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

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State of Illinois

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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 OUD.
- Incorporate person-centered language in the care of patients with SUD.

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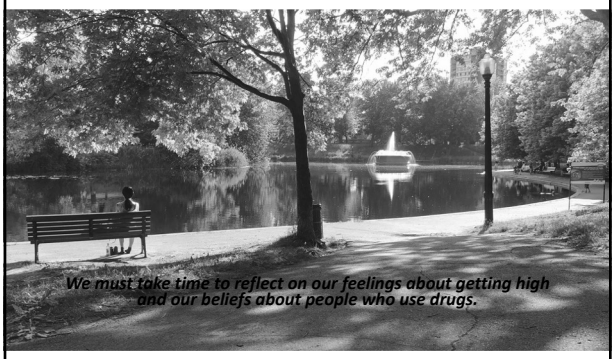

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Outdated Substance Use Treatment Philosophies

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.

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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
- 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

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

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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

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What is Harm Reduction?, 2020

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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.

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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)

JAMES KOWALSKY

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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[a]	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	32.9[c]	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	8.7	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	40.2	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[c]	10.6	10.9[c]	21.1	23.8
Might Cause Neighbors/Community to Have Negative Opinion	8.3[c]	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	3.5	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
- **A Drug and Alcohol Sobering Center** is an evidence-based program staffed by health workers focused on harm reduction, safety, and low- threshold engagement. A safe, welcoming, and trauma-informed space for individuals, especially those experiencing homelessness, to move through drug-induced altered states and reduce harms
- **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

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.

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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

Permission for Use by Dr. Elizabeth Salisbury-Afshar

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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.

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%2Frr6501e1.htm

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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.*

(Doe-Simkins & Bell, 2014)

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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

(Cook, 2019)

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Test Strips: Fentanyl, Xylazine

- Over 90% of opioid-related overdose deaths in Cook County in 2020 involved Fentanyl
- Check for the presence of a substance in their drugs
- Literature Outcomes/Highlights:
  - Increased overdose safety by 77%
  - Changed any behavioral 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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Sobering Centers

- A Drug and Alcohol Sobering Center is an evidence-based program staffed by health workers focused on harm reduction, safety, and low- threshold engagement
- A safe, welcoming, and trauma-informed space for individuals, especially those experiencing homelessness, to move through drug-induced altered states and reduce harms
- An opportunity for low-threshold engagement to discuss less self-destructive coping strategies and move clients towards wellness recovery
- Sobering centers accept clients through multiple referral sources including ambulatory and vehicular outreach teams, walk-ins, police, emergency medical services, and emergency departments

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Sobering Centers

- Addressing Health Care and Inequity:
  - Public intoxication related charges were among the top ten reasons for arrest with Black/American Indian/Alaska Native are arrested at greater annual rates per capita for public intoxication charges
  - As drugs and alcohol are increasingly consumed in public spaces, individuals who encounter intoxicated persons exhibiting harmful behaviors on the street to themselves or others, have few options aside from contacting emergency services (police or EMS). There are limited interventions for police other than arrest or transport of the individual to the hospital or emergency room
  - Houston Recovery Center is a nationally recognized sobering center model, serving the largest metropolitan population among all sobering centers in the US; Jail admissions for public intoxication in Harris County, Texas decreased by 95 percent (from 15,357 to 835) from 2012 to 2017 following the opening of the Houston Recovery Center
  - The US has the highest incarceration rate in the world and incarceration can result in a series of social sequelae affecting a person's ability to maintain housing, personal health, employment, and other necessities – it is critical to support a health-based response to public intoxication rather than criminalization
- Impacts Cost: Decreases Incarceration Cost, Unnecessary Emergency Care, Unnecessary Law Enforcement Processing of those Publicly Inebriated
- Safe Alternate Destination: Of 11,596 visits at the SF Sobering Center (35% were referred by EMS and 12% by the ED), only 4.4% were secondarily transferred to the ED

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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 by reducing harm and overdose death.
- 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
- OnPoint NYC – Opened November 30, 2021
  - 3,258 Participants
  - 72,660 OPS Utilizations
  - 898 Overdose Interventions
  - No Deaths

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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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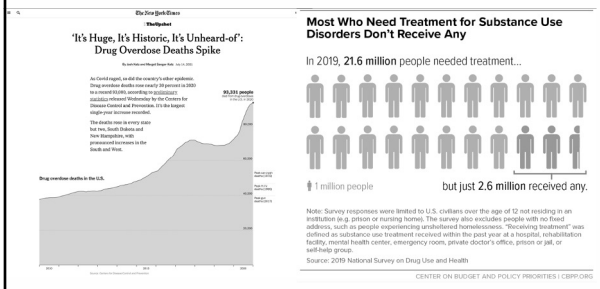
Background



Katz J, Sanger-Katz M. 'It's huge, it's historic, it's unheard-of': Drug overdose deaths spike. The New York Times. https://www.nytimes.com/interactive/2021/07/14/upshot/drug-overdose-deaths.html. Published July 14, 2021. Accessed February 1, 2022.
Most who need treatment for substance use disorders don't receive any. Center on Budget and Policy Priorities. https://www.cbpp.org/most-who-need-treatment-for-substance-use-disorders-dont-receive-any. Accessed February 1, 2022.

