Questions Asked During Live Webinar Broadcast on 12/02/2020

Harm Reduction for the Clinical Setting

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Is there a continuum of use that aligns more with the DSM-5? DSM-5 takes out the variations of dependence and abuse; but places it on a continuum of mild, moderate severe. Should this use continuum be updated?

A: There are several different versions of this out there, this is just the one that I prefer. I should note, for diagnostic purposes, I would adhere strictly to what it outlined in the DSM-5. The version in the power point is simply the version I like best as a teaching and conceptual tool. I like that it includes categories like experimentation and social use.

How do we get buy in for harm reduction from parents of underage people living with a substance use disorder?

A: I always start with compassion—acknowledging how stressful, how overwhelming it is to be in their position. I try to build connection by honoring their struggle. For most parents, the overriding feeling is fear, so I always emphasize the focus on safety. How the goal of harm reduction is to first and foremost keep people safe and alive. I also explain it as AN option, and try to relay to them why it might be a good fit for their child, based on what they have told me about their child. I also offer information about other treatment approaches as well. In my experience people often have an easier time moving forward when they understand the different paths.

I get calls relatively often from overwhelmed parents not knowing where to begin. I give them a free consultation and walk them through the various options (dependent on the substance(s) involved), i.e. detox, inpatient, IOP, AA/NA, harm reduction, etc.

If they decide against harm reduction, or me as a provider, it's ok. It's not about selling harm reduction (or my services), but helping people find the right fit. I won't always be the right fit, but the door is always open if they need me down the road.

Can you list the authors of the books you mentioned?

A: I am not sure I remember all of the books I mentioned, but I will take my best guess!

Practicing Harm Reduction Psychotherapy by Patt Denning
Over the Influence by Patt Denning & Jeannie Little
Chasing the Scream by Johann Hari
*I don't think I mentioned this one, but I also recommend *In the Realm of Hungry Ghosts* by Gabor Mate

Working with courts and court mandated clients how do we convince court that punishment and demanding abstinence is less effective-- do you have any god reference sources that we can present to courts

A: Where to begin will certainly vary from state to state and in some places county to county. With regards to opioids, the best tool we have is that methadone and buprenorphine are evidenced based treatments. While some courts will still argue for abstinence, they now have to argue against science to make their point. I included a few quick links on MAT from the National Harm Reduction Coalition and SAMSHA.
https://www.samhsa.gov/medication-assisted-treatment
https://harmreduction.org/issues/medication-for-opioid-use-disorder/

We can also look to what other states are doing. Rhode Island Department of Health and the Washington State Department of Health both promote harm reduction practices. (I know many other states are incorporating harm reduction measures through their health departments, these are just two examples.)
https://health.ri.gov/programs/detail.php?pgm_id=1080

https://www.doh.wa.gov/YouandYourFamily/DrugUserHealth/SyringeServicePrograms

The last link here is from the CDC and it outlines evidence based strategies for preventing overdose, and includes the criminal justice system.

https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf

I am a probation officer in a DWI Recovery Court Program. I work with those with co-occurring disorders. Do you have any advice on how I can hold people accountable for requirements while not blurring the line between treatment and probation?

A: That is such a complex and nuanced question, I hope I can do it justice.

I am not sure of the requirements in your program, but I would try to separate (as much as possible), the clinical issue, say alcohol use disorder, from the programmatic requirements, say attending meetings and not drinking and driving. Having a legitimate clinical problem (AUD) does not excuse us from managing the consequences of our actions.

While remaining totally abstinent may be beyond what they can realistically manage, they can still be accountable to their responsibilities. In her book, *Unbroken Brain*, Maia Szalavitz makes a beautiful point, which may be relevant here. She says that although addiction itself is not a choice, it involves choices made both consciously and unconsciously—that on the whole, our decision making may be impaired, addiction does not eliminate free will (though the level of impairment may vary). Szalavitz, using herself as an example, talks about how even at her worst, she never used drugs in court or in the view of the police.

The connection here, is that you can both simultaneously have compassion for the addiction, and expectations from the behavior, i.e. they may not be currently able to not stop drinking, but they can make the choice to not drive.

I would love to know if or what thoughts you have on peer support groups for harm reduction?

A: Love it. Peers are able to connect and model in ways that no amount of my book learning and work experience can touch. I do not think it is necessary for someone to have experienced the issues they support (and truthfully, some clients prefer it that way). However, peers are an invaluable asset and I wish all clients/patients had access to a peer support program of some sort as an option.

When I worked at the methadone clinic, we had some staff that were also in treatment. I learned SO much from them and remain grateful about how they open they were with me in sharing their experiences and insights and then seeing how they used it to relate with clients. They were amazing in the way they could relate, but also understand they just because they had a similar experience, did not mean they had all the answers, or that the same things would necessarily work for the clients, just because it worked for them. I felt like it helped me learn new ways of considering and using self-disclosure—something that can be tricky for therapists…

Are you familiar with moral reconation therapy? Do you have any thoughts on MRT in the context of harm reduction?

A: I apologize, I am not familiar enough with MRT to discuss it as it relates to harm reduction.

Public Health England promotes vaping as an evidence-based tool of harm reduction for smoking, even handing out vaping products to medically indigent adult smokers. Why are we so different?

A: Yes, we tend to lag behind Canada and much of Europe. I think there are a multitude of different factors at play in our country. Much of it comes down to the US continuing to see substance use as primarily a criminal/morality issue, rather than as first and foremost a public safety issue.

