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Opioid Use Disorder and Harm Reduction

Dec. 8

1-2:30 p.m. CT

Featured Speaker

Dr. Nicole Gastala

Dr. Gastala is board certified in Family Medicine and Addiction Medicine. She graduated from Loyola Stritch School of Medicine and completed her Family Medicine residency at the University of Iowa. In her clinical role, she has developed and expanded MAR by mentoring new prescribers, precepting residents, and training clinicians within the Chicago and Illinois communities. She has also focused on the development of a walk-in integrated behavioral health, addiction, and primary care program within her FQHC system. In January 2021, Dr Gastala joined the team at the Substance Use Prevention and Recovery Division of IDHS as the medical director.

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Pre-Webinar Poll #1

What is your disciplinary role in the dialysis facility?

- ❑ Social Worker
- ❑ Clinical Manager/Facility Administrator
- ❑ Nurse
- ❑ Patient Care Technician
- ❑ Nephrologist
- ❑ Dietician
- ❑ Other

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Pre-Webinar Poll #2

Do you (or have you) worked with patients whose dialysis treatments are affected by OUD or SUD?

- ❑ Yes
- ❑ No
- ❑ I'm not sure

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Pre-Webinar Poll #3

What is your comfort level with the topic of harm reduction in OUD?

- ❑ I have very little knowledge
- ❑ I have a basic knowledge
- ❑ I have a moderate level of knowledge
- ❑ I am a subject matter expert

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The Recovery Continuum, Harm Reduction, and Evidence-Based Practices

Nicole Gastala, Medical Director SUPR

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State of Illinois

Disclosure

I have no relevant financial conflicts of interest in relation to this activity to disclose.

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Learning Objectives

- Recognize the role of harm reduction on the recovery continuum.
- Apply evidence-based harm reduction and treatment services for Substance Use Disorders, particularly Opioid Use Disorder (OUD).
- Incorporate person-centered language in the care of patients with SUD.

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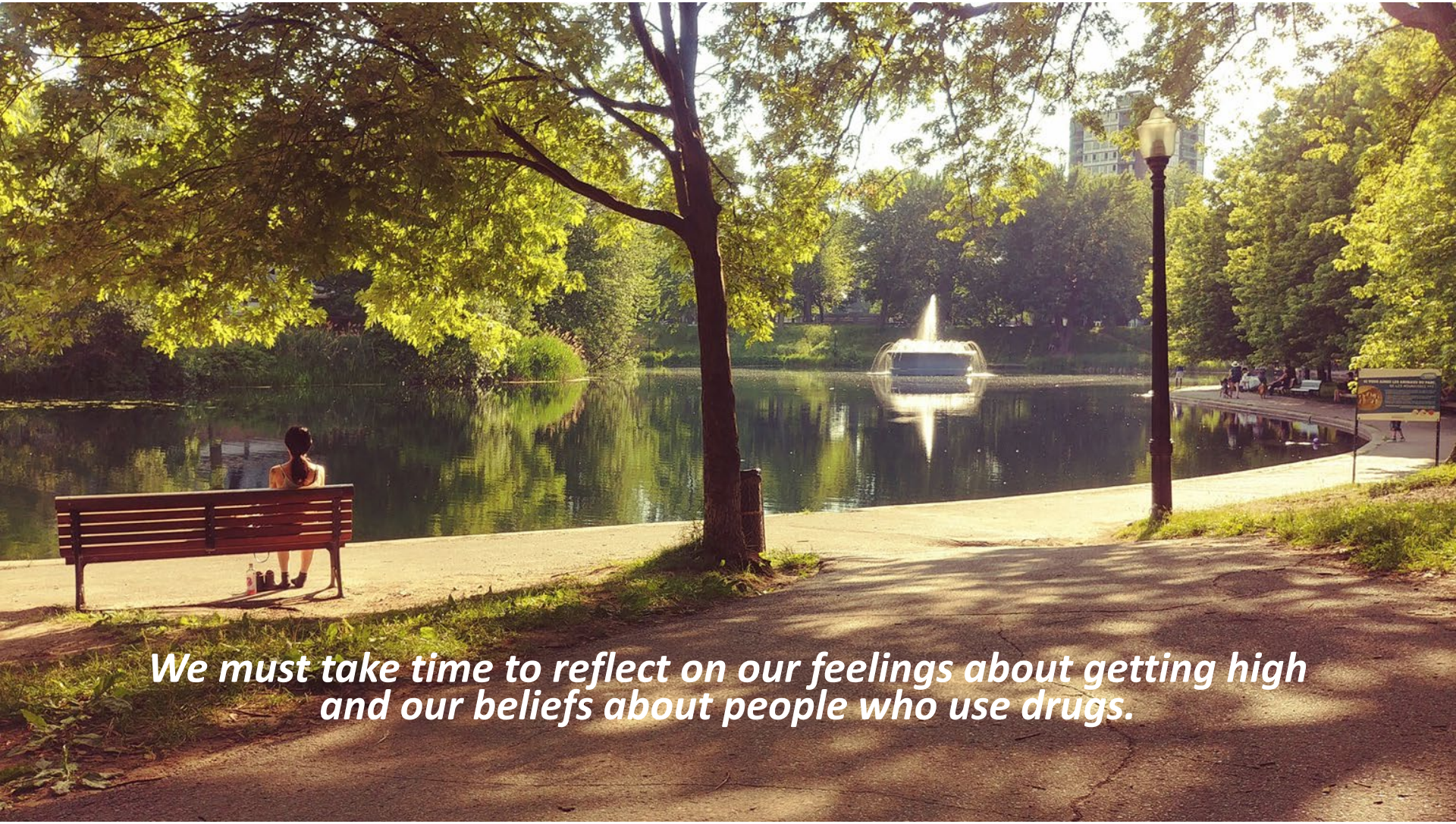

