Harm Reduction Best Practices

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Please share your tools and resources!

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Nicole’s Story
Harm Reduction Strategies for a Public Health Crisis

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Harm Reduction

- Doesn’t minimize harms that can be related to drug use, but accepts drug use as a part of our world.

- Does a particular drug-related harm come from the drug use itself, or is it due to legal status, stigma or other factors?

- Example: Heroin doesn’t cause HIV. If sterile syringes are always used or heroin is ingested without needle use, heroin use would not cause HIV.

- Fentanyl does not cause overdose, taking an unknown dose that is greater than your body is accustomed to, causes overdose. If people know what is in their drug supply, overdose risk is reduced.
Prevention Point Pittsburgh

Harm Reduction Services

- Providing Sterile Injection Equipment to prevent HIV & Hep C since 1995.
- Testing for HIV and Hepatitis C
- Case Management, assistance to treatment
- Overdose Prevention & Response Training
- Naloxone Distribution since 2005.
- Wound Care Consultation Clinic
- Education on safer injection.
- Safer Smoking Supplies
- Fentanyl test strips for drug checking
- All Services Free of Charge
- Anonymous/Confidential
- Low Threshold
Allegheny County Accidental Drug Overdose Deaths
2000-2017*

85% of cases include more than one drug

*Data from Allegheny County Medical Examiners Annual Reports. Includes all overdose deaths where these drugs were present at time of death, alone or in combination with other substances.
People who are dependent on prescription opioids and can’t get them anymore — whether because their physician, afraid of consequences, has stopped writing prescriptions or because the street supply has dried up — have three choices, said Clark. They can quit, they can go to treatment or they can turn to heroin… in many states there is no coordination between the enforcement against overprescribing of opioids and the need for treatment for people who are dependent and can’t quit… And there is still a pervasive attitude against agonist medications like methadone and buprenorphine, even among many in the substance abuse treatment community. The unintended consequence of the successes in reducing prescription drug abuse may well be an increase in heroin use, said Clark, noting that medication-assisted treatment has resulted in reducing HIV and hepatitis by reducing needle sharing.”

“Of course, the consequences are “unintended,” but that doesn’t mean they couldn’t have been foreseen. “It was never the intention to force people to take heroin,” said Clark. “But if you shut down treatment, and there is an increase in heroin, there will be an increase in HIV, increase in hepatitis, increase in crime, increase in complications associated with using and an increase in international criminal activity.” There will also be an increase in overdoses, which is painfully ironic given that the main reason prescription opioids have had so much attention is the overdoses. “You can predict the dosages that will cause overdoses with prescription medication,” said Clark. “But with heroin, you’re moving to a market where not only can you not predict the dosage, but you can’t predict the quality — you can’t predict anything — and the risks really start to climb.”

- Quoting H. Westley Clark, M.D., director of SAMHSA’s Center for Substance Abuse Treatment (CSAT) in 2012
Supply Reduction Without Increased Access to Treatment and to Naloxone Had Devastating Consequences.

- Since 2010 Prescription Opioid Overdose deaths plateaued, but overall opioid overdose deaths more than doubled, primarily driven by illicit fentanyl overdose deaths.

- In addition to overdose deaths, Hepatitis C infections have increased 250% since 2010. Rural states have seen Hep C increase of 364%.

- HIV Outbreaks: Over 200 injection-related HIV cases rural, Scott County, Indiana, from 2015 outbreak.

- Lowell/Lawrence, MA – 129 cases of HIV; CDC concerned about possible outbreaks in small towns/rural areas without access to SEP.

- Huntington WV - 80 injection-related HIV cases, up from 8 or 9 annually.

- Restricting access to sterile injection equipment is not effective strategy.
"If you believe that the opioid epidemic is in fact iatrogenic, as you do, if you believe we must restrict prescribing to reverse it, then we have the highest ethical standard to not further harm people as we try to fix this problem.

Akin to a surgeon removing an instrument left in an abdomen, we would not rip out what we left behind and tell you to get out of our office.

