Harm Reduction and Medical Respite (Dead People Don’t Recover)

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Objectives

• Provide an overview of harm reduction by defining shared language and key terms.

• Collaboratively discuss two case examples of harm reduction in a Respite program.

• Discuss practical application of harm reduction while understanding community and partner constraints.
Figure 1. Opioid-related Deaths, All Intents
Massachusetts Residents: January 2000 - December 2016

<table>
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<tr>
<th>Year</th>
<th>Confirmed</th>
<th>Estimated</th>
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<td>2016</td>
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FIGURE. Percentage of opioid overdose deaths testing positive for fentanyl and fentanyl analogs, by state — 10 states, July–December 2016

Percentage of opioid overdose deaths

Fentanyl
Fentanyl analog

Oklahoma  New Mexico  Wisconsin  West Virginia  Ohio  Maine  Missouri  Rhode Island  Massachusetts  New Hampshire  Total
Mortality Among Homeless Adults in Boston

Shifts in Causes of Death Over a 15-Year Period

Travis P. Baggett, MD, MPH; Stephen W. Hwang, MD, MPH; James J. O’Connell, MD; Bianca C. Porneala, MS; Erin J. Stringfellow, MSW; E. John Orav, PhD; Daniel E. Singer, MD; Nancy A. Rigotti, MD

- Cohort of 28,033 adults seen at BHCHP in 2003-2008
- Drug overdose was the leading cause of death
- Opioids implicated in 81% of overdose deaths

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use.
Harm Reduction Strategies, especially when people relapse / fall out of treatment

Rehabilitation Services Continuum of Care

- Acute Treatment Services / Detox
- Clinical Stabilization Services / Rehab
- Transitional Support Services
- Residential Treatment or Halfway House
- Alcohol & Drug-Free / Sober Homes
- Outpatient Services

Medication for Addiction Treatment

Mental health services, job training, housing, family support, HIV services, living skills, etc.
Harm reduction refers to a range of services and policies that lessen the adverse consequences of drug use and protect public health. Unlike approaches that insist that people stop using drugs, harm reduction acknowledges that many people are not able or willing to abstain from illicit drug use, and abstinence should not be a precondition for help.¹

Harm Reduction is Not:

- Use reduction
- Brief Intervention
- Motivational Interviewing
Evidence Base for HR Based Programs

- HR based Housing Programs
  - Decreased alcohol use and alcohol-related problems over time
  - Decrease in costs for high utilizers with AUD.

- Safe Injection Facilities
  - Safer injection practices, decreased overdoses, decreased publicly discarded syringes,
  - Increased referral to detox and treatment
  - No increase in drug-related crime or rates of relapse among former drug users.


But how does harm reduction fit into a medical respite program?
Case #1 Opioid Use Disorder

- 33F with OUD, bipolar disorder, past DVT admitted at week 31 of her pregnancy
  - Recent preterm labor and suicidal ideation
    - 5 admissions during her pregnancy so far
      - Utox + for cocaine and benzos
  - On admission contracts for safety and wants to stay sober
    - On methadone 85mg
    - Loosely connected to OB care at local hospital
Case #1 OUD

Thoughts or comments?
Case #1 OUD – Plan of Care

• Treat addiction and support pregnancy
  – Transported to MMT daily
  – Transport to OB appointments
  – Engage with mental health care

• Consider private room

• Try to support staff
Case #1 OUD - Challenges

• Substance use during stay
  – Frequently observed to be sedated
    • Endorsed use of clonidine, bzd, cocaine

• Health of baby at risk
  – Non reassuring NST
  – Not following plan for OB

• Challenging behaviors
  – Outbursts towards patients and staff
Case #1 OUD - Challenges

Administratively discharged on day +32
Case #1 OUD – Lessons Learned

• Improve capacity to treat addiction on site
  – Suboxone detox/induction
  – Sedation monitoring protocol