JAMES KOWALSKY

Outdated Substance Use Treatment Philosophies

Treatment rooted in punitive interventions	Substance Use = Moral Failing
Moralization of individuals with substance use disorders (SUD) has led to:	Biases that contribute to deficient interventions Judgmental language and stigma Poor recovery outcomes
Criminalization of drugs exacerbates punitive treatment of individuals with addiction	Incarceration is the primary consequence rather than treatment of SUD
Philosophies, moralization, and criminalization lead to:	An “all or nothing” approach to treatment, and corresponding punitive policies and practices

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Frank & Nagel, 2017.

Recovery Continuum

Recovery can take many different forms, not only abstinence.

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Recovery Continuum

Recovery is a continuous process.

A patient in recovery should always have access or can reconnect to any level of care.

- SUD is a life-long chronic condition (like diabetes/hypertension)
- If patient is in maintenance, recovery support is important

Treatment and recovery work hand in hand:

- Community recovery support groups
- Counseling

Harm reduction is an important part of the recovery continuum.

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Harm Reduction

- Meets people where they are at and is based on their goals
- Harm Reduction (HR) in Other Areas of Public Health
  - Condoms to prevent infection, unintended pregnancy
  - Seatbelts
  - Taxi Service initiated by Bar Tenders
- HR in SUD: Reducing potential harms of substance use
  - Death
  - Overdose
  - HIV/hepatitis C transmission
  - Bacterial infections associated with intravenous drug use
- For all people using substances, not just those who are working towards sobriety/recovery

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Source: Substance Abuse and Mental Health Services Administration. SAMHSA Opioid Overdose Prevention Toolkit. HHS Publication No. (SMA) 18-4742. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018

Examples of Harm Reduction in Clinical Practice

- **Naloxone** to prevent overdose death
- **Fentanyl testing strips** to prevent overdose death
- **Syringe exchange** to prevent infection transmission
- **Safe consumption spaces** is an evidence-based approach that has been used internationally to prevent infection transmission and overdose death. Rhode Island will be the first state in U.S. to adopt this model – not currently sanctioned in Illinois.
- **"Medication First" - Medication-Assisted Recovery including opioid replacement medications** for opioid use disorder (MAR) (methadone, naltrexone, and buprenorphine) to prevent overdose death
- **Harm Reduction Psychotherapy**
- **Trauma informed, person centered, and recovery-oriented** care

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Source: Substance Abuse and Mental Health Services Administration. SAMHSA Opioid Overdose Prevention Toolkit. HHS Publication No. (SMA) 18-4742. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

What does harm reduction mean within the recovery continuum?

- Goals of care not focused on abstinence but reducing harm including morbidity and mortality
- If you are not tracking abstinence (e.g., patient report or via toxicology), how do you help patients improve? Example goals:
  - Decreasing use
  - Not using alone, using test doses
  - Utilizing clean materials
  - Quality of Life Scale
  - Social Determinants of Health
    - Employment status – meeting employment goals
    - Housing status – meeting housing goals
  - Relationship building – re-building or forming new relationships
  - Addressing whole health, including chronic disease management and prevention
  - Meeting familial or partner responsibilities (e.g., caregivers)

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Harm Reduction

Harm Reduction International identifies five primary characteristics of harm-reduction practices:

1. Identifying specific risks for individuals who use substances, understanding the roots of these risks, and tailoring interventions to reduce them
2. Acknowledging the significance of any positive change
3. Accepting people who use drugs as they are and treating them with dignity and compassion
4. Protecting the human rights of people who use drugs
5. Maintaining transparency in decisions about interventions as well as their successes and failures

*Harm Reduction does not ignore dangers of drug use or other risky behaviors

Harm Reduction – Stages of Change Model

- Conceptual framework that supports individuals willing to engage in services, but not ready to set goals related to abstinence
- Alignment with Stages of Change Model, recognizing that goals and treatment outcomes should align with client's relevant needs
    - Stages of Change are not linear, and goals must be adjusted depending on the client's identified stage of change (precontemplation, contemplation, preparation, action, and maintenance)
    - Patients may move between stages of change as a result of health, mental health, or life circumstances that impact their ability to prioritize recovery
- Primary foci of harm reduction are:
    - To destigmatize people who use drugs
    - To protect their health and reduce morbidity and mortality

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MacMaster, 2004.
Tatarsky, 2003.

