TRANSFORMING CLINICAL ATTITUDES: EVERYTHING IS HARM REDUCTION

LAURA HASELDEN, MD MPM

DISCLOSURES AND A DISCLAIMER

- No relevant financial disclosures.

- Harm reduction as a mainstream medical/clinical endeavor is a different discussion than harm reduction as an absolute entity. I am not an expert in the excellent on-the-ground harm reduction that has been occurring for generations, but as a recent graduate of our medical education system, will attempt to contextualize the philosophy, scope, and strategy of harm reduction for a clinical audience that is largely not exposed to this field.

OBJECTIVES

- Define harm reduction as a philosophy that applies to all aspects of clinical care
- Review clinical rationale and evidence base for harm reduction in PWUD
- Demonstrate strategies for incorporation of harm reduction principles for everyday clinical practice
- Discuss stigma as a major impediment to health and equitable healthcare
- Explore solutions at the micro and macro level to narrow healthcare disparities

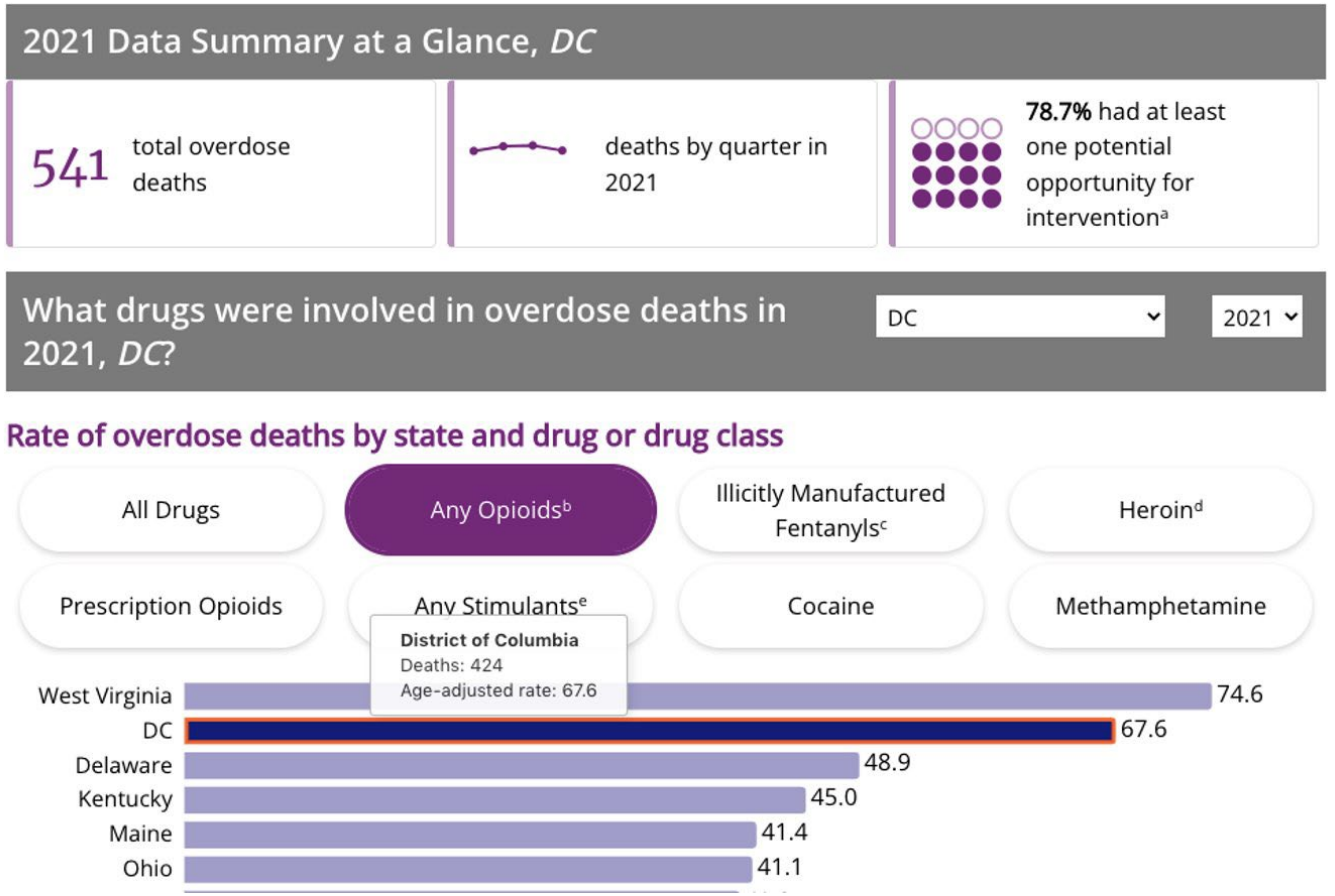
TERMS:

- MOUD vs MBT
- Patients vs PWUD vs PWID
- Drugs
- OTP vs methadone clinic
- Any brand name referenced is used due to its popular use in this field, and is not endorsement of that specific product.

STATE OF SUBSTANCE USE

- 101,751 annual overdose deaths reported (Oct 2022)
- 66.8% of OD deaths in 2021 had potential for intervention
- $1,021 billion (OUD + OD) total healthcare costs (US)
- 87% of all patients don’t get treatment for opioid use disorder

SUBSTANCE USE IN DC



HOW CAN WE DO BETTER?
HARM REDUCTION - NOT A DIRTY WORD

HARM REDUCTION IS CONTENTIOUS

- Biden's "crack pipes"
- Syringe Service Programs
- Supervised consumption sites
- Fentanyl test strips

The New York Times

Uproar Over 'Crack Pipes' Puts Biden Drug Strategy at Risk

President Biden has made "harm reduction" a central pillar of his plan to fight a record number of drug-related deaths, but a conservative backlash is threatening the effort.

HARM REDUCTION INTERNATIONAL:

WHO WE ARE

WHAT IS HARM REDUCTION?

Harm reduction refers to policies, programmes and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies and drug laws.

Harm reduction is grounded in justice and human rights. It focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that people stop using drugs as a precondition of support.

HARM REDUCTION VS. MEDICINE

Principles of Harm Reduction

- Humanism
- Pragmatism
- Individualism
- Autonomy
- Incrementalism
- Accountability without termination

Principles of Medical Ethics

- Beneficence
  - Informed consent
  - Truth-telling
  - Confidentiality
- Nonmaleficence
- Autonomy
- Justice

EVERYTHING WE DO IN MEDICINE IS HARM REDUCTION

- BP medication
- Diabetes medication… or diet adjustments
- Surgery
- CPR

HARM REDUCTION IN SUBSTANCE USE IS A SPECTRUM

- Information on safer drug use
- Drug consumption rooms
- Needle and syringe programs
- Overdose prevention and reversal
- Drug checking
- Opioid agonist therapy/MOUD
- Housing
- Legal/paralegal services

- Humanization & destigmatization
- Autonomy in medical decisions
- Minimally disruptive medicine
- Equity & intersectionality re: SDOH
- Decriminalization and decarceration
- Hospital policy
- Legal policy

CLINICAL HARM REDUCTION

SAFER DRUG USE, OVERDOSE REVERSAL, MOUD, WOUND CARE, INFECTIOUS DISEASE MANAGEMENT

MEDICATION BASED TREATMENT

- Buprenorphine
- Methadone
- Naltrexone
- Internationally: full agonist therapy (prescribed heroin)
- Gabapentin, naltrexone (alcohol use disorder)

OVERDOSE PREVENTION AND REVERSAL

- Naloxone
- Supervised consumption sites
- Drug checking

DRUG TESTING

- Fentanyl test strips
  - With counseling: start low, go slow, give a tester shot, use with friends, have Narcan available
  - In DC/Baltimore region, most of supply contains fentanyl – less useful
  - Testing non-opioid substances (stimulants, benzos)
- Xylazine test strips
- Population health drug surveillance
  - Iso vs xylazine
  - Evolving threats

WOUND CARE AND INFECTIOUS DISEASE MANAGEMENT

- Local wound care
- HIV PrEP
- HIV treatment + risk reduction
- HCV treatment
- Cannot separate treatment of infectious disease from prevention of infectious disease
  - Safer cooking and injection practices
  - Alternate routes of administration
  - Safe supply: needles, cookers, syringes, substances