We would very carefully repair the problem and serve you with the utmost care and caution until that issue and any complications were managed. “

Phillip Coffin, MD, MIA
San Francisco Department of Public Health
Plenary Session Harm Reduction Conference, Baltimore, MD
October 23, 2014
Opioid Replacement Therapy:
- Methadone and buprenorphine (suboxone) very effective in reducing overdose deaths when there are no arbitrary limits on duration of treatment.

Abstinence-based drug treatment:
- Can play an important role in addressing problems, but only a small percent never use opioids again. Risk of overdose increases when relapse occurs. It is vital that programs make sure their participants have naloxone.

Vivitrol/naltrexone:
- Can also be useful treatment, but no evidence that it reduces risk of overdose. Vital that participants have naloxone!

Different paths for different people.
- Methadone or buprenorphine may not be best treatment for everyone, but everyone should have the option as this is most effective!
The Medication IS the Treatment rather than “assisting.”

Research shows people do just as well on bup or methadone alone as methadone plus counseling.

Counseling, therapy, support groups can undoubtedly be beneficial for some, BUT the benefits of medication are not contingent on auxiliary treatment.

In the age of fentanyl, refusing medication to someone because they don’t go to counseling may be a death sentence! Opioids Replacement medication should be more easily available than illicit fentanyl in order to reduce deaths.

MA Retention in OUD Treatment
8,327 community care members with an OUD enrolled in methadone program from Jan 2015 – Dec. 2017
3,047 community care members with an OUD (80%) or AUD (20%) who received a XR Naltrexone Injection
18,866 individuals with an OUD who received buprenorphine (OBOT) treatment in MA’s Medicaid system
EFFECTIVE NALOXONE DISTRIBUTION
Prevention Point Pittsburgh
Cumulative Data - July 2005- December 2019

97% of Naloxone Rescues Performed By Individual Who Use Opioids

Third Party Implemented

Total Number of Individuals Who Received Naloxone
Total Number of Overdose Reversals
NUMBER ONE priority: Put naloxone in the hands of those most likely on the scene and first to respond, individuals who use opioids, themselves. Reached through SSP’s, Jails, Hospitals, SUD Tx Programs, Homeless Service Programs, Medical Clinics.

Make naloxone EASILY available and plentiful enough to saturate communities of people who use drugs. Pharmacy dispensing has had minimal impact as PWUD’s are not likely to access. Hospital dispensing is essential component of effective strategy.
An almost 2000% increase in naloxone distributed through SSP, jail, hospital ED's, SUD Tx Providers, Pharmacies, ACHD.

The U.S. Drug Enforcement Administration reports that the number of people in Pennsylvania who died of drug overdoses decreased by 18 percent between 2017 (5,456 deaths) and 2018 (4,492 deaths).

Allegheny County was responsible for 32% (305 out of 964) of the decrease in deaths seen 2017-2018 statewide.

PPP distributed 5158 Doses in 2019.
Allegheny County, Pennsylvania
Accidental Drug Overdose Deaths  2000-2018

2018: 41% Decrease in Deaths

2018: 77% of deaths involve Fentanyl and/or analogues
87% of cases include more than one drug

*Data from Allegheny County Medical Examiners Annual Reports. Includes all overdose deaths where these drugs were present at time of death, alone or in combination with other substances.
Naloxone in the Age of Fentanyl

- Does naloxone work on all types of fentanyl? **YES**
- Can you overdose from casual contact with fentanyl or with someone who has used fentanyl? **NO**
- How many doses of naloxone does it take to reverse a fentanyl overdose? Typically 1-2
- Have there been cases of fentanyl found in methamphetamine and cocaine? **YES**
- Have there been cases of fentanyl found in marijuana? **NO**
medical and toxicology professionals...agreed that it’s implausible that one could overdose from brushing powder off a shirt. Skin cannot absorb even the strongest formulations of opioids efficiently or fast enough to exert such an effect. “There is a reason that the fentanyl patches took years [for pharmaceutical companies] to develop,”

Ed Boyer, M.D., Ph.D., medical toxicologist, Harvard Medical School

Fentanyl cannot cause clinically significant effects, let alone near-death experiences, from mere skin exposure.
The idea: If you know they're about to inject, snort, smoke or swallow fentanyl, you'll take smaller doses, avoid using alone, and make sure you have naloxone handy in case of overdose.