Harm Reduction and Goal Setting

- Patients are more successful in
  - Lower threshold programs – “Housing First” and “MOUD First”
  - Less punitive programs with lower initial demands, open door policies
  - Programs that integrate biopsychosocial approaches to substance use
- Patient-centered perspective to encourage continued engagement in treatment, aligning the goals of the client and treatment provider.
- Long-term treatment goals (LTGs) should still encourage client toward attaining long-term recovery. (ie. Stabilizing on medications)
- Timeframes associated with these LTGs are specific to each client.

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How to Set Patient Goals in a Harm Reduction Model

- Long-term (LTG) vs. short-term goal (STG)
  - LTG: “I want to stop using heroin.”
  - STG: Consider the action steps necessary to support the client in achieving this LTG.
    - Remember, behavioral change takes time. Use over 30 years will not be changed with a single dose of Suboxone.
- Examples of short-term goals:
  - “I will tell people I’m using and not use behind a locked door.”
  - “I will take my medication daily and decrease my use from 7 days to 3 days in the next week.”
  - “I will come to my appointments even if I am not meeting my goals, even if I relapse.”
  - “I will carry my naloxone with me.”

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“If abstinence was required as a precondition for me to get any therapy at the beginning, I would never have started treatment of any kind.”

—Person treated by Alan Marlatt (2004)

Why follow harm recovery goals and not abstinence goals?

- Negative toxicology and patient report is not always the best primary outcome or patient centered
- Studies show, even with continued use, retention in treatment is associated with a significant reduction in morbidity and mortality
- To mitigate the Abstinence Violation Effect (AVE)
- Effective way to engage those in “precontemplation”

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Who Are We Missing in Treatment?

About 40% of people who need treatment are not ready to stop using

Table 7.67B Detailed Reasons for Not Receiving Substance Use Treatment in Past Year among Persons Aged 12 or Older Classified as Needing But Not Receiving Substance Use Treatment at a Specialty Facility and Who Perceived a Need for Substance Use Treatment in Past Year: Percentages, 2015-2019

Reason for Not Receiving Substance Use Treatment[1]	2015	2016	2017	2018	2019
TOTAL POPULATION	100.0	100.0	100.0	100.0	100.0
No Health Care Coverage and Could Not Afford Cost	30.0	26.4	30.3	32.5[a]	20.9
Had Health Care Coverage But Did Not Cover Treatment or Did Not Cover Full Cost	4.6	11.5	10.5	10.4	4.6
No Transportation/Programs Too Far Away or Hours Inconvenient	11.8	7.2	6.7	7.6	7.3
Did Not Find Program That Offered Type of Treatment That Was Wanted	10.8	14.2	9.0	11.0	14.7
Not Ready to Stop Using	40.3	37.7	39.7	38.4	39.9
No Openings in a Program	4.5	3.1	5.0	5.3	5.2
Did Not Know Where to Go for Treatment	12.5[a]	18.6	10.9[a]	21.1	23.8
Might Cause Neighbors/Community to Have Negative Opinion	8.3[a]	13.2	17.2	14.9	17.2
Might Have Negative Effect on Job	16.1	11.5	20.5	16.0	16.8
Did Not Feel Need for Treatment at the Time	7.3	3.7	12.3	5.3	6.4
Could Handle the Problem Without Treatment	8.2	8.9	12.6	11.1	11.7
Treatment Would Not Help	3.3	2.1	3.9	3.8	4.6
Did Not Have Time	8.9	4.8	7.9	7.0	8.5
Did Not Want Others to Find Out	9.6	4.6	7.1	6.2	7.6
Some Other Reason	2.1	1.4	3.0	4.4	4.2

Source: SAMHSA (2020). 2019 National Survey on Drug Use and Health (NSDUH). Available at: https://www.samhsa.gov/data/report/2019 -nsduh-detailed -tables

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Examples of Harm Reduction

- **Naloxone** to prevent overdose death
- **Fentanyl testing strips** to prevent overdose death
- **Syringe exchange** to prevent infection transmission
- **Safe consumption spaces (Overdose Prevention Sites)** to prevent infection transmission and overdose death
- **Opioid replacement medications** for opioid use disorder (MAR) (methadone, naltrexone, and buprenorphine) to prevent overdose death
- **Trauma informed, person centered, and recovery-oriented** care

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Source: Substance Abuse and Mental Health Services Administration. SAMHSA Opioid Overdose Prevention Toolkit. HHS Publication No. (SMA) 18-4742. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

Overdose Response & Naloxone - Evidence

- No increase in drug use; increase in drug treatment
  - Seal et al. J Urban Health 2005; 82:303-11
  - Galea et al. Addict Behav 2006; 31:907-912
  - Wagner et al. Int J Drug Policy 2010; 21: 186-93
  - Doe-Simkins et al. BMC Public Health 2014; 14:297
- Cost effective
  - Coffin & Sullivan Ann Internal Med 2013; 158: 1-9
- Reduction in overdose deaths
  - Walley et al. BMJ 2013; 346:f174
- Should be centered around people who use drugs
  - Rowe et al. Addiction 2015; 1301-1310

Overdose Education & Naloxone - Recommendations

CDC Guidelines recommend offering naloxone when:

- History of Overdose
- History of Substance Use Disorder
- Higher Opioid Dosages (>50 MME/day)
- Concurrent benzodiazepine use

Surgeon General's Advisory on Naloxone and Opioid Overdose

I, Surgeon General of the United States Public Health Service, VADM Jerome Adams, am emphasizing the importance of the overdose-reversing drug naloxone. For patients currently taking high doses of opioids as prescribed for pain, individuals misusing prescription opioids, individuals using illicit opioids such as heroin or fentanyl, health care practitioners, family and friends of people who have an opioid use disorder, and community members who come into contact with people at risk for opioid overdose, ***knowing how to use naloxone and keeping it within reach can save a life.***

BE PREPARED. GET NALOXONE. SAVE A LIFE.

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Surgeon general release came out April 5, 2018
https://www.surgeongeneral.gov/priorities/opioid-overdose-prevention/naloxone-advisory.html
https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm

Encouraging People To Carry Naloxone: Suggested Language

- *If you stop using opioids and then start again, for whatever reason, this is a high-risk time for possible overdose, so it's important to have a plan for what to do in that situation.*
- *This is practical information that everyone should have, just like knowing how to do CPR or the Heimlich Maneuver, everyone should know how to prevent and manage overdose.*
- *Hopefully, you will never find yourself in a position in the future where you would be at risk of overdose yourself, but you never know when you could be the person who could save the life of someone else.*

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(Doe-Simkins & Bell, 2014)

Opportunities To Address Overdose

- Outreach and engagement
- Waitlists
- Intake and assessment
- Orientation
- Individual and group counseling
- Peer support groups or family groups
- Following an overdose or positive drug screen
- Discharge
- International Overdose Awareness Day (Aug. 31)

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(Doe-Simkins & Bell, 2014)

Coping With Overdose Fatalities: Supporting Staff

- Employ trauma-informed principles
- Acknowledge the death—*the pause*
- Process strong emotions
- Address people's ongoing needs
- Grieve after an overdose

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(Cook, 2019)

Fentanyl Test Strips

- Over 90% of opioid-related overdose deaths in Cook County in 2020 involved Fentanyl
- Check for the presence of fentanyl in their drugs
- Literature Outcomes/Highlights:
  - Increased overdose safety by 77%
  - Changed any behavior related to use by 50%
  - Resulted in using less drug than usual in 32% of patients
- Empowers individuals on how to approach uncertainty and potential unknown substances in their drug supply

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Overdose Prevention Sites

- Overdose Prevention Sites (OPS) are harm reduction programs that can save thousands of lives in communities hardest hit by overdose deaths.
- OPS provide a safe, hygienic space to consume pre-obtained drugs, staff trained and ready to administer naloxone if an overdose occurs, and access to additional harm reduction and support services

Insite, North America's first legal SIF, in Vancouver, Canada.

SIS in Strasbourg, France.

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Overdose Prevention Sites

Table 1. Supervised Consumption Sites around the world

Country	Cities with SCSs	SCSs operating
Netherlands	25	31
Germany	15	24
Canada*	11 (5 more planned)	20** (11 more planned)
Switzerland	8	12
Spain	7	13
Denmark	4	5
Norway	2	2
France	2	2
Australia	2	2
Luxembourg	1	1 (1 more planned)
Ireland	1 planned	1 planned
Scotland	1 planned	1 planned

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Pardo et al. Assessing the Evidence on Supervised Drug Consumption Sites. RAND Health Care and RAND Social and Economic Well-Being. 2018

Overdose Prevention Sites

Table 2. Characteristics of Supervised Consumption Sites in Vancouver and Sydney

	Medically Supervised Injecting Centre	Insite
Location	Kings Cross Neighborhood, Sydney	Downtown Eastside, Vancouver
Year opened	2001	2003
Hours of operation	12 hours a day Monday-Friday and eight hours on the weekends	18 hours, 7 days a week and 24 hours Wednesday to Friday when social assistance is disbursed
Number of booths	8	12
Injection room capacity	16 clients	12 clients
Registered clients (cumulative)	16,142	12,000+
Cumulative supervised injections	More than 1 million	More than 3.6 million
Cumulative overdoses managed	7,428	6,440
Estimated supervised injections per day	180	415
Referrals to health and rehabilitation services (cumulative)	13,000 (Cumulative)	443 (2017 only)
Annual operating cost	$2.77 million Australian in 2008	$3 million Canadian in 2008

Pardo et al. Assessing the Evidence on Supervised Drug Consumption Sites. RAND Health Care and RAND Social and Economic Well-Being. 2018

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Overdose Prevention Sites - Canada

- 221 Overdose Interventions
- No Fatalities
- 3383 Clinical treatment interventions, 5268 referrals
- 458 onsite detox admission – 43% completion
- Death – 35% decrease
- Prevented 1,191 new HIV infections over 10 years

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Overdose Prevention Sites - Australia

- 4400 Overdose interventions
- No Fatalities
- 9500 referrals
- Monthly ambulance service calls decreased by 80%
- Opioid emergency department episodes decreased by 35%