• Increase mental health support
  – 2 on site SW + students + outpatient staff

• Partnerships
  – Methadone clinics
  – SUD experts at local hospitals
Case #2 Alcohol Use Disorder and Behavioral Management

- 58 y/o woman with ETOH use disorder and memory impairment
- Has not engaged in any medical work up
- Now DOS’d from Shelter for aggressive behavior and inability for self care (forgets to shower)
- Admitted to Respite for neuropsych testing, service linkage
Case #2 Alcohol Use Disorder and Behavioral Management

• Medical challenges
  – Linkage to services
  – Neuropsych eval
  – New chronic diagnoses

• Behavioral challenges
  – Gets lost in the facility
  – Behavior while intoxicated
  – Fixed delusion
  – Drinking in the facility
Case #2: Alcohol Use Disorder and Behavioral Management

• High risk of a TROS from Respite
• Behaviorally too complex for a prolonged Respite stay
• Subsequently admitted for short term needs while community case manager works with Placement Team.
  – Primary Care follow up
  – Colonscopy
• Take home message: Very short term admissions can lead to long term success.
  – Important to support staff in discharging vulnerable clients
How does this work in the real world?

What are other ways Harm Reduction can be applied in the Respite setting?
Harm Reduction in Medical Respite

- What have been your successes?
- Who have been your partners?
- What are the challenges, limits and obstacles?
- What can you share with others here?
Thanks for a great discussion!
Safe Injection Facility

DATA: SIF
1. SIFs reduce overdose mortality

Researchers mapped fatal overdose rates before (left) and after (right) the opening of Vancouver’s SIF (●) in city blocks within 500 m of the facility.

2. SIFs reduce neighborhood burden of drug use

Wood et al. (2004) Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users. CMAJ, 171(7) 731-4
3. SIFs increase access to substance use disorder treatment

4. SIFs increase access to substance use disorder treatment

In multivariate analyses, an average of at least weekly use of the SIF and any contact with the facility’s addictions counselor were both independently associated with more rapid entry into a detoxification program.

Vancouver, Canada – SEOSI cohort study

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<th>SIFs DON’T:</th>
<th>Further Reading</th>
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| **Encourage people to initiate injection drug use** | Kerr 2007 examined length of injecting career and circumstances surrounding initiation into injection drug use among 1065 SIF users and found that the median years of injection drug use was 15.9 years, and that only 1 individual reported performing a first injection at the SIF. These findings indicate that the SIF’s benefits have not been offset by a rise in initiation into injection drug use.  
| **Act as a barrier for attendees to seek employment** | Richardson 2008 surveyed 1090 SIF users and found in a multivariate analysis of factors associated with employment, using the SIF for ≥ 25% of injections (versus < 25% of injections) was not statistically significant, suggesting that use of the SIF is not having an adverse impact on efforts to seek employment.  
| **Attract drug dealers to the area**            | Wood 2006 used Vancouver Police Department data to examine the effect of a SIF on crime rates before and after opening and no increases were seen with respect to drug trafficking (124 vs. 116) or assaults/robbery(174 vs. 180), although a decline in vehicle break-ins/vehicle theft was observed (302 vs. 227). The SIF was not associated with increased drug trafficking or crimes commonly linked to drug use.  
| **Increase relapse rates or decrease rate of stopping injection drug use** | Kerr 2006 performed an analysis of periods before and after the facility's opening that showed no substantial increase in the rate of relapse into injected drug use (17% v 20%) and no substantial decrease in the rate of stopping injected drug use (17% v 15%).  
| **Increase the likelihood of overdose**         | Milloy 2009 surveyed injection drug users and found at baseline, 638 (58.53%) reported a history of non-fatal overdose and 97 (8.90%) reported at least one non-fatal overdose in the last six months. In the analysis, factors associated with recent non-fatal overdose included: sex-trade involvement and public drug use. Using the SIF for ≥75% of injections was not associated with recent non-fatal overdose in univariate or multivariate analyses.  