

About California Institute for Behavioral Health Solutions (CIBHS) and Our Presenter

*Eric Haram, LADC*  
Haram Consulting LLC




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## Harm Reduction in A Virtual Environment



Eric Haram  
Haram Consulting LLC

June 24, 2020

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## What is Stigma?

- A mark of shame: "Stain"
  - An identifying mark or characteristic; especially: a specific sign that indicates the presence of a disease

- Merriam-Webster


- In 2017, Dr. Kim Johnson, former Director of CSAT
  - Providers should talk less about stigma and more about discrimination and racism

Slide Credit: UCLA Integrate Substance Abuse Programs

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## Stigma, Discrimination & Racism

- Stigma refers to negative stereotypes. An attribute, behavior, or condition, that is socially discrediting
- Discrimination is the behavior that results from the negative stereotype
- Racism is the belief that different races possess different characteristics, abilities or qualities so to distinguish them as superior or inferior to one another



Slide Credit: UCLA Integrate Substance Abuse Programs

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## Implicit Bias

Unconscious attitudes or stereotypes

Affect our understanding, actions, and decisions

Poor at seeing bias in ourselves, but good at seeing it in others



Ahlfors, RD, Brown, AH & Curtis, B (2018). The Language of Substance Use and Recovery: Novel Use of the Go/No-Go Association Task to Measure Implicit Bias. Health Communication.

Slide Credit: UCLA Integrate Substance Abuse Programs

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## Institutional and Social Stigma

- Structural practices, intended or unintended, that restrict certain individuals or groups from community or governmental opportunities based upon policies, practices and traditions
- The disapproval of, or discrimination against, a person based on perceivable social characteristics that serve to distinguish them from other members of a society.

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# Stigma and Self-Stigma

Self-stigmatization results in part from public stigmatization in a process leading to the internalization of the negative stereotypes associated with addiction



Stigmatization of People with Mental Illness, ARTHUR H. CRISP, MICHAEL G. GELDER, SUSANNAH RIK, HOWARD I MELTZER and OLWEN J. ROWLANDS, British Journal of Psychiatry  
Stigma and Self-Stigma in Addiction, Steve Matthews & Robyn Dwyer & Anke Smeek, Catherine Chichester, APRN, CCAMP 2019

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# Stigma, Discrimination and Racism Interact w/Systems and Distort Individual Outcomes and Public Health Overall

- "I struggle [with] people offering me help, I still think that I'm not worthy of it."
- "Once we start something good we feel guilty because we feel like we don't deserve it."
- "They don't care about me, why would I possibly show up there?"  
"Last time I went to the ED for help, I sat for hours, everyone was rude and police and security keep asking me why I was there!"
- "Don't tell white folks your business...." "...keep your hands out of your pockets" "ask permission to show ID"

Catherine Chichester, APRN, CCAMP 2019

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# Treatment begins with the First Contact

- The first contacts our SUD programs have w/ those seeking help sets a tone for pt. show rates, engagement, retention and ultimately their outcomes.
- Most processes directly dealing with initial engagement are operationally designed to comport with regulatory and financial obligations.
- Often these are not designed with the patient experience as the driver.
- In Behavioral Health Services we often find poor integration of Clinical and Operational front-end processes as a major internal barrier to both clinical and business improvements.

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### Access - Front End Processes and Pt. Impact - Universal Truths

- The steps we take from first contact through the end of the 1<sup>st</sup> clinical encounter make or break a prospective pts. resolve to attend and return.
- No one aspires to attend an SUD evaluation or treatment.
- The many steps in the road to recovery are not palatable in the first contact or appointment.
- Rules and lists at initial points of contact are distracting from the intent of the contact.
- We rarely remember what we are asked in services access. We always remember how long we wait and if the people are nice.

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### Foundation: Access to Treatment

- According to SAMHSA, only 11.6% of the people who need addiction treatment actually get it.
- Front end or Access processes contribute heavily to Engagement or Show Rates
- The processes are defined by either High Demand or Low Demand Characteristics.
- What are some examples of High or Low Demand Characteristics in pt. access that you can think of?

