Harm Reduction in Medical Respite

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Seattle's Historical SA Approach

- Shelter-based respite program, 1996
- Shelters clean and sober
- No intentional SA philosophy designated
- Most patients had active SA issues
- Initial discharged users, trended towards harm reduction
- Kept SA use confidential
- Pt's deserving of care regardless of use
- Worthy goal to just resolve medical issue

WILLIAM BOOTH CENTER

Consequences of Differing Philosophies

- Tension between shelter philosophy and respite program
- Shelter drug screens/breath tests
- Large numbers of respite pts discharged for SA prior to medical recovery
- Risk complications/readmissions/ED use
- Ultimately, not meeting program mission

SAMHSA Background

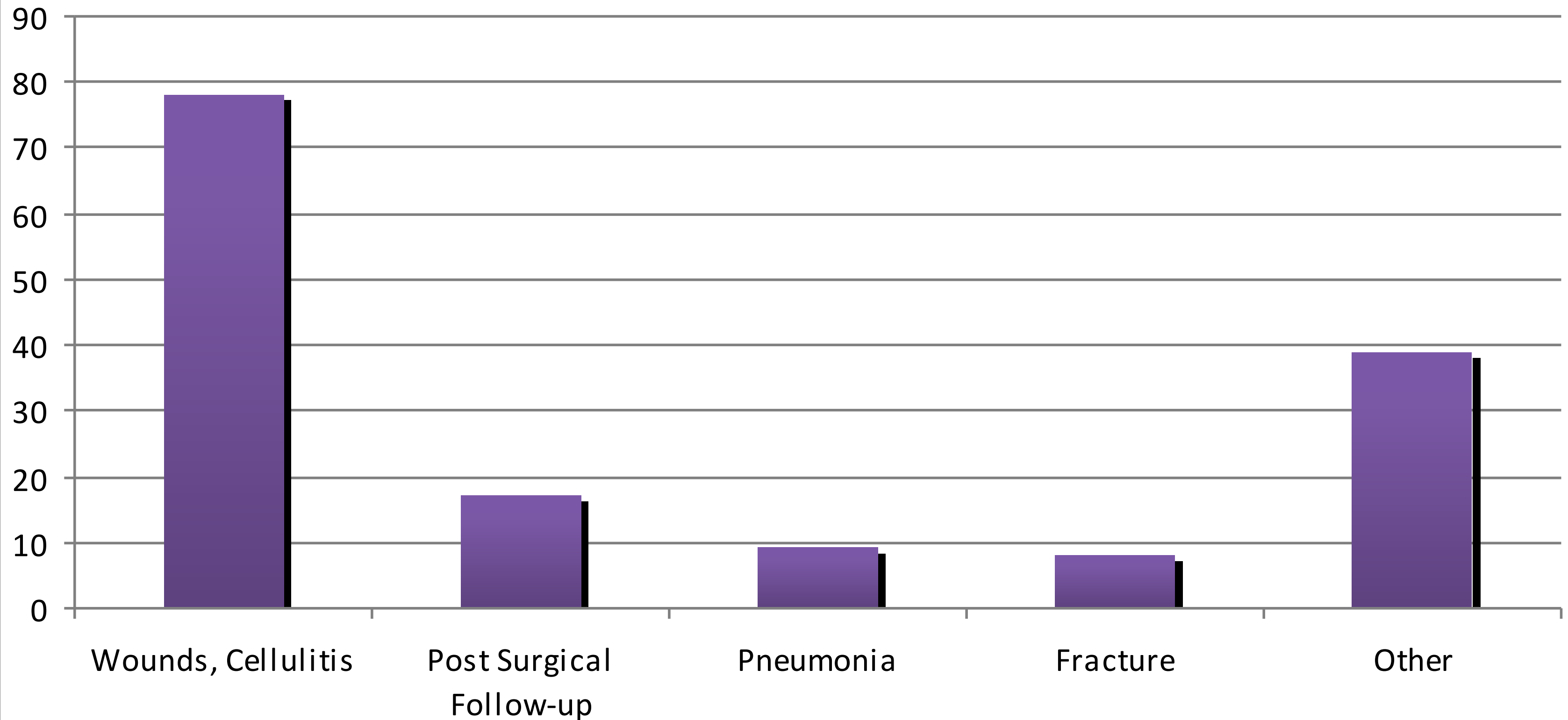
- ½ homeless adults have a SA disorder
- 23% homeless hosp. admits have COD
- ~ 50% of those with COD receive no treatment for either disorder, only 6% get treatment for both
- (Tx for those with COD difficult)
- Tx needs exceed access to services

