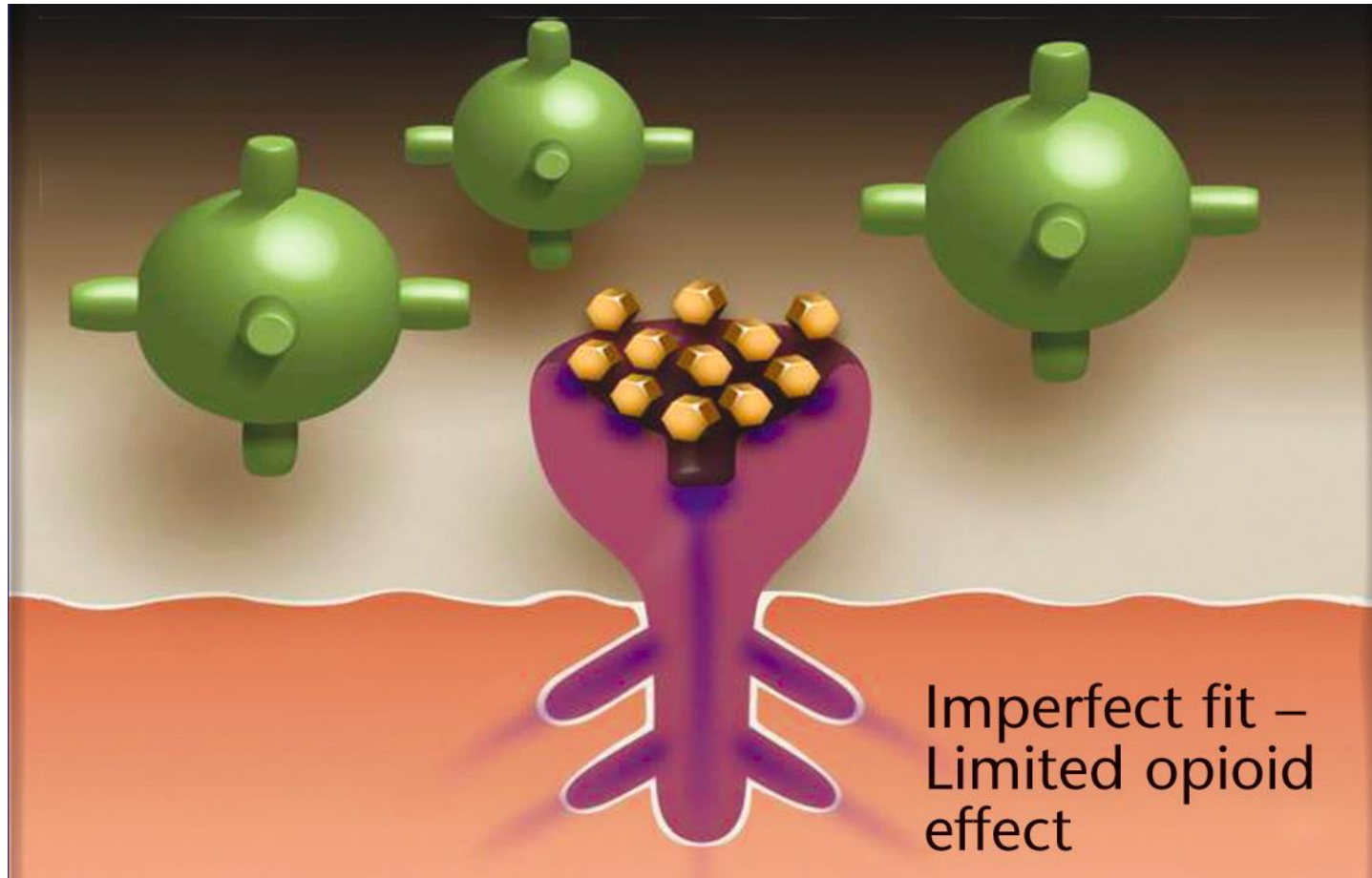
FULL AGONIST OPIOIDS



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



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

BUPRENORPHINE 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

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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?