Understanding Harm Reduction and Medication Assisted Treatment – The Basics

Harm Reduction (HR) –

> **"Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.**
> Harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to meet drug users "where they're at," addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction." – *From www.harmreduction.org*

Harm Reduction Simplified:

In its simplest terms, harm reduction is about

1) **Starting where the person is**

2) **Accepting incremental change**

1) **Starting where the person is:** This concept is exactly what it sounds like. It is important to allow the change process to stem from the place where a person is willing to work from. Discuss:

- "A bird in the hand is worth two in the bush"

- "Start where you are, use what you have, do what you can" – Arthur Ashe

Consider where the person is ***realistically***

- Example – Imagine unloading a truck with a group of workers but one person is a young child and another is in a wheelchair or on crutches. Would you expect everyone to carry the same load? (Or would you realistically accept people's contribution based on their abilities and limitations?)

The same is true with someone who has a substance use issue. Quite often, there are co-occurring mental health issues as well (Studies show about 2/3 of the time) – **Isn't it important to take this into consideration when developing your expectations?**

Not everyone is the same - Comparing can be unfair and counterproductive

- "I am in recovery from alcohol, why can't my son do it"

- "My neighbor's husband stopped using, why can't mine?"

It's not *"apples to apples"* when it comes to change. **People's individual circumstances, experiences and abilities are different and we all change differently and at our own pace.**

- Also "**point in time"** is a factor – What may be difficult today may come easier later, you can never be sure.

An example to consider: Going to the doctor

Imagine you go to the doctor and the doctor tells you that you have a chronic illness that needs to be taken care of immediately (like diabetes, for example) – He goes through a list of things he wants from you which includes:

- Lose ___ amount of pounds
- Stop eating _____
- Start eating _____ daily
- Exercise ____ times per week
- Take these vitamins _____
- Take these medications _____
- Go on the following website and read ______

Realistically, how many things on the list will you end up sticking with in the beginning?

Now consider someone struggling with substance use issues and possibly mental health issues as well. Think of all the complex life problems that brings with it and the struggles to function.

Now this person enters treatment and is told:

- Stop using all substances immediately and stay that way
- Find new ways to cope
- Change all of your friends
- Come to this program __ times per week
- Take these medications
- Believe in a higher power, rely on that power, pray, mediate, and do this list of things ____
- Go to meetings
- Learn to be assertive and effectively manage emotions without getting high
- Find new ways to have fun without drugs
- Get a job
- Etc.…

Is it realistic to expect all of this right away?

- ***The "Ideal" Perspective:***
  - Focusing on a predetermined, highly-regarded set of future goals and expectations that often come from sources outside of the client including family, society and counselors themselves. Looking at client "best case scenarios" as the benchmark for progress
  - Treatment interventions are often geared toward ushering clients toward preconceived measures of progress regardless of whether or not the client is expressing readiness or willingness to commit toward working on these types of loftier goals

- ***The "Real" Perspective***:
  - Focusing on the present; what we have right before us in the here and now
  - Accepting the current situation for what it is, factoring in both strengths as well as areas that still may need work and areas of resistance. Remaining hopeful about potential progress but also being realistic about potential obstacles and struggles
  - In treatment, willing to put our own viewpoint as counselors about what is ideal for our clients off to the side to instead focus on considering what our clients are willing and able to do in the present to make even small amounts of progress now

"The pessimist complains about the wind, the optimist hopes for it to change, the realist adjusts the sails" – W.A. Ward

- We do not want to let go of our ideals. It is important to have ideals. However, while working towards goals, we must be realistic - **Discuss what is ideal vs what is realistic**

2) Accepting incremental change

- What is incremental change? – To simplify this even further, incremental change is just **baby steps**

Illustration – Failing student – Suppose you had a child who failed every class in school. Straight F's. Obviously you would do what you can to help that child and talk to him or her about doing better. Suppose next report card the child comes home with straight D's. Would you punish him or her for still having a very poor report card or praise and reward the child for their progress?