Even when someone assumes they have fentanyl, the experience of testing the drugs and seeing positive confirmation that it's fentanyl has an impact.

It encourages people to use more safely.

Fentanyl Test Strips

Implications for Practice

As a harm reduction intervention, the best available evidence on outcomes related to drug checking services provides descriptive reports that some individuals discard their drugs after receiving the results, and some report reducing the amount of drug they used afterward.

Drug checking may be a useful component of harm reduction services or contribute to a surveillance system on drug use. There are also
Simply warning people to avoid fentanyl or the plethora of new synthetic analogs is both naive and ineffective. Although it is widely accepted that liberal prescribing practices have contributed to the current crisis,...[e]ncouraging physicians to reduce their opioid prescriptions in an environment where the illegal alternatives are lethal is harmful. Abruptly cutting people off their prescription will likely lead to withdrawal. A reduction in the overall number of prescriptions creates a shrinking supply of diverted drugs, the unintended consequence of which may be to push people, many of whom were not even known to be chronic opioid users, into much more unstable and dangerous drug markets. People who once had consistent access to either prescribed or diverted pharmaceutical opioids are suddenly in grave danger of being poisoned by a single lethal purchase.

Although a number of important “upstream” interventions are critical to our response, including a functioning system for treating addiction, supportive housing programs, screening programs for at-risk youth, a cultural shift in how we view drug users and a reduced reliance on the criminal justice system, these will come too late for the families who will lose a loved one this year or the next. We cannot simply give up on the current group of chronic opioid users who are playing a form of “Russian roulette” with every injection or inhalation.

The public health response to any poisoning epidemic should be to provide safer alternatives for people at risk. In the case of the overdose crisis, this would mean providing a regulated supply of pharmaceutical-grade opioids to people at highest risk of overdose. Any options to expand access to pharmaceutical-grade opioids runs counter to prevailing narratives regarding the origins of the current overdose crisis. However, it is now clear that the rapid rise of overdose deaths across the country is a result of illegal, unregulated and lethal synthetic compounds that have largely replaced the regular street supply.
Hepatitis C, increased by more than eight-fold in the 10-county Southwestern Pennsylvania region — climbing from 335 cases in 2003 to 2,818 in 2014, driven by the spike in injection drug use and shared needles, creating an explosion of hepatitis C among younger injection drug users.

Sterile syringes cost about 7 to 10 cents each (about $185/year average) when purchased in bulk, compared to the cost of treating hepatitis C — which can range from $50,000 to $80,000.

New data from West Virginia DOH revealed 1,114 newly reported chronic hepatitis C cases in 2018.
Prescribing syringes should be one element of a comprehensive relationship between the physician and the patient and should be done within the context of the patient's overall medical and health needs, as part of a non-judgmental, culturally sensitive interaction that includes an openness to discussing injection-related activities and a willingness to provide links to other needed programs and services.

Physician prescription of injection equipment is legal in 48 jurisdictions to legality."

Physicians generally have broad discretion to prescribe drugs and devices that they believe are medically beneficial for their patients. Several major medical and legal societies, including the American Medical Association, the Infectious Diseases Society of America, and the American Bar Association all support efforts to improve IDUs' access to sterile syringes, including physician prescription.
Evidence from randomized controlled trials of HAT in Canada and Europe indicates that supervised injectable HAT — with optional oral methadone — can offer benefits over oral methadone alone for treating OUD among individuals who have tried traditional treatment modalities, including methadone, multiple times but are still injecting heroin.

Although heroin cannot be prescribed in the United States because it is a Schedule I drug, it would be legal to conduct a human research trial on HAT. The literature on treating OUD with hydromorphone (e.g., Dilaudid) is less extensive than the literature on HAT; however, the existing results are encouraging. Hydromorphone trials in the United States would face fewer barriers than HAT trials.
Stimulant safe supply: a potential opportunity to respond to the overdose epidemic

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Abstract

Background: Occurring against the backdrop of an overdose crisis, stimulant use and stimulant-involved deaths in North America are increasing at an alarming rate. Many of these deaths are being attributed to fentanyl and related analogs, which have been increasingly found within street-level stimulant supplies. Within this, people experiencing socio-economic marginalization are at the greatest risk of overdose and other harms from adulterated stimulants. Current treatments for stimulant use disorder have limited effectiveness, and even less applicability to the lived realities of marginalized stimulant users. Emerging technologies, such as drug checking, are being implemented to support safer stimulant use, but the accessibility and utility of these technologies to stimulant users are framed by experiences of vulnerability that render them largely ineffective.

Stimulant safe supply: Solutions that provide a legal and safe supply of non-adulterated stimulants of known quality, and within a health care framework, are needed to directly address the risk of an increasingly adulterated stimulant supply. Similar innovative opioid-focused interventions are being piloted with medications that have a similar pharmacological effect as their illicit counterparts. While there are currently no approved pharmacotherapies for stimulant use, research has demonstrated a number of stimulant medications that are promising substitutes for cocaine and methamphetamine use. Much like with opioid-focused pharmacotherapies, having a consistent and safe supply of stimulants can lead to improved health outcomes and will drastically reduce overdose risk. However, for a stimulant safe supply intervention to be a success, it must provide the high and performance-enhancing effects that people seek from the illicit market, which requires doses and user agency that trials to date have not provided.

Conclusion: Efforts are needed to investigate the feasibility of pharmacological stimulant-based interventions that address safe supply needs. The promise of similar opioid-focused approaches in addressing both overdose-related risks and experiences related to vulnerability underscores the need to advance safe supply approaches targeted towards people who use stimulants. Given the current overdose crisis and rising stimulant use across North America, the implementation and evaluation of such novel stimulant-focused interventions should be a public health priority.
Safer Consumption Sites In HOSPITALS? Is that crazy?

- Safe drug-use rooms are typically designed to help keep people who use drugs out of the hospital, but they could work within hospitals. A safe place to inject for patients in the hospital could reduce conflict with staff, protect patients and providers from needle sticks and other hazards, and enable patients to receive respectful, high-quality care in their hospital beds. Safe drug-use rooms could also offer treatment for addiction, a step often neglected in hospitals.

- Alternatively, if patients are prescribed medications they need of the type needed, in adequate doses and with sufficient regularity to ensure they remain comfortable and do not experience withdrawal symptoms, patients may not need to provide their own medications in the hospital and reduce conflicts, leaving AMA, and the need for staff to adopt a police role.
Of 73 visits to PPP’s wound care consultation program, when people were asked the question “If you hadn’t come here for this problem, where would you have gone?”

- 9 people reported they would have gone to ED.
- 19 stated they would have gone to a “clinic,” “urgent care,” or their PCP.
- 50 stated they would have done “nothing” or treated the problem themselves.
Harm Reduction Practices in Hospitals

- Reduce Overdose Deaths:
  - Provide naloxone in hospital ED’s and other outpatient settings. People should leave with naloxone!
  - Dispense buprenorphine and insure additional doses available.

- HIV, Hep C, Endocarditis, soft tissue infections.
  - Offer testing for HIV, Hep C.
  - Prescribe/Dispense sterile injection equipment.

- Foster effective, compassionate, provider relationship with patients. End “policing” role, prevent patients leaving AMA.
  - Provide medication to prevent withdrawal symptoms and keep patient comfortable.
  - Treat whatever health issues people present with.
“Harm reduction is the radical notion that drug users are people.”
– Iowa Harm Reduction Coalition
Questions?
Future Opioid LAN Events

• Webinars
  • March 26, 2020—11:00 AM
  • March TBA

• Office Hours
  • March 19, 2020—11:00 AM
  • April 2, 2020—11:00 AM

• Regional Meetings
  • February 19, 2020 (Southeast Regional Hospitals/Orgs)
  • March 31, 2020 (Northwest Regional Hospitals/Orgs)