Harm Reduction Is Treatment

Risk Reduction Best Practices for Emergency Medical Providers
OVERVIEW

- HARM REDUCTION
- STIGMA IN HEALTHCARE SETTINGS
- EVIDENCE-BASED RISK REDUCTION PRACTICES
- NEXT STEPS
HARM REDUCTION
Perceived need for substance use treatment among people aged 12 or older who needed but did not receive substance use treatment in the past year: 2015

- Perceived a need: 5.0%
- Did not perceive a need: 95.0%

WHAT DOES HARM REDUCTION DO?

- Focuses NOT on use, but rather on reducing negative consequences.
- Acknowledges individuals as the experts on their own care.
- Recognizes that use & recovery exist along a continuum.
- Supports ANY POSITIVE CHANGE.

Source: http://harmreduction.org/about-us/principles-of-harm-reduction
HARM REDUCTION IS TREATMENT!

- RIGHT treatment
- THIS patient
- THIS time
- Guided by individualized goals
STIGMA
WHAT IS STIGMA?

a mark of disgrace associated with a particular circumstance, quality, or person

Stigma permeates every aspect of a marginalized person’s life – relationships, healthcare, housing, employment, and education.

Source: https://languages.oup.com/google-dictionary-en/
**STIGMA LEADS TO HEALTH DISPARITIES:**

**HIV**
Global prevalence among PWID 28x higher

50-90% of PWUD living with HIV also have HCV

**HEPATITIS C**
53% of PWID, 70-90% of older & former PWID

**INCARCERATION**
2.3 million in 2018 (198,000 for drug offenses)

58% of PWID have been incarcerated.

**ARREST**
1,632,921 in 2017 (86% of those for possession)

**ENDOCARDITIS**
20% of people who inject opioids predicted to die from endocarditis by 2030.

**EDUCATION**
Financial aid denied for students w/ drug convictions

**HOUSING**
Federal policies allow for discrimination against people with substance use histories

## STIGMA IN HEALTHCARE

<table>
<thead>
<tr>
<th>Language</th>
<th>Junkies, addicted, frequent flyers, drug-seeking</th>
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<tbody>
<tr>
<td>Avoidance</td>
<td>EMS response times, combative patients</td>
</tr>
<tr>
<td>Inadequate pain control</td>
<td>People with substance use history, Black people</td>
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RISK REDUCTION PRACTICES
Experiencing an overdose is a crucial risk factor for experiencing another overdose.

• Harm reduction education can prevent future overdose.

• Assess readiness to change prior to release and treat accordingly.

• Take-Home Naloxone Kits are safe, accessible, and empowering.

• Follow-up to show you truly care.

RISK FACTORS FOR OVERDOSE

- Mixing drugs
- Variation in purity
- Tolerance changes
- Using alone
- Physical health
Why EMS?
Encounter with EMS: Missed opportunity?

A single county in WA:

- Matched all fatal OD’s in 2018 to EMS data
- Found that 40% of decedents had at least one encounter with EMS in the year prior to fatal OD
- Majority of their chief complaints were related to drugs or alcohol

North Carolina:

- A similar retrospective study
- Nearly 1/3 of individuals who died from accidental opioid OD used EMS in the year before their death
EMS reversal = Poor prognostic factor

Boston:
10% estimated one-year mortality

North Carolina:
13-fold increase in one-year mortality compared to the general population
Retrospective cohort study of 3,085 patients
One-year mortality was 12% in those who responded

OEND Programs work

• Effectively train people how to recognize an OD and administer naloxone

• Participants more likely to reduce opioid use and enter treatment

• Reduce fatal ODs

• May be particularly effective in populations that may delay called 911 due to fear of arrest

Medical risks associated with naloxone administration are low

Most common adverse event is withdrawal

Pulmonary edema is extremely rare

It appears that individuals who receive naloxone but do not receive additional medical care are not at increased risk of negative outcomes:

- A 2003 study of 5 years of data in San Diego found no deaths in the 12 hours after patients who were administered naloxone by EMS refused transport to the hospital (n=998).
- A 2005 study from Finland found no life-threatening events in the 12 hours after overdose patients (n=84) were treated prehospital and refused further treatment, which lead the authors to conclude that permitting “presumed heroin overdose patients to sign out after pre-hospital care with naloxone is safe”
- A 2011 retroactive study of 20 months of data from San Antonio found no evidence that any patients who had been administered naloxone and refused transport died in the next 48 hours (n=542).

Liability?

Some prescribers worried that prescribing naloxone may increase their risk of civil liability

**Burris et al’s Legal review:**

- Every tort claimant must establish that he or she suffered an *injury* actually caused by the *negligence* of the defendant health-care provider.

- **Negligence?**
  - Naloxone has long been the standard of care for reversing opiate overdose.
  - It would be virtually impossible for a plaintiff to get a claim that it was not to a jury, let alone to prevail.