Substance Abuse and Respite

- SA is a risk factor for acute illness or injury that would require respite care
- SA even more prevalent in respite
- Medical risks if engagement fails
- Increased utilization if engagement fails
- Many shelters won't serve active SA

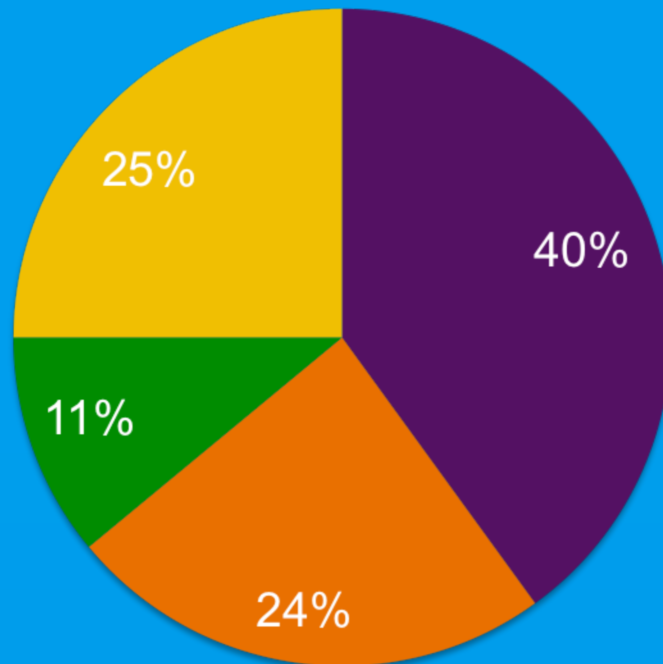
Respite and Substance Abuse

- Many respite programs won’t accept or keep pts actively using drugs/EtOH
- This excludes a large part of the homeless population in need of respite services
- How do communities manage this?
- Respite is an ideal setting for engagement


Primary Diagnosis At Entry (n=151)
Clients Discharged between 9/12/11 (operational start date) and 1/31/12
90
80
70
60
50
40
30
20
10
0
Wounds, Cellulitis
Post Surgical Follow-up
Pneumonia
Fracture
Other