If you are interested, here is a link to the 2018 Harm Reduction International Global State of Harm Reduction Overview. It's interesting to see what other countries are doing in regards to harm reduction.

https://www.hri.global/files/2018/12/10/GlobalOverview-harm-reduction.pdf

Isn't there a very high liability for the clinician if the client continues to use and may overdose?

A: By refusing to see people who are continuing to use, I do nothing to help them. I am asking them to essentially solve their problem before coming to me for help. By accepting clients who continue to use, I have the ability to actively help promote safer use and hopefully prevent or minimize the likelihood of overdose. I never avoid the conversations of the dangers of their use, but neither do I force a goal or issue an ultimatum (I won't work with you if you use).

Most substance use clients do not want to harm themselves. Most are stuck—they are afraid and confused and suffering. The question I ask myself, is 'do I think I can be of use to this person and their current situation?'. If not, I provide resources and referrals for other treatments and/or other clinicians.

I'm listening from New Zealand. Government has given permission to a company to test the illegal drugs concert goers are using to make sure they are "safe". This is harm reduction here which is hugely supported in this country. What do you think?

A: I think New Zealand is awesome. This is a great example of putting mortality before morality. This was occurring some in the US, but is not widely accepted. Many US venue operators disallow it from being done onsite for fear of potential legal ramifications (see RAVE ACT). Europe leads the world in providing life-saving, drug checking services for ecstasy users.

Where does harm reduction come into SUD treatment when the treatment center is an abstinence-based program?

A: I think a key thing is giving information. Information about substance use and safety does not need to be considered at odds with the goal of abstinence. We know that relapse rates are quite high. We can support recovery, people can strive for abstinence, and we can still provide life saving information and referrals. If we continue to see objective, truthful information as condoning use, we put people's lives at risk.

For example, someone discharging from an abstinence based program for opioid use disorder could be provided information about tolerance reduction, and their risk of overdose increasing after discharge if they choose to use. They could provided Narcan and information and resources for harm reduction services in their community, alongside the information and referrals for continued counseling, narcotic anonymous schedules, etc.

People need choice, they need options. They need plans and support for the best of their days and the worst of their days.

I'd also like to hear more about how harm reduction intersects with ASAM criteria.

A: These article can likely explain it better than I can. Both are directly from ASAM and discuss harm reduction.
https://www.asam.org/docs/default-source/public-policy-statements/2018-statement-on-role-of-recovery-in-addiction-carec806229472bc604ca5b7ff000030b21a.pdf?sfvrsn=4fba42c2_0

https://www.asam.org/Quality-Science/publications/magazine/read/article/2014/04/17/med-sci-harm-reduction-fits-in-with-patient-centered-approach

Why reduce harm? Why not prevent harm or remove harm?

A: Prevention efforts are critical and certainly underutilized.

However, we must also focus on reducing harm, because eliminating it is simply not possible. People have sought out psychoactive substances for thousands of years and are unlikely to stop. The US has certainly tried the route of removing harm through the war on drugs, and even earlier during Prohibition. During Prohibition, people were so desperate for alcohol that used methyl alcohol when ethyl alcohol was too hard to come by. Methyl alcohol is very

dangerous to consume and among many problems, it can cause blindness, hence the term blind drunk. In County Derry Irelnad, alcohol was briefly banned, and people turned to ether, which seemed like a good work around until they realized it caused excess gas & was highly flammable—a bad combination.

My perhaps long winded point is that it is not simply possible to remove harm. Sometimes we have to work backwards—help them reduce the harm they are already enduring and help support them and address the biopsychosocial issues that have led to and sustained the harmful behaviors. And of course, whenever possible enhancing prevention efforts on the front end.

What are some ways, for those of us working in clinic settings, to back harm reduction as evidence based when it's questioned by other providers (medical, psychiatric, etc.)?
A: Well, the question of whether some strategies are evidence based is not really debatable at this point. Narcan, buprenorphine, methadone, and needle exchange programs are pretty well proven as evidence based at this point.

These are articles from the American Medical Association, regarding harm reduction (they are in favor by the way)
https://www.ama-assn.org/delivering-care/opioids/policy-road-map-shows-way-end-overdose-epidemic

https://www.ama-assn.org/delivering-care/opioids/taking-action-opioid-use-disorder-pain-harm-reduction-during-covid-19

These articles pulled from the ASAM site could be helpful as well.
https://www.asam.org/docs/default-source/public-policy-statements/2018-statement-on-role-of-recovery-in-addiction-carec806229472bc604ca5b7ff000030b21a.pdf?sfvrsn=4fba42c2_0

https://www.asam.org/Quality-Science/publications/magazine/read/article/2014/04/17/med-sci-harm-reduction-fits-in-with-patient-centered-approach

We have to look beyond our own preferences and biases and be willing to do what is right for the person standing before us. I would hope that if the patient needs care that is outside of how the physician chooses to practice, then they would provide referrals elsewhere.

The ultimate goal of harm reduction is the same as in abstinence only programs—to keep people alive and safe. The reality is we need as many methods as possible to keep people alive and well as possible—we need more choices not less.

What do you tell a person who uses marijuana and says it's just a choice and it's going to be legalized anyway?
A: I don't tell them anything, I listen to them. I try to understand alongside them why marijuana is important to them. I take the stance of objective curiosity and support their goals, while sharing objective concerns, especially safety related concerns about their use. If their goals for therapy do not include stopping their marijuana use, then I would not force the issue.