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### Access Characteristics

#### High Demand

- Leave a Message
- Long Hold Time
- Bring ID/Proof of Income
- Call weekly while on wait list.
- Reviewing rules for participation (initial contact)
- Multiple contacts prior to disposition.
- Administrative process delays care.
- Stigma and Discrimination

#### Low Demand

- Real time, human answers 1<sup>st</sup> call for help.
- Clinical triage vs. financial
- Low (less than 3 days) or no wait times.
- Providing what is tolerable
- Availability to trouble shoot barriers- Transportation, childcare, tx. or medication assistance.
- MAT and Medication 1<sup>st</sup> processes.

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### Strategies for Lower Front End Demand Characteristics for Pt. Access (Case Examples)

- Reduce wait times
- Streamline Intake and Assessment Paperwork
- Improve real time phone answering and scheduling
- Increase volumes/admissions
- Review and adapt policies which restrict access goals. (Re-Admission rules, Relapse policies, no MAT)
- Implement an Evidence Based Practice and monitor performance.

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### Using Motivational Interviewing in Brief Interventions?

- Brief opportunistic interventions are short, Virtual or face-to-face conversations regarding Risk-Oriented Behavior, motivation to change, and options for change which are provided during a window of opportunity or potentially teachable moment; Often occasioned by a medical event.
- Brief interventions are successful when clinicians relate a person's risky behavior to what the Person sees as the issues.

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### A SHIFT IN OUR THINKING

FROM  
"Why isn't this person motivated?"

TO  
"For what are they motivated?"

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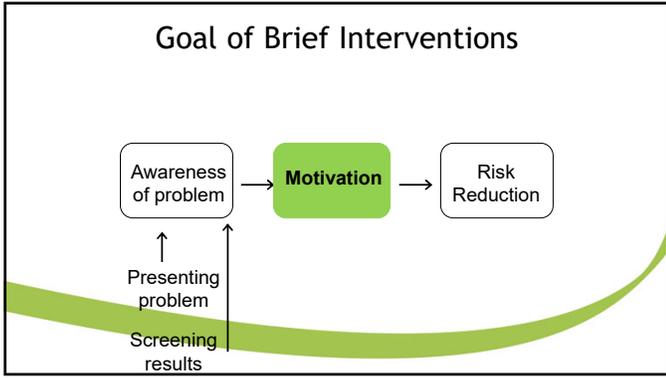
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### Brief Interventions for Persons at Risk Due to Substance Use

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- ### Motivational Interviewing, Common Elements FRAMES
- Personalized **F**eedback
  - **R**esponsibility
  - **A**dvice
  - **M**enu of options
  - **E**mpathy
  - **S**elf-efficacy

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### Brief Intervention Effect

- Brief interventions trigger change.
- A little counseling can lead to significant change, e.g., 5 min. has same impact as 20 min.

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### Where Do I Start?

- What you do depends on where the person is in the process of changing.
- The first step is to be able to identify where the person is coming from.
- "People are better persuaded by the reasons they themselves discovered than those that come into the minds of others"  
*Blaise Pascal*

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### Ambivalence

- All change contains an element of ambivalence.
  - We "want to change and don't want to change"
- People's ambivalence about change is the "meat" of the brief intervention.

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## Reflective Listening

- Listen to both what the patient says and to what the person means
- Show empathy and don't judge
  - You do not have to agree
- Be aware of intonation
  - Reflect what people say with statements not a question, e.g., "You couldn't get up for work in the morning."

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## Open Ended Inquiry

- Requests a story "*tell me about*"
- Searches for meaning "*help me to understand*"
- Asks *what* and *how* questions "*what would it be like if*"
- Not *why* questions "*why do you continue to*"
- Not questions that can be answered in one word

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**F**  
Feedback

**L**  
Listen & Understand

**O**  
Options Explored

~~**W**~~  
Warn

Avoid Warnings!

(that's it)

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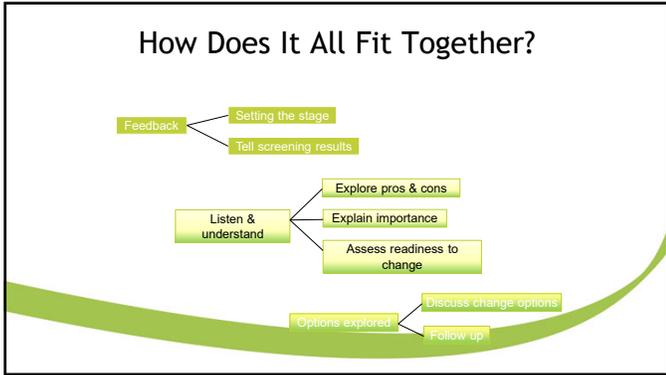
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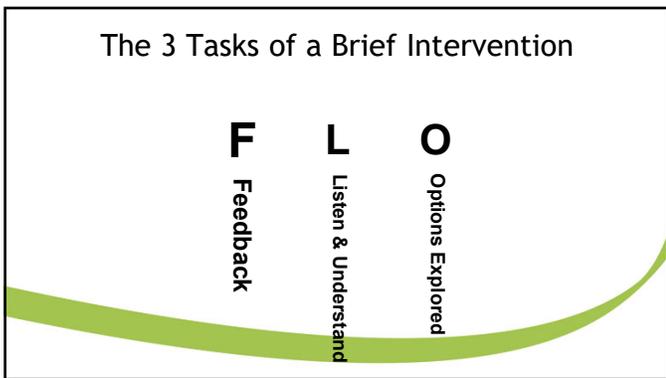
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### Rolling with Resistance

- Look, I don't have a drug problem.
- My dad was an alcoholic; I'm not like him.
- I can quit anytime I want to.
- I just like the taste.
- Everybody drinks in college.
- Why should I change any of this?!

What would you say?

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### Easy Ways to Let Go

- I'm not going to push you to change anything you don't want to change.
- I'd just like to give you some information.
- What you do is up to you.

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### The 2<sup>nd</sup> Task: Listen & Understand



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### The 2<sup>nd</sup> Task: Listen & Understand

#### Listen for the Change Talk

- Maybe drinking did play a role in what happened.
- If I wasn't drinking this would never have happened.
- Using is not really much fun anymore.
- I can't afford to be in this mess again.
- The last thing I want to do is hurt someone else.
- I know I can quit because I've stopped before.

**Summarize, so they hear it twice!**

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**The 2<sup>nd</sup> Task: Listen & Understand**

**Importance/Confidence/Readiness**  
On a scale of 1–10...

- How important is it for you to change your drinking?
- How confident are you that you can change your drinking?
- How ready are you to change your drinking?

For each ask:

- Why didn't you give it a lower number?
- What would it take to raise that number?

1 2 3 4 5 6 7 8 9 10

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**The 3 Tasks of a Brief Intervention**

**F**  
Feedback

**L**  
Listen & Understand

**O**  
Options Explored

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**The 3<sup>rd</sup> Task: Options for Change**

What now?

- What do you think you will do?
- What changes are you thinking about making?
- What do you see as your options?
- Where do we go from here?
- What happens next?

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### The 3<sup>rd</sup> Task: Options for Change

#### Offer a Menu of Options

- Manage drinking/use (cut down to low-risk limits)
- Safer drug use (needle exchange, cleaning works, Narcan access)
- Eliminate your drinking/drug use (quit)
- Never drink and drive (reduce harm)
- Utterly nothing (no change)
- Seek help (refer to treatment)

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### The 3<sup>rd</sup> Task: Options for Change

- Closing the Conversation (“SEW”)
- **S**ummarize patients views (especially the pro)
- **E**ncourage them to share their views
- **W**hat agreement was reached (repeat it)

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### Encourage Follow-Up

- At follow-ups:
- Inquire about use
- Review goals and progress
- Reinforce and motivate
- Review tips for progress

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### Covid-19 and Harms to People Who Use Drugs

- War on Drugs policies fueled by racism, xenophobia
- Many people have chronic medical conditions unaddressed that are risk factors for Covid
- Stigma, distrust, fear and alienation from healthcare system
- Criminalization of people who use drugs and/or live in poverty
- Housing insecurity/homelessness (sleep, nutrition)
- Lack of means to enact Covid-19 prevention measures
- Living in everyday state of emergency and structural violence

*These guides for people who use drugs and harm reduction programs were created by: [Liggett-Creel](#), [Harm Reduction](#), [Reynolds Health Strategies](#), [Harm Reduction Coalition](#), and [Vital Strategies](#).*

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### Overdose Prevention in a time of Covid

- Use universal precautions, especially regarding changing sources and using alone
- Stock up in substances and be prepared for possible w/d (alcohol, Benzes, opioids)
- Re-envision safety planning during physical distancing
  - If not physically together, try and utilize other tools if available
  - Calls/Facetime
  - Hotlines
    - Never Use Alone (800) 484-3731
    - Mutual Aid Networks
      - As hotlines get full, perhaps create local ones
      - Consider
        - What you will do if someone does not respond
        - Options if EMS/paramedics are unable to respond

*These guides for people who use drugs and harm reduction programs were created by: [Liggett-Creel](#), [Harm Reduction](#), [Reynolds Health Strategies](#), [Harm Reduction Coalition](#), and [Vital Strategies](#).*

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### Build a Safety Plan: NYS DOH Guidance



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## Overdose Response

- Check Responsiveness
- Administer naloxone
- Alert EMS
- Rescue Breathing/CPR
- Recovery Position
- Aftercare

These guides for people who use drugs and harm reduction programs were created by: [Higher Ground Harm Reduction](#), [Reynolds Health Strategies](#), [Harm Reduction Coalition](#), and [Vital Strategies](#).

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## Medications for Opioid Use Disorder

The DEA has changed their guidance regarding prescribing and dispensing methadone and prescribing buprenorphine

- Telemedicine is permitted for initial visits as well as regular visits for controlled substances including buprenorphine and other opioids
- Can be done via Facetime, Skype or any other video method. They are waiving HIPAA enforcement

<https://www.deadiversion.usdoj.gov/coronavirus.html>  
<https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html#:~:XmEjN73dJuc:Twitter>

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## Emergency Department MOUD Access2 Pathways To Follow

**COWS ≤ 7**

- 1 - JMEC mobile crisis unit will assess patient
- 2 - After being in the ED, Inpatient monitor for up to 48 hrs, recheck COWS score. If still ≤ 7
- 3 - Mobile Crisis unit will complete JMEC Disposition and Referral Process - remote appointment
- 4 - Hospital pt to consider return to ED should it's worsen before scheduled appointment
- 5 - Discharge Planning, to include Direct Contact with

**COWS ≥ 8**

- 1 - JMEC mobile crisis unit will assess patient
- 2 - Order Librium utilizing induction order set
- 3 - JMEC in ED - Eng in Buprenorphine/induction. Observe for Adverse Reaction
- 4 - Repeat COWS Score in 1 hr from first dose  
If COWS Score is 5 consider 2nd dose of Eng in Buprenorphine - Max dose of 16mg
- 5 - Follow up plan =  
1) JMEC outpatient, 2) with patient 3) in 48 hr appointment continuing to 5 days  
Return Visit Protocol

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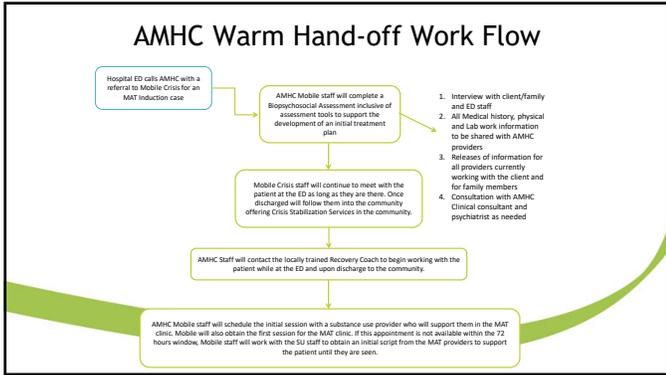
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### Medication First Model for treatment of OUD

The Medication First (or low-barrier maintenance pharmacotherapy) approach to the treatment of Opioid Use Disorders (OUD) is based on a broad scientific consensus that the epidemic of fatal accidental poisoning (overdose) is one of the most urgent public health crises in our lifetimes. Increasing access to buprenorphine and methadone maintenance is the most effective way to reverse the overdose death rate. Increased treatment access will best be achieved by integrating buprenorphine induction, stabilization, maintenance, and referral throughout specialty addiction programs as well as primary care clinics and other medical settings throughout the mainstream healthcare system.

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### 4 Principles of the Medication First Model:

1. People with OUD receive pharmacotherapy treatment as quickly as possible, prior to lengthy assessments or treatment planning sessions;
2. Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits;
3. Individualized psychosocial services are continually offered but not required as a condition of pharmacotherapy;
4. Pharmacotherapy is discontinued only if it is worsening the person's condition.

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### Prepare for Possible Withdrawal

- Call your doctor and ask if there are any medications they can prescribe to treat withdrawal - alcohol, Benzes, opioids
- Buy and stock OTC meds to treat withdrawal symptoms (Tylenol, Imodium, Pepto, Gatorade/Ensure)
- Call your doctor or call an urgent care doctor hotline about any symptoms you may be having before you go into the Emergency Room

*These guides for people who use drugs and harm reduction programs were created by: [Hitcher Ground](#), [Harm Reduction](#), [Reynolds Health Strategies](#), [Harm Reduction Coalition](#), and [Vital Strategies](#).*

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### Syringe Services Program (SSP) Best Practices

- Prioritize Staff and Program Participant Safety
- Take Stock of your Essential Services
- Review/Create a Communication Plan
- Plan for Employee Absences
- Offer Extra Supplies
- Pre-package supplies for participants
- Keep Calm and Don't Panic

*These guides for people who use drugs and harm reduction programs were created by: [Hitcher Ground](#), [Harm Reduction](#), [Reynolds Health Strategies](#), [Harm Reduction Coalition](#), and [Vital Strategies](#).*

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### Covid-19 and Sex Work

- Risks are highest being close to someone with Covid for >10 minutes
- Covid-19 has not been detected in semen/vaginal secretions, however has been detected in feces and blood; use barriers as much as possible
- If possible avoid kissing, close face to face contact
- Engage regular clients as much as possible, if you can say no to someone who looks or sounds ill, please do
- Wash hand and shower before and after each booking
- Access digital platforms if available

These guides for people who use drugs and harm reduction programs were created by: [Ligette Secund](#), [Harm Reduction](#), [Reynolds Health Strategies](#), [Harm Reduction Coalition](#), and [Viral Strategies](#).

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### Resources as Guidelines

[International Journal of Drug Policy](#), Volume 31, May 2016, Pages 25-31. Harm reduction for young people who use prescription opioids extra-medically: Obstacles and opportunities. Brandon D.L. Marshall, Traci C. Green, Jesse L. Yedinaka, Scott E. Hadland

[J Addict Med](#). 2020 May 12 : 10.1097/ADM.0000000000000685. 2020 May 12. Innovation During COVID-19: Improving Addiction Treatment Access. Elizabeth A. Samuels, MD, MPH, MHS, Seth A. Clark, MD, MPH, FASAM, Caroline Wunsch, MD, Lec Ann Jordison Keeler, BSW, Neha Reddy, MPH, Rahul Vanjani, MD, MSc, and Rachel S. Wightman, MD

<http://bit.ly/CoronavirusResourceKit>

<http://bit.ly/COVIDSSP>

<https://www.virusanxiety.com/>

<http://bit.ly/covid19collectivecare>

NYC United Against Coronavirus - Resources and Information

Database of Localized Resources

<https://safe.app.box.com/v/COVID19HarmReductionGuidance>

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Questions

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Contact information for Our Presenter

Eric Harum  
eharam@gmail.com



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Information

1. What to expect after the webinar
2. The next webinar in our series:  
**Wednesday, June 24, 2020, 10:00 am – 11:30 am**
  - Staying Focused and Aligning with Clients Around Long-Term Recovery Goals
  - Elizabeth Morrison, LCSW, MAC
  - Rick Gotscho, PhD, MSW



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