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Overdose Prevention Sites – Overall Summary

- Decreases
  - Overdose deaths
  - Substance Use
  - Public disorder/public injecting
  - HIV and Hepatitis C Risk
  - Cost
- Increases
  - Entry into treatment
  - Entry into medical treatment
  - Entry into social service use
  - Health care value

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Opioid Use Disorder Treatment

- Behavioral support (could be through formal treatment program, individual counseling)
- Medication for Opioid Use Disorder (MOUD)/MAR:
  - Methadone
  - Buprenorphine (Suboxone®, Bunavail™, Zubsolve®, Subutex, Probuphine® implant, Sublocade injection)
  - Injectable extended release (ER) Naltrexone (Vivitrol®)
- Withdrawal Management for OUD alone is NOT treatment and actually increases risk of overdose without linkage to next level of care (Strang et al., 2003).
- Approximately one-third of treatment providers offer methadone or buprenorphine (SAMHSA N-SSATS, 2016).

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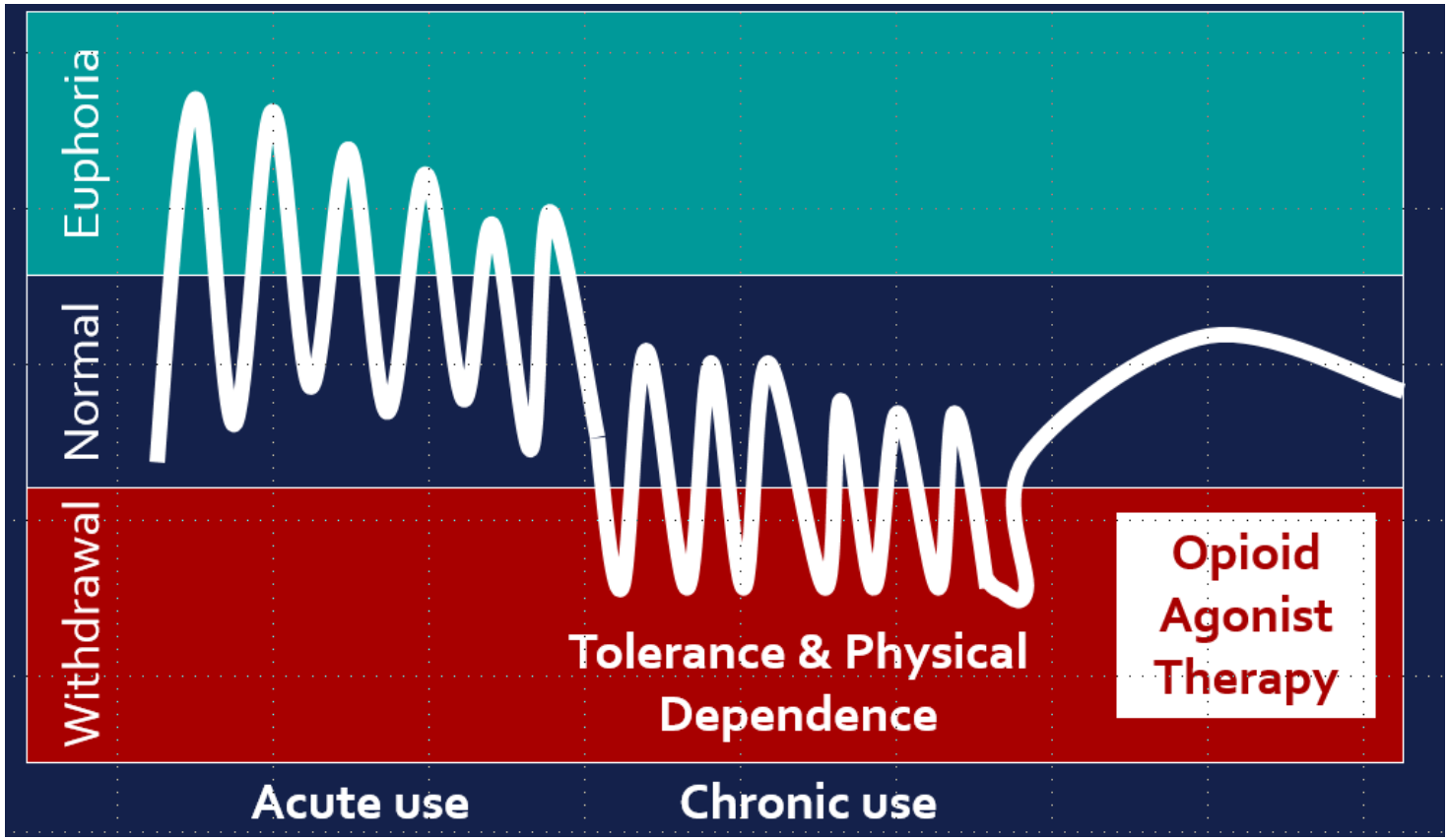
Medication Assisted Recovery



Source: American Society of Addiction Medicine. ASAM Buprenorphine Waiver Training.