SAFER COOKING

- Sterile acid + appropriate pH (venous sclerosis, infection, injury)
  - Citric and ascorbic acid vs. vinegar or lemon juice
- Sterile water (SSTI)
- Sterile cookers + filters (Hep C)

SAFER INJECTION

- Single use syringes + needles (HIV, HCV, SSTI)
- Bevel up (reduced soft tissue trauma)
- Alcohol or soap + water prep (SSTI)
- Tourniquet (soft tissue injury)

*available at most syringe service programs

INJECTION SITE SELECTION AND ALTERNATE ROUTES

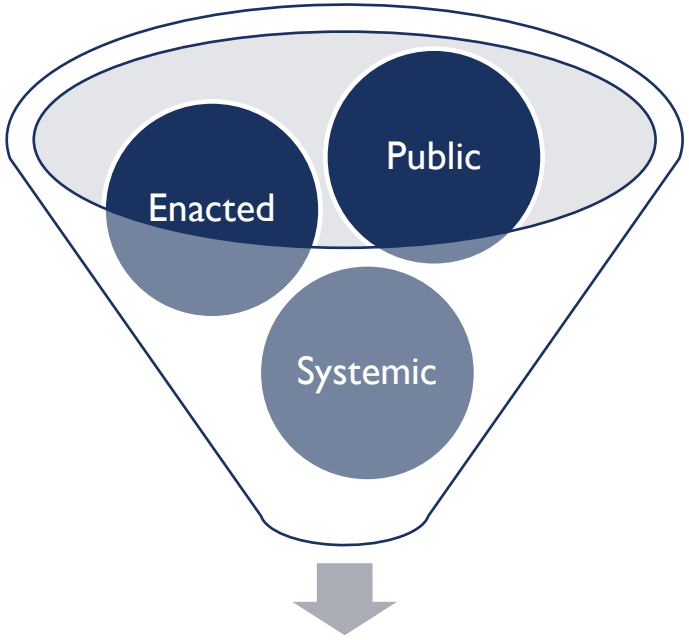
- IV vs. subcutaneous (bacteremia/endocarditis vs. SSTI)
- Large vessel injection (pseudoaneurysms, arterial injection, ischemia)
- Smoking pressed fentanyl pills vs. injecting (injection injuries)
- Pipe access reduces injection use and reduce health harms (cuts, burns, HIV)
- Rectal administration (boofing, plugging, booty bumping) – alternative to injection
- Higher stigma towards and within PWID amongst PWUD – changing route reduces stigma

https://nextdistro.org/
https://www.hips.org/

SOCIAL AND ETHICAL HARM REDUCTION

STIGMA, BARRIERS TO CARE, SDOH

STIGMA: A CYCLE



Experienced stigma

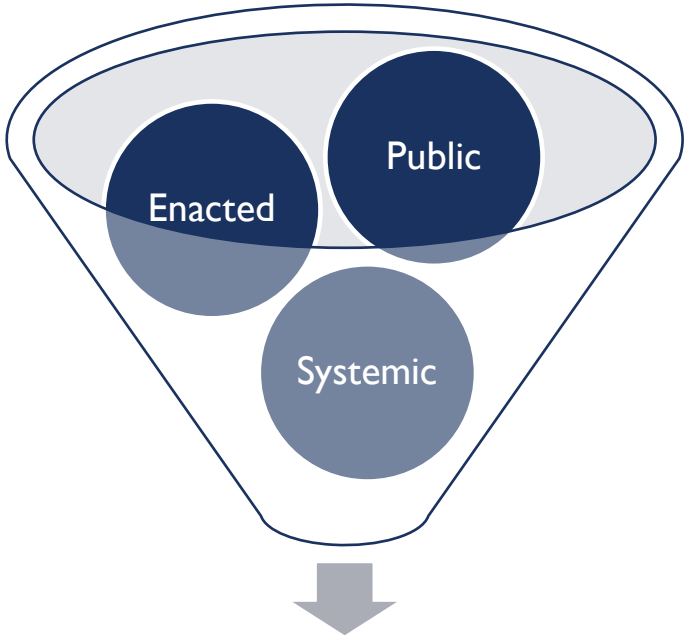
HEALTH CONSEQUENCES OF STIGMA

- Patient side:
  - Delayed care
  - Internalized stigma of MOUD
  - Decreased treatment engagement
  - Decreased utilization of harm reduction services
  - Increased risk behaviors
- Provider side:
  - Anchoring
  - Undertreating pain & withdrawal (patient directed discharges)
  - Punitive care – "firing" or cutting off patients