MH or SA Dx, n=151

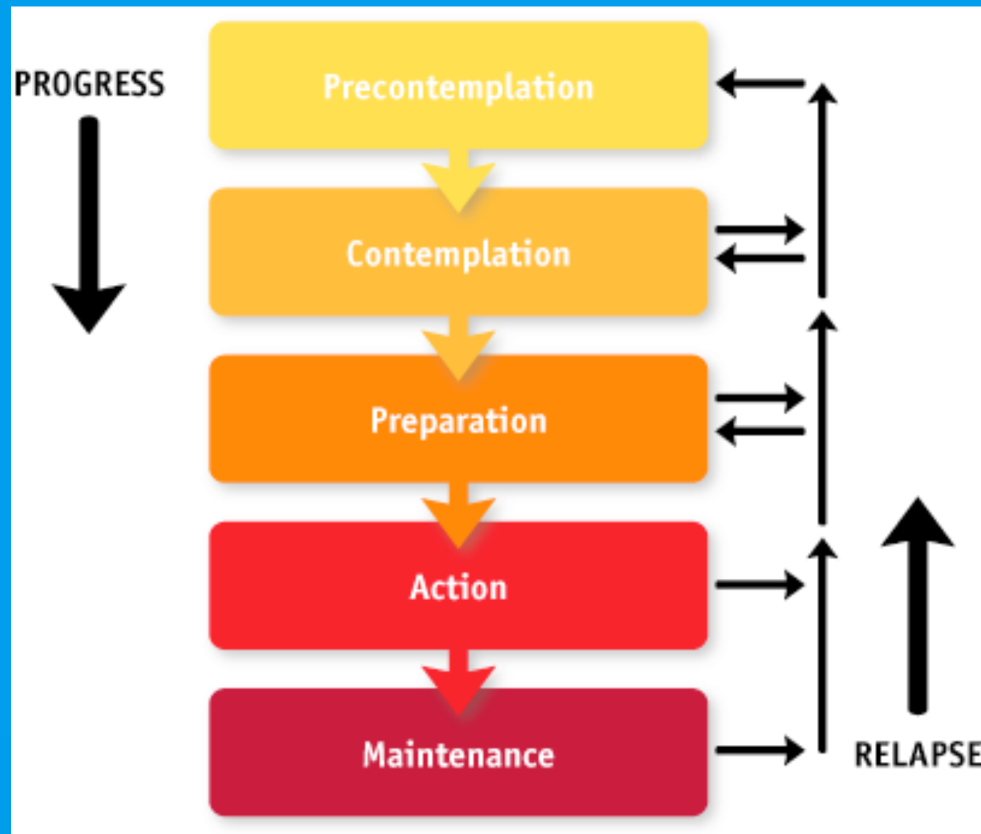
■ MH & SA ■ SA Only ■ MH Only ■ Neither



Limitations of Traditional Treatment

- Historically, SA Rx focused on reducing/ eliminating drug use while neglecting the prevention of adverse consequences of drug use
- SA Program drop-out rates $\geq$ 2/3 common
- Only 20-40% those who complete Tx achieve long-term success, even if both abstinence and moderation is considered (Keso 1990, Nordstom 1987, Helzer 1985)