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Medication Assisted Recovery in Harm Reduction

- As compared to behavioral therapy with placebo or no medication, MAR:
  - Reduces illicit opioid use
  - Retains people in treatment
  - Reduces risk of opioid overdose mortality and all-cause mortality (buprenorphine and methadone)

"Discussing medications that can treat OUD with patients who have this disorder is the clinical standard of care"—SAMHSA Tip 63

SAMHSA, TIP 63, 2020.

Retention in Treatment at 12 Months With Reduced Illicit Drug Use

Treatment type	Retention in treatment at 12 months with reduced illicit drug use
Behavioral therapy without medication	6%
XR Naltrexone*#	10–31%
Buprenorphine*	60–90%
Methadone*	74–80%

Based on meta-analysis of research studies; rates of success lower in real-world settings.
#Most XR Naltrexone studies were only 3–6 months; 12-month registry study only had % discontinued due to meeting goals; numbers presented here are different than report referenced because they were updated based on Jarvis study.

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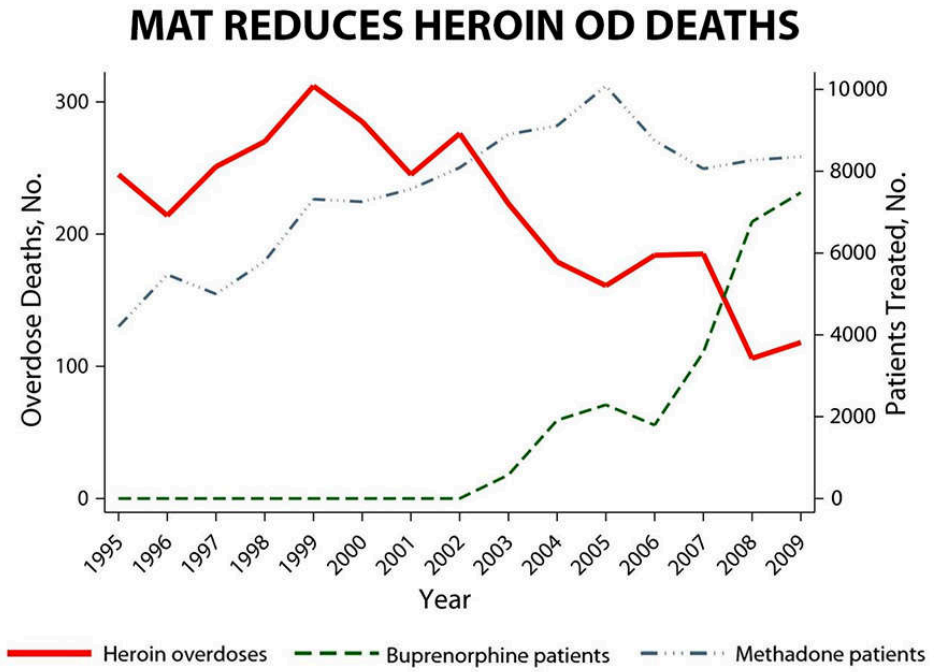
Permission for Use by Dr. Elizabeth Salisbury-Afshar, Elitzer, 2017, Jarvis, Holtyn, et al., 2018
Elitzer, J. (2017). Why health plans should go to the "MAT" in the fight against opioid addiction. California Health Care Foundation.
https://www.chcf.org/wp-content/uploads/2017/12/PDF-Why-Health-Plans-Should-Go-to-the-MAT.pdf

OUD Treatment Outcomes—Evidence

MAR *Decreases* opioid use, opioid-related overdose deaths, criminal activity, and infectious disease transmission.

After buprenorphine became available in Baltimore, heroin overdose deaths decreased by 37 percent during the study period, which ended in 2009.



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Medication Assisted Recovery and Mortality

- Number Needed to Treat to Prevent 1 Death in 1 Year
  - Statins 415
  - Mammogram 2970
  - Buprenorphine after an overdose 33
  - Methadone after an overdose 31

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Duration of Treatment with MAR

- Longer length of treatment associated with better outcomes (methadone and buprenorphine).
  - Patients should continue as long as they benefit and have no contraindications.
- Limited data for long-term use of XR-Naltrexone but current recommendation is that clients should continue as long as they benefit and want to continue.

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SAMHSA, TIP 63, 2020.

Addressing Myths about Medications

- **Methadone and buprenorphine DO NOT substitute one addiction for another.** When someone is treated for an opioid addiction, the dosage of medication used does not get them high–it helps reduce opioid cravings and withdrawal. These medications restore balance to the brain circuits affected by addiction, allowing the client's brain to heal while working toward recovery.
- **Diversion of buprenorphine is uncommon; when it does occur it is primarily used for managing withdrawal.** Diversion of prescription pain relievers, including oxycodone and hydrocodone, is far more common; in 2014, buprenorphine made up less than 1 percent of all reported drugs diverted in the U.S.

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Addressing Myths about Medications

In a study on medication sharing, of the 700 participants, 160 (22.9%) reported loaning their prescription medications to someone else.