SYSTEMIC STIGMA AND SDOH

- Criminalization:
  - Disenfranchisement
  - Housing
  - Employment
  - Medicaid/insurance access
- Healthcare access:
  - Pay parity
  - Addiction workforce shortages
  - Insurance coverage
- Superimposed marginalization:
  - Racial disparities:
    - In criminalization
    - In treatment
    - In funding/services
  - Sexual and gender minorities
  - Language barriers
  - Disability

STIGMA: BREAKING THE CYCLE



Experienced stigma

PUBLIC STIGMA: UNPACKING OUR OWN BIASES

- Public stigma includes our own stereotypes, negative attitudes, which influence our clinical practices.
- Our biases are formed by history, culture, and our own lived experiences.

Unpack that:

- Drug use may be adaptive for your patient
- Even if it's not, they might believe it is, or be otherwise unwilling or unable to change
- A conversation about safety that doesn't stigmatize a behavior that is important to them allows them to engage with you safely.
- You are not enabling their drug use. You are enabling their access to medical care.

ENACTED STIGMA: IMPROVING OUR CLINICAL PRACTICE

- Enacted stigma includes the ways in which our stereotypes cause discrimination, non-evidence-based care, or avoidance of patients we feel are difficult or dangerous.
- Practice minimally disruptive medicine:
  - Incorporates patient's goals + smallest possible burden on patient's life
  - Patient centered goals of care might be different from your goals, and that's okay
    - Reducing chaotic use vs. abstinence, reduced infection/mortality
- Change language: changingthenarrative.news
- Treat pain and withdrawal
- Incorporate prevention strategies

ENACTED STIGMA: LOW-THRESHOLD MOUD

- Minimally disruptive: All patients should have access to MOUD; all providers should know how to provide basic MOUD.
- Current paradigm is disruptive – OTPs with daily check-ins, testing, commuting, etc.
- People who use drugs are not inherently more "difficult" than any other patient – they are more failed and abandoned by our social systems, and more in need of our help.

SYSTEMIC STIGMA: RECOGNIZE AND ADDRESS BARRIERS

- Consider relevant SDOH in determining goals and plan of care: Housing status, sexual/gender identity, race and systemic racism, language, education, employment, food insecurity, social inclusion/stigma, insurance
- Where possible, address adverse SDOH.
- Where impossible, creatively adaptive your plans to accommodate SDOH using "next best" alternatives
- Know your community resources

COMMUNITY SERVICES: HARM REDUCTION AND SOCIAL

- Supervised consumption sites
- Syringe service programs
- Narcan distribution programs
- Peer provided services – opioid survivor overdose programs + harm reduction initiatives
- Wound care
- Housing, food, employment support (Housing First model)
- Prison re-entry
- Violence intervention programs