- **Harm?**
  - No – naloxone is extremely safe, and can’t blame prescriber for pt’s decision to use

Source: Beletsky et al., 2007; Burris et al., 2009.
OPIOID EDUCATION/NALOXONE DISTRIBUTION ORDER

INCLUSION

- Patient who overdosed on opioids, now s/p reversal with Naloxone
- Patient who is at risk of opioid overdose
  - History of illicit drug use or prescription opioids
  - Physical exam findings of IVDU (track marks)
  - Physical environment with illicit opioids or paraphernalia, multiple, or high-dose prescription opioids present
- Bystander who is in close contact with persons at risk of opioid overdose

Orders

- Provide a kit
  - Naloxone IM (three 1mL vials of 0.4mg/mL), three 3cc syringes with 25g x 1” needles or
  - Naloxone IN (two sprays, each containing 4mg/0.1 mL)
- Provide overdose recognition and response training
- Explain various options for treatment of opioid use disorder and provide follow-up information

Offer to make any of the following referrals:

- HOPE
- Community Medical Services (Nogales, Sierra Vista, & Tucson)
- Mariposa Community Health Center (Nogales, Tubac, Patagonia, Rio Rico)
<table>
<thead>
<tr>
<th>OPIOID HIGH</th>
<th>OPIOID OVERDOSE</th>
</tr>
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<tbody>
<tr>
<td>Muscles become relaxed</td>
<td>Pale or gray, clammy skin</td>
</tr>
<tr>
<td>Speech is slowed or slurred</td>
<td>Breathing is infrequent or has stopped</td>
</tr>
<tr>
<td>Sleepy looking</td>
<td>Deep snoring, gurgling, or rattling</td>
</tr>
<tr>
<td>Responsive to shouting, sternal rub, or earlobe pinch</td>
<td>Unresponsive to any stimuli</td>
</tr>
<tr>
<td>Normal heart rate and/or pulse</td>
<td>Slow or no heart rate and/or pulse</td>
</tr>
<tr>
<td>Normal skin tone</td>
<td>Blue or gray lips and/or fingertips</td>
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RESPONDING TO AN OPIOID OVERDOSE

1. Sternum rub
2. Call 911
3. Administer naloxone, if on hand
4. Rescue breathe
Step an Opioid Overdose Using Naloxone

1. Remove the needle and needle shield.
2. Unplastic wrap the syringe.
3. Remove the needle at a 90-degree angle, straight into the buttocks, hips, or upper arm. Push down until you have administer all the liquid into the syringe.

SPW NUMBERS
January 2017 – February 2021

499,270 Naloxone doses

13,871 Reported overdose reversals*

*Reflects overdose reversals directly reported to Sonoran Prevention Works
MEDICATIONS FOR OPIOID USE DISORDER

(MOUD, aka Medications for Addiction Treatment aka MAT)
MOUD decreases mortality

- Meta-analysis of 19 cohorts
- Followed:
  122,885 people treated with methadone over 1.3-13.9 years
  15,831 people treated with buprenorphine over 1.1-4.5 years.
- Retention in methadone and buprenorphine treatment is associated with substantial reductions in the risk for all-cause and overdose mortality in people dependent on opioids

MOUD reduces (some) risky behaviors

- Thirty-eight studies, involving some 12,400 participants, were included

- Majority were descriptive studies

- MAT reduces:
  - Illicit opioid use
  - Injecting use
  - Sharing of injecting equipment
  - Number of sexual partners
  - Exchange of sex for drugs/money

Replacing one drug with another?

Addiction is more than just dependence

Bupe and Methadone are legal and regulated
  We know what is in them = safer
  Don’t have to illicitly obtain them = safer
  Have a team supporting the patient = safer

What about abstinence?

“Compared with use of α2-adrenergic agonists or psychosocial treatment alone, opioid agonist treatment with buprenorphine–naloxone or methadone has proven superior in terms of retention in treatment, sustained abstinence from illicit opioid use, and reduced risk of morbidity and death.”

Source: 2018 - Management of opioid use disorders: a national clinical practice guideline
Do people stay on MOUD for life?
Taper vs Ongoing Treatment

Can we prescribe without guaranteed counseling?

Reviews - 3 prominent reviews and 27 recent studies

Wide range of psychosocial methods used, but most seemed to enhance clinical outcomes

Most of the studies looked at methadone, and not bupe

Benefit of concurrent psychosocial interventions with bupe was less robust

Some studies show no difference

“Providers should not link the initiation of MAT to the immediate availability of or patient willingness to participate in counseling.”

If your patient is ready, be there!
COWS (Clinical Opiate Withdrawal Scale)

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Scores</th>
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<tbody>
<tr>
<td>Resting pulse rate</td>
<td>0-4</td>
</tr>
<tr>
<td>Diaphoresis</td>
<td>0-4</td>
</tr>
<tr>
<td>Restlessness</td>
<td>0-5</td>
</tr>
<tr>
<td>Pupil size</td>
<td>0-5</td>
</tr>
<tr>
<td>Bone or joint aches</td>
<td>0-4</td>
</tr>
<tr>
<td>Runny nose or tearing</td>
<td>0-4</td>
</tr>
<tr>
<td>GI upset (n/v/d)</td>
<td>0-5</td>
</tr>
<tr>
<td>Tremor (outstretched hands)</td>
<td>0-4</td>
</tr>
<tr>
<td>Yawning</td>
<td>0-4</td>
</tr>
<tr>
<td>Anxiety/irritability</td>
<td>0-4</td>
</tr>
<tr>
<td>Gooseflesh skin</td>
<td>0-5</td>
</tr>
</tbody>
</table>

5-12: Mild  
13-24: Moderate  
25-36: Severe
Lived experience >> What you learned in school

- Substance use vernacular is often hyperlocal, and decidedly NOT clinical.
- Real empathy is possible.
- Potential for ongoing support / connection / fellowship.
- HOPE for a brighter path forward.

https://www.theiacp.org/sites/default/files/SJCResponding%20to%20Individuals.pdf
Hint: Referrals aren’t good enough.

- “Warm hand-offs”
- Don’t forget about social determinants of health.
- Arizonans are a highly traumatized lot.
- SSPs are also treatment.

SYRINGE SERVICES

It’s SO not just about the needles.

- Safe disposal
- Built-in peer support
- Linkages to care

FACT: People who use syringe service programs are MORE likely to stop injecting!

NOW WHAT?
THANK YOU!

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