TABLE 2— Prescription Medications Shared by Study Participants: United States, 2006

Prescription Medication	Had Loaned or Borrowed, %
Allergy medications (e.g., Allegra, Claritin)	25.3
Pain medications (e.g., Darvoset, oxycontin)	21.9
Antibiotics (e.g., amoxicillin, doxycycline, Bactrim/Septra)	20.6
Mood medications (e.g., Paxil, Zoloft, Valium, Ritalin)	7.1
Acne medication (e.g., Accutane)	6.4
Birth control pills	5.3
Other	2.0
None	53.1

Note. Participants were asked, "Which, if any, of the following prescription medications have you loaned or borrowed?"

Goldsworthy RC, Schwartz NC, Mayhorn CB. Beyond abuse and exposure: framing the impact of prescription-medication sharing. American Journal of Public Health. 2008 Jun;98(6):1115-21.

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Addressing Myths about Medications

- Methadone does not weaken bones or teeth, likely it is more related to the combination of factors such as dental care/access and those who experience trauma, homelessness, and other co-morbidities are at higher risk.
- MAR/MOUD is effective independent of counseling
- Have you heard of other concerns about medications? Let's myth bust!

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Relapses on MAR

- Relapses are not signs of failure (on your part or the patients)
  - The same way that patients with diabetes may have periods when their sugars are poorly controlled, or when they gain more weight, they still have knowledge and skills obtained during periods of better control
- Most patients' will already feel ashamed and may not disclose a lapse, even if they have a positive drug screen
- Emphasize you are there to support them and help them meet their health goals
- Be positive and hopeful- remind them of the progress they've made

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Drug Toxicology and Clinical Utility

Drug tests detect the presence of a substance within a given **window of time.** They **do not provide a full picture** of an individual's substance use history and must be interpreted in the context of a patient interview, history, and physical exam findings, if available.

A positive drug test…	A negative drug test…
• Does not measure patterns of use over time. • Does not provide information on polysubstance use.	• Does not rule out history or presence of SUD. • Does not make a patient ineligible for admission or treatment.

A positive drug test is not required to diagnose a patient with an OUD/SUD. Drug tests should always be accompanied by a comprehensive assessment.

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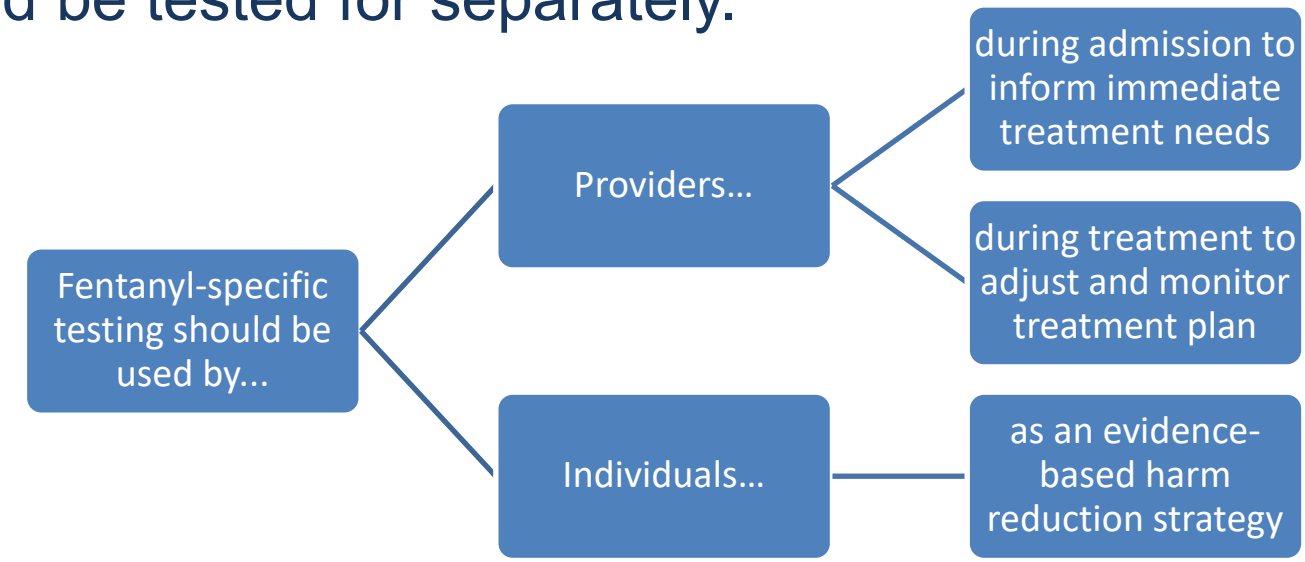
Fentanyl Testing and Clinical Utility

Fentanyl is a potent synthetic opioid that **will not be detected** in a standard opiate immunoassay. Fentanyl should be tested for separately.



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Drug Testing and Communication

Testing should be used and communicated to patients as a **therapeutic tool** to:

- Aid in evidence-based treatment planning
- Initiate therapeutic discussion with patients
- Provide useful information on admission and during treatment

Test results should be communicated in an, objective, **non-punitive** and **non-stigmatizing** way (e.g., positive/negative vs. dirty/clean).

Patients who refuse to provide a drug screen or who test positive should not be discharged from treatment or receive other punitive measures but rather should be engaged and work with the medical director.