SYSTEMIC STIGMA AND POLICY-BASED HARM REDUCTION

UNPACKING POWER STRUCTURES THAT CREATE HARMS

INTEGRATING HARM REDUCTION INTO HEALTHCARE

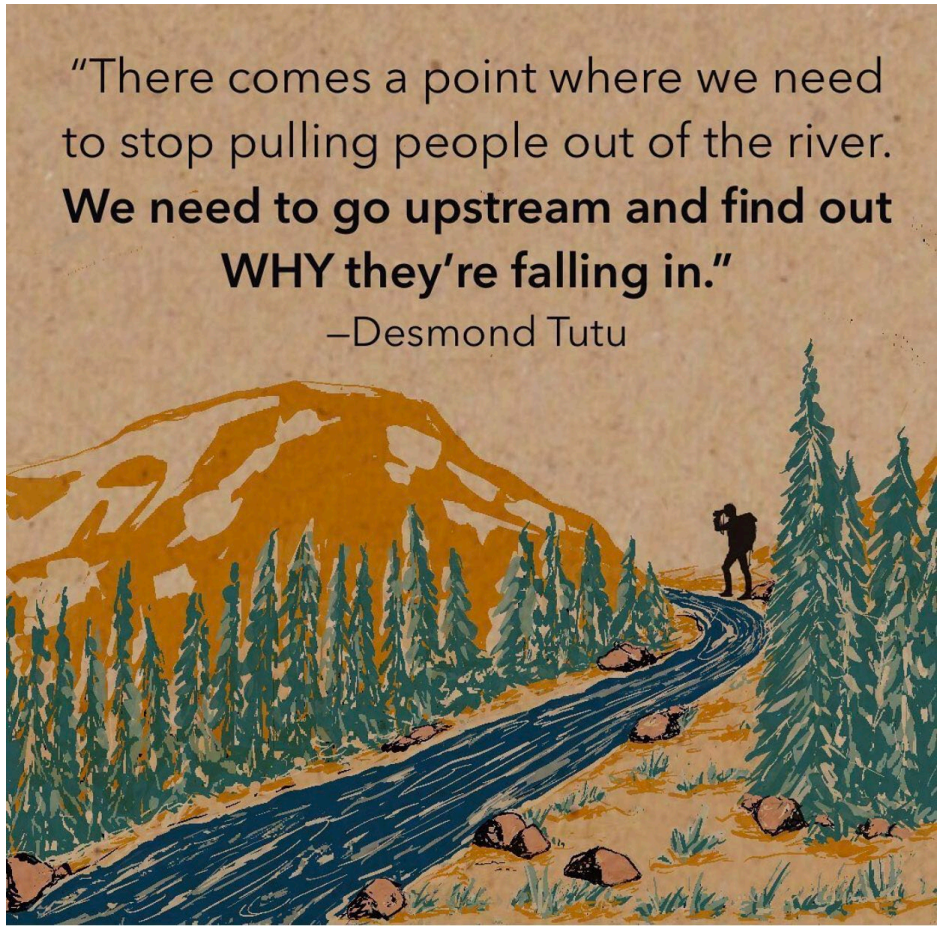
- Hospital and health system policies:
  - Inpatient addiction consult services
  - Integrated primary care
  - ED initiation and bridge clinics
  - Full spectrum of MOUD (include methadone policies)
  - Fairly compensate peers and PWUD with lived experience in development and implementation of policies
  - Adequately treat pain/pain consult services
  - Syringe services and prescriptions
  - Supervised consumption sites
  - Examine confiscation policies
  - Upstream investment in SDOH and community health

REPRESENTATION

- ”Nothing about us, without us”
- Power imbalance within medical hierarchy and research
- Forcing patients to comply with our beliefs to provide treatment or harm reduction is paternalism
- Unpack your own biases
- Included voices of people with lived experience (including those who still use drugs) in your solutions
- Our scope of understanding is inherently limited. Meaningful participation (and compensation) of people with lived experience is essential to making ethically and practically meaningful change.

CRIMINALIZATION

- Impossible to discuss harm reduction without discussing criminalization
- Many of the health harms of drugs arise from their legal status
  - Directly: safe supply, safe use practices, safe consumption sites
  - Indirectly: incarceration's impact on health and SDOH



ADVOCACY

118th Congress:

- S. 818/H.R. 1620 – MORE Savings Act – no cost coverage of MOUD under CMS → private insurance
- H.R. 2804 – Harm Reduction Through Community Engagement Act – increased community engagement in OTP operations
- H.R. 3065 – School Access to Naloxone Act of 2023
- S. 644/H.R. 1359 – Modernizing Opioid Treatment Access Act – methadone reform

Broad strokes:

- Decriminalization/decarceration, reinfranchisement
- Housing first + wraparound services
- Universal mental health access – pay parity, community health workers, peer workers, expanded training pathways
- Center solutions advocated by people with lived experience

SUMMARY:

- Harm reduction has historically been a "dirty word," but the philosophy underlying harm reduction is consistent with the philosophy of medicine.
- Harm reduction works.
- Harm reduction makes your patients' lives better.
- Harm reduction makes your job easier.
- Harm reduction starts with your attitudes towards drug use and PWUD.

DC: COMMUNITY HARM REDUCTION RESOURCES

- HIPS
- Bread for the City
- Us Helping Us, People Into Living
- Family and Medical Counseling Services