THE STAGES OF CHANGE CONTINUUM

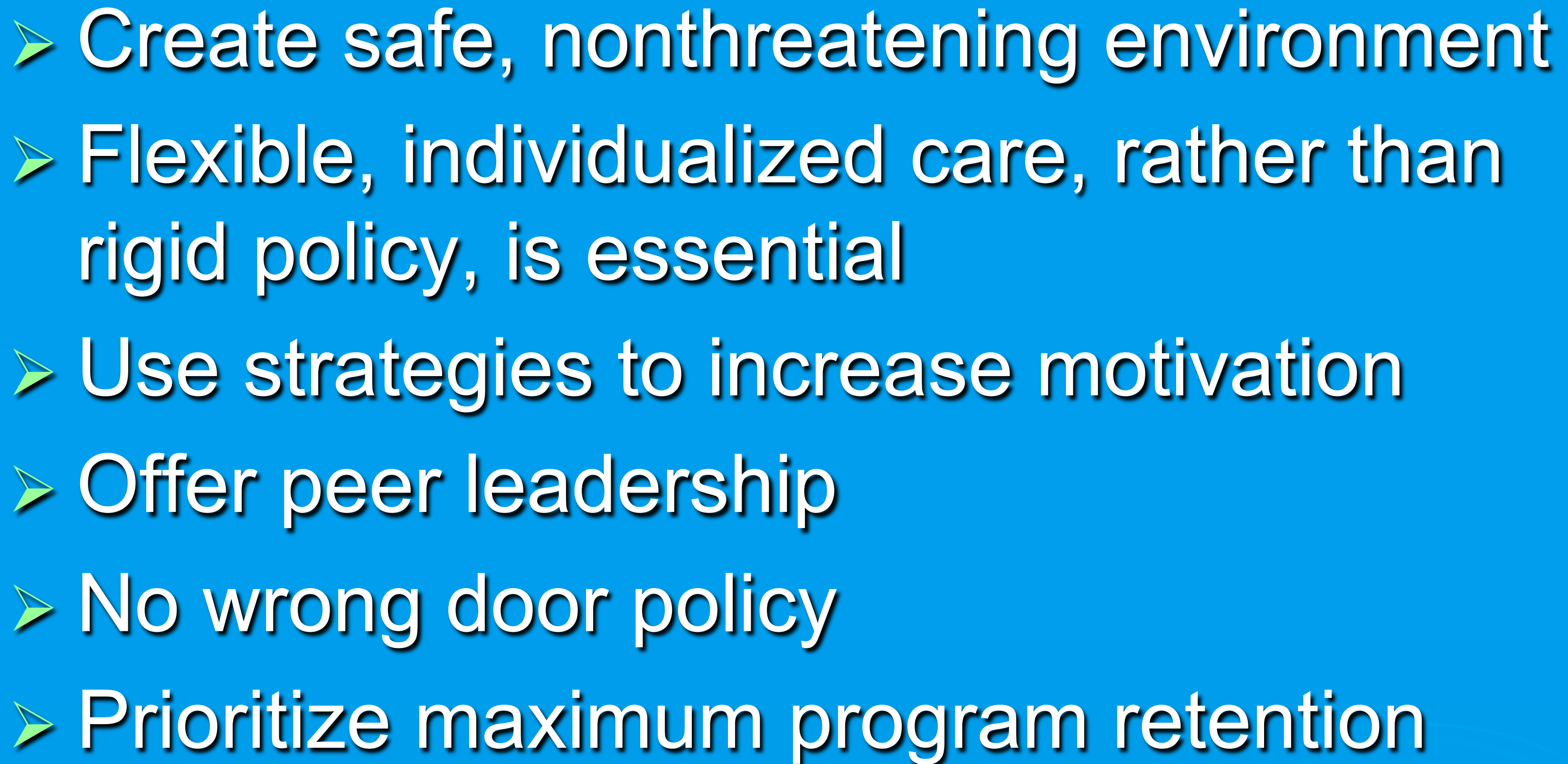


Source: Adapted from DiClemente and Prochaska, 1998

Addressing the Challenge

- Addiction is a chronic and relapsing condition
- Relapse must be considered an integral component of treatment
- Engagement barriers: social isolation, distrust, depression, hopelessness
- Non-judgmental intervention critical for success

Addressing the Challenge



Edward Thomas House

- Free-standing program
- We would govern CD & discharge policies
- Intentional Harm Reduction Philosophy
- Staffed to support this model
- Care for more medically and behaviorally complex patients
- $: Multi-hospital, HUD, BPHC, tax $

What is Harm Reduction?

- Management of risks assoc with dangerous activities
- Sometimes perceived as condoning dangerous activities
- Abstinence falls within harm reduction goals

Adverse Consequences of Drug Use: The 4 L’s Model

- Liver: physical or psychological health issues: disease, injuries, mental health sequelae, withdrawal, overdose
- Lover: Relationship problems (and community impact of violence/theft/accidents)
- Livelihood: Impact on work, hobbies, productivity
- Law: Legal issues related to drug acquisition/ trafficking, sex-trade, driving under the influence

Roizen, 1979

"Harm reduction is often made an unnecessary controversial issue as if there was a contradiction between prevention and treatment on one hand and reducing the adverse health and social consequences of drug use on the other. This is a false dichotomy. They are complementary."

Antonio Maria Costa, UNODC, 2007

Harm Reduction Hierarchy

- 1. Don’t use drugs
- 2. If you use drugs, don’t inject
- 3. If you inject drugs, use sterile injecting equipment and never share equipment
- 4. If you use non-sterile or shared equipment, use bleach to clean between injections

Examples of Harm Reduction

- Needle exchange or drug kits to decrease spread of HCV/HIV and risk of infection
- Teaching optimal injection techniques
- Decreasing quantity/frequency of use
- Narcan dispensed to IVDU's
- Free taxis by bars
- Switch to lower % EtOH
- Wet housing
- Safety plan for patients in DV situations

Harm Reduction Outcomes

- NSP's Effectively prevents HIV & reduces risk behaviors that transmit Hep B & C
- Methadone Maintenance: effective at program retention, less heroin use, HIV prevention, decreased mortality, crime and is cost-effective (lit review, Hunt 2010)
- Improved housing, income, health care, handling (-) feelings, dealing with drug use, dealing with legal problems. n=381 (Rogers, 2004)

46 yo male with EtOH dependence, diabetes, infected foot ulcers

- Slept in the woods
- In an actively abusive relationship
- Never consistently engaged in care
- Admitted to respite, received wound care, continued to drink heavily, non-compliant with NWB, ulcers did not heal

- Referred for primary care, mental health, engage with CM for chronic inebriates
- 2 toe amputation recommended
- Transported to hospital– never arrived
- Few weeks later showed up from the woods for a scheduled primary care appt.
- Wound was larger, dirty and grossly infected, was off diabetic Rx, intoxicated
- Partial foot amputation
- Hospital calls to refer him back to respite

What Do You Do?

- Decline admission because of non-compliance
- Readmit to respite?

Respite Course

- Drank daily across the street from respite
- Attended most wound care visits, functioned in group setting, Glucoses not wildly out of control, mostly complied with NWB
- Supervising nurse: daily reports of drinking
- Pt not discharged from respite, eventual shelter discharge after wound mostly healed

Divergent Expectations

- Nursing felt pt sabotoged health and respite care unsuccessful
- Admission was great success! Patient did not get wound infection/leg amputation
- Often can’t effectively fix maladaptive lifestyle issues, but can prevent serious complications from an acute process

How to Support Successful Process?

- Difficult to witness self-destructive behavior
- Clarify case goals with team
- Weigh impacts of various decisions
- Offer venue for venting, discussion, support
- Training on harm reduction

Perceived Downsides of Harm Reduction

- Negative program perception
- Threatens sobriety for other patients
- Behavioral difficulties
- Compromised Safety
- Liability concerns
- Overdose potential
- Harm reduction makes drug users worse, lack of consequences.

Harm Reduction Success Story

- 36 year old homeless male referred from local hospital in January to respite for wound care (7 abscesses).
- Diagnosis of end stage Renal failure, refusing dialysis or any labs
- Long history of IV heroin use and failed methadone treatment in community

CM role

- Met with pt to complete psychosocial assessment to identify mutual goals
- CM advocated and assisted patient to restart methadone at community clinic
- CM referred patient to Housing First Case Manager for permanent housing
- CM continued to build rapport and allow relationship to grow.

Medical Provider Role

- Apprise pt of risks of not dialyzing/no labs
- Refusal of care form signed
- Monitor for volume overload
- Was decision-making capacity intact?
- Message Pt Got: "I am not worth dialysis"
- Expedited renal appt. with new MD
- Medical Dx → top of Methadone List

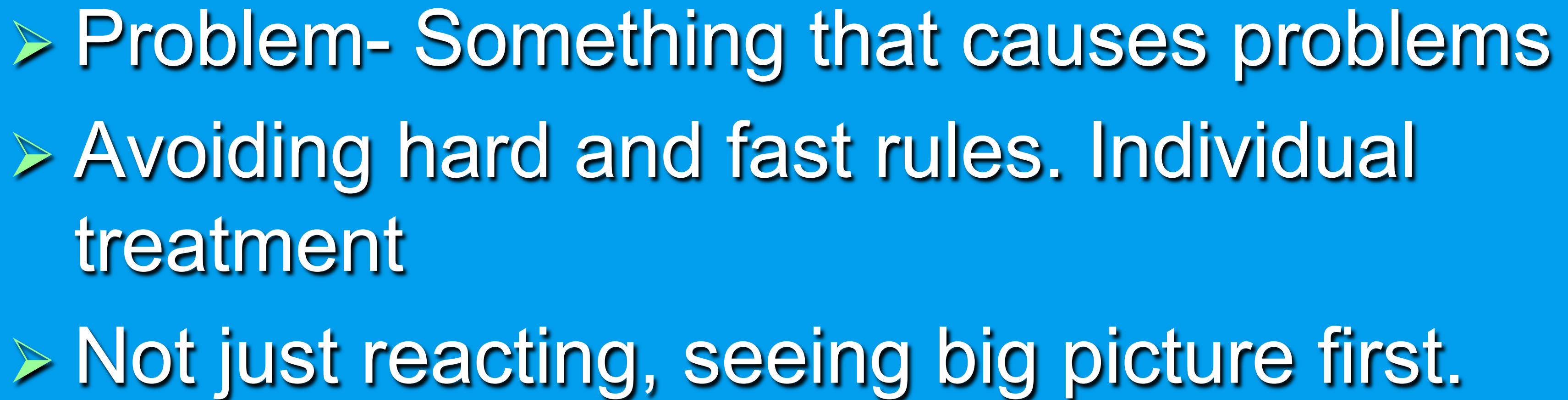
Potential Stumbling Blocks

- Many reports of patient seeming over-sedated at night.
- Strong evidence patient was about to use heroin in room and was asked to leave for night
- Patient discharged for sedation the following night (two weeks before housing move-in date)

Success!

- Patient was referred back to respite by hospital a few days later with dialysis line
- Patient completed medical treatment
- Patient established on Methadone
- Patient moved directly into Permanent Housing and established ongoing CM’t
- Patient got established with a Primary Care Physician.