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Stigma

Access to Treatment for Drug Use Disorders at US Health Centers: a National Study

Benjamin Bearnot, MD[1,2], Danielle R. Fine, MD[1,2], Nancy A. Rigotti, MD[1,2,3], and Travis P. Baggett, MD, MPH[1,2,4]

[1]Division of General Internal Medicine, Department of Medicine, Massachusetts General Hospital, Boston, MA, USA; [2]Department of Medicine, Harvard Medical School, Boston, MA, USA; [3]Tobacco Research and Treatment Center, Division of General Internal Medicine, Department of Medicine, Massachusetts General Hospital, Boston, MA, USA; [4]Institute for Research, Quality, and Policy in Homeless Health Care, Boston Health Care for the Homeless Program, Boston, MA, USA.

In a national survey, among patients with substance use disorder **who wanted but did not receive treatment**, the most commonly reported reason for not obtaining treatment was **stigma** (69% of respondents).

Bearnot B, Fine DR, Rigotti NA, Baggett TP. Access to Treatment for Drug Use Disorders at US Health Centers: A National Study. J Gen Intern Med. 2019;34(12):2723-2725. doi:10.1007/s11606-019-05043-1

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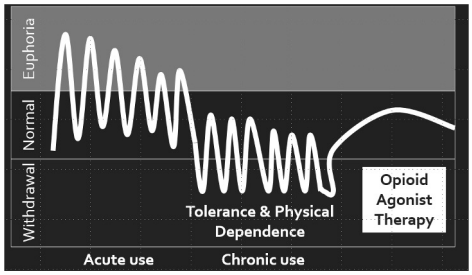
Medication Assisted Recovery



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.

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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.

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-WhyHealthPlansShouldGoToTheMAT.pdf

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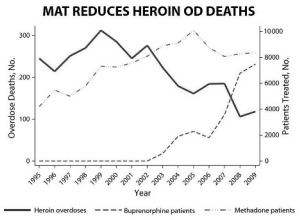
OUD Treatment Outcomes—Evidence

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.



Swartz

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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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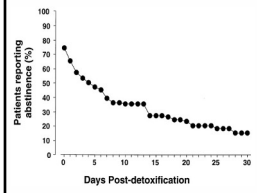
What about detox or medically supervised withdrawal for OUD?



"Medically supervised withdrawal" for OUD is a process in which providers offer methadone or buprenorphine on a short-term basis to reduce physical withdrawal signs and symptoms."

Formerly called ***detoxification***, this process decreases the dose until the medication is discontinued, typically over a period of days…"

"Studies show that most patients with OUD who undergo medically supervised withdrawal will start using opioids again and won't continue in recommended care."

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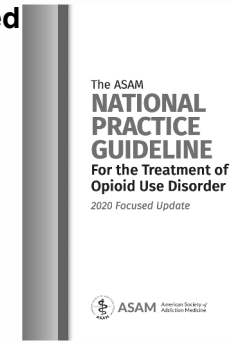
Best Practices of the MSU or Inpatient: Evidence-based

"Opioid withdrawal management (i.e. detoxification) on its own, without ongoing treatment for opioid use disorder, **is not a treatment method for opioid use disorder and is not recommended."**

Patients should be advised about the risk of relapse and other safety concerns, including increased risk of overdose and overdose death.

"Ongoing maintenance medication, in combination with psychosocial treatment appropriate for the patient's needs, **is the standard of care for treating opioid use disorder."**



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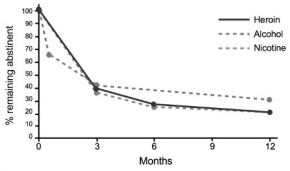
Duration of Treatment with MAR

- 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



SAMHSA, TIP 63, 2020.

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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

- 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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MAR for Alcohol Use Disorder

- Reduced risk of return to any drinking (abstinence)
- Reduced risk of return to heavy drinking
- Reduced number of drinking days
- Reduced number of heavy drinking days
- Reduction in the number of drinks per drinking day

Medication Includes: Naltrexone, Acamprosate, and Disulfiram

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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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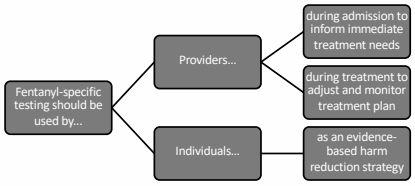
Fentanyl Testing and Clinical Utility

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/A856.33/

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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

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https://www.ncbi.nlm.nih.gov/books/NBK64116/table/A856.33/

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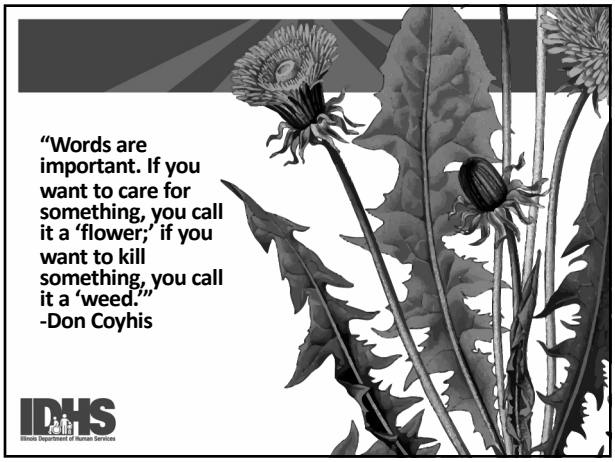

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Does Language Matter?

- 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.

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

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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

Addiction Policy Forum, Language Matters, 2019.

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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

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IDHS Illinois Department of Human Services

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