Can we help, support and encourage our loved one to get him or her moving in a positive direction? Accepting baby steps (incremental change)

Understanding Addiction as a Disease

Disease: (Defined) – An illness; A particular destructive process in an organism. A condition with a specific set of **Diagnosable Symptoms**

The Disease of Addiction is often compared with cancer or diabetes which are much more "black and white" diseases (you either have them or you don't). Rather, addiction compares better with a cold as it can be seen across a spectrum (The "sniffles" all the way to pneumonia with everything in between)

The following statements are - Addiction Myths - Discuss the alternative TRUTHS

- "A drug is a drug is a drug"
- Psychotropic Medication is a "crutch"
- MAT is a "crutch"
- Someone has to want to stop using
- There are no exceptions to the rule
- Inpatient and residential is required - You can't possibly do detox on an outpatient basis
- Willpower is useless
- Relapse and recovery are polar opposites, you are either doing one or the other
- You have to admit you are an addict to get better
- Family has to apply tough love
- "Addicts" always lie and therefore can never be trusted
- You have to hit rock bottom

Medication Assisted Treatment for Opioid Use Disorders (MAT)

The following is taken from the US Substance Abuse and Mental Health Association – SAMHSA - https://www.samhsa.gov/medication-assisted-treatment and **The National Alliance of Advocates for Buprenorphine Treatment - https://www.naabt.org/faq_answers.cfm?ID=5**

What's this agonist / antagonist stuff?

An ***agonist*** is a drug that activates certain receptors in the brain. *Full agonist opioids* activate the opioid receptors in the brain fully resulting in the full opioid effect. Examples of full agonists are heroin, oxycodone, methadone, hydrocodone, morphine, opium and others.

An ***antagonist*** is a drug that blocks opioids by attaching to the opioid receptors without activating them. Antagonists cause no opioid effect and block full agonist opioids. Examples are naltrexone and naloxone. Naloxone is sometimes used to reverse a heroin overdose.

A ***partial agonist*** activates the opioid receptors in the brain, but to a much lesser degree than a full agonist. (Buprenorphine)

Medicated-Assisted Treatment (MAT) is the use of FDA- approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders

There are three medications commonly used to treat opioid addiction:

- Methadone – clinic-based opioid agonist that does not block other narcotics while preventing withdrawal while taking it; daily liquid dispensed only in specialty regulated clinics
- Naltrexone – office-based non-addictive opioid antagonist that blocks the effects of other narcotics; daily pill or monthly injection
- Buprenorphine – office-based opioid agonist/ antagonist that blocks other narcotics while reducing withdrawal risk; daily dissolving tablet, cheek film, or 6-month implant under the skin

Methadone

Methadone tricks the brain into thinking it's still getting the abused drug. In fact, the person is not getting high from it and feels normal, so withdrawal doesn't occur. Pregnant or breastfeeding women must inform their treatment provider before taking methadone. Methadone is approved for women who are pregnant or breastfeeding.

Buprenorphine

Like methadone, buprenorphine suppresses and reduces cravings for the abused drug. It can come in a pill form or sublingual tablet that is placed under the tongue.

Buprenorphine is a *partial agonist* meaning, it activates the opioid receptors in the brain, but to a much lesser degree than a full agonist.

Buprenorphine also acts as an antagonist, meaning it blocks other opioids, while allowing for some opioid effect of its own to suppress withdrawal symptoms and cravings.

Buprenorphine is different from other opioids in that it is a **partial opioid agonist**[3]. This property of buprenorphine may allow for;

- less euphoria and physical dependence*[3]
- lower potential for misuse*[3]
- a ceiling on opioid effects*[3]
- relatively mild withdrawal profile*[3]

At the appropriate dose buprenorphine treatment may:

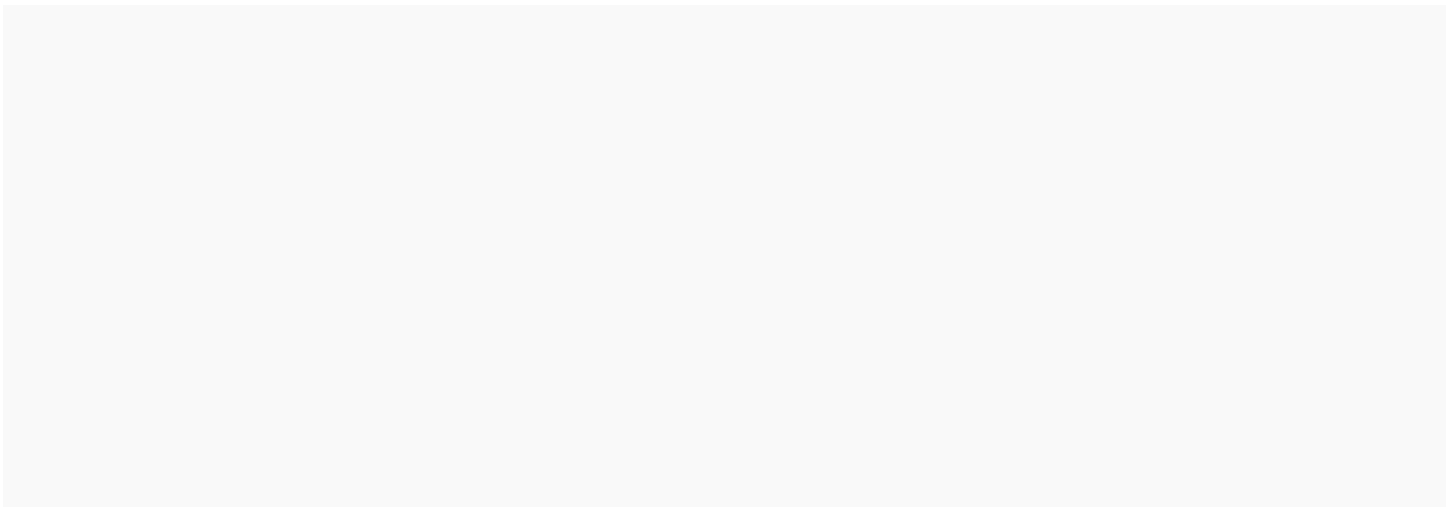
- Suppress symptoms of opioid withdrawal[2]
- Decrease cravings for opioids[2]
- Reduce illicit opioid use[2]
- Block the effects of other opioids[2]
- Help patients stay in treatment[2]

Naltrexone

Naltrexone works differently than methadone and buprenorphine in the treatment of opioid dependency. If a person using naltrexone relapses and uses the abused drug, naltrexone blocks the euphoric and sedative effects of the abused drug and prevents feelings of euphoria.

Opioid Overdose Prevention Medication

FDA approved naloxone, an injectable drug used to prevent an opioid overdose. According to the World Health Organization (WHO), naloxone is one of a number of medications considered essential to a functioning health care system



MAT Effectiveness

In 2013, an estimated 1.8 million people had an opioid use disorder related to prescription pain relievers, and about 517,000 had an opioid use disorder related to heroin use. MAT has proved to be clinically effective and to significantly reduce the need for inpatient detoxification services for these individuals. MAT provides a more comprehensive, individually tailored program of medication and behavioral therapy. MAT also includes support services that address the needs of most patients.

The ultimate goal of MAT is full recovery, including the ability to live a self-directed life. This treatment approach has been shown to:

- Improve patient survival
- Increase retention in treatment
- Decrease illicit opiate use and other criminal activity among people with substance use disorders
- Increase patients' ability to gain and maintain employment
- Improve birth outcomes among women who have substance use disorders and are pregnant

Research also shows that these medications and therapies can contribute to lowering a person's risk of contracting HIV or hepatitis C by reducing the potential for relapse.

Unfortunately, **MAT is greatly underused**. For instance, according to SAMHSA's Treatment Episode Data Set (TEDS) 2002-2010, the proportion of heroin admissions with treatment plans that included receiving medication-assisted opioid therapy fell from 35% in 2002 to 28% in 2010. The slow adoption of these evidence-based treatment options for alcohol and opioid dependence is partly due to misconceptions about substituting one drug for another.

Discrimination against MAT patients is also a factor, despite state and federal laws clearly prohibiting it. Other factors include lack of training for physicians and negative opinions toward MAT in communities and among health care professionals.