Methadone and Buprenorphine/Naloxone ONLY treat OUD.

Do NOT withhold medications or treatment secondary to a positive drug screen, rather engage patients in supportive treatment, do NOT discharge them.

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Signs of Opioid Intoxication

Opioid Intoxication
Signs
Bradycardia (slow pulse)
Hypotension (low blood pressure)
Hypothermia (low body temperature)
Sedation
Meiosis (pinpoint pupils)
Hypokinesis (slowed movement)
Slurred speech
Head nodding
Symptoms
Euphoria
Analgesia (pain-killing effects)
Calmness

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https://www.ncbi.nlm.nih.gov/books/NBK64116/table/A85633/

Signs of Opioid Withdrawal

Opioid Withdrawal
Signs
Tachycardia (fast pulse)
Hypertension (high blood pressure)
Hyperthermia (high body temperature)
Insomnia
Mydriasis (enlarged pupils)
Hyperreflexia (abnormally heightened reflexes)
Diaphoresis (sweating)
Piloerection (gooseflesh)
Increased respiratory rate
Lacrimation (tearing), yawning
Rhinorrhea (runny nose)
Muscle spasms
Symptoms
Abdominal cramps, nausea, vomiting, diarrhea
Bone and muscle pain
Anxiety

https://www.ncbi.nlm.nih.gov/books/NBK64116/table/A85633/

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“Words are important. If you want to care for something, you call it a ‘flower;’ if you want to kill something, you call it a ‘weed.’”
-Don Coyhis

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Does Language Matter?

- Research shows language can affect attitudes and treatment toward people with substance use disorder (SUD).
- A randomized controlled trial was held with mental health professionals.
  - Two groups were given the same clinical scenario: one with a "substance abuser" and the other with a "person with a substance use disorder."
  - Those in the "substance abuser" condition agreed more with the notion that the character was personally culpable and that punitive measures should be taken.

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Kelly, J. F., & Westerhoff, C. M., 2010.

Professional Conduct and the Patient Experience

Stigmatizing	Respectful Alternatives
Addict, junkie, alcoholic, crackhead, pothead	Person-first language: a person who uses drugs
Substance Abuse	Substance use disorder
Dropping clean/dirty	Positive/negative drug test
Relapse	Recurrence of use
In denial	In precontemplation
Addiction to drugs	A relationship with drugs
Enabling	Supporting
Medication Assisted Treatment	Medication Assisted Recovery or Pharmacotherapy

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Addiction Policy Forum, Language Matters, 2019.

The Patient Experience: Biases

- Try to understand the patient's previous and current experiences
  - If you have security, some patients may have anxiety with individuals in uniform due to prior experiences.
- Know the biases of your community and the patient's access points.
- Know what your biases are and seek support/training.

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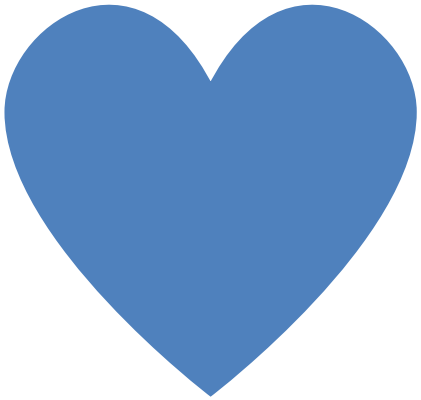
Summary: Incorporating Harm Reduction And Overdose Prevention In Practice

- Provides space to process past trauma
- Increases the likelihood of preventing or surviving future overdoses
- Improves the therapeutic relationship
- Affirms people's value as community members who can save lives
- Enhances system capacity to address trauma
- Supports treatment providers

JAMES KOWALSKY (Doe-Simkins & Bell, 2014)

#1 Goal: Impact Mortality



- We don’t think twice about someone having a heart attack, getting stabilized in the emergency department, and then getting ongoing care from the cardiologist.

  And the risk of death within a year after an opioid overdose is greater than it is for a heart attack.”

  -- Dr. Kelly Pfeifer, director of high-value care at the California Health Care Foundation.

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Drug use does not have to result in overdose.

Drug overdose does not have to result in death.

Harm reduction makes that possible.

Harm reduction saves lives.

JAMES KOWALSKY

INTENTION SETTING

- **What are you already doing well that you want to CONTINUE?**
- **What is the MOST important thing you learned today?**
- **What is ONE specific change you will make moving forward?**

Post-Webinar Poll #1

Following this webinar, my comfort level with the topic of harm reduction in OUD has improved.

- ❑ True
- ❑ False

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Post-Webinar Poll #2

I plan to share this webinar information or recording with others in my field or organization.

- ❑ Yes
- ❑ Maybe
- ❑ Probably Not

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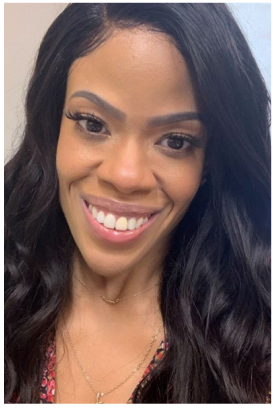

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Thank You

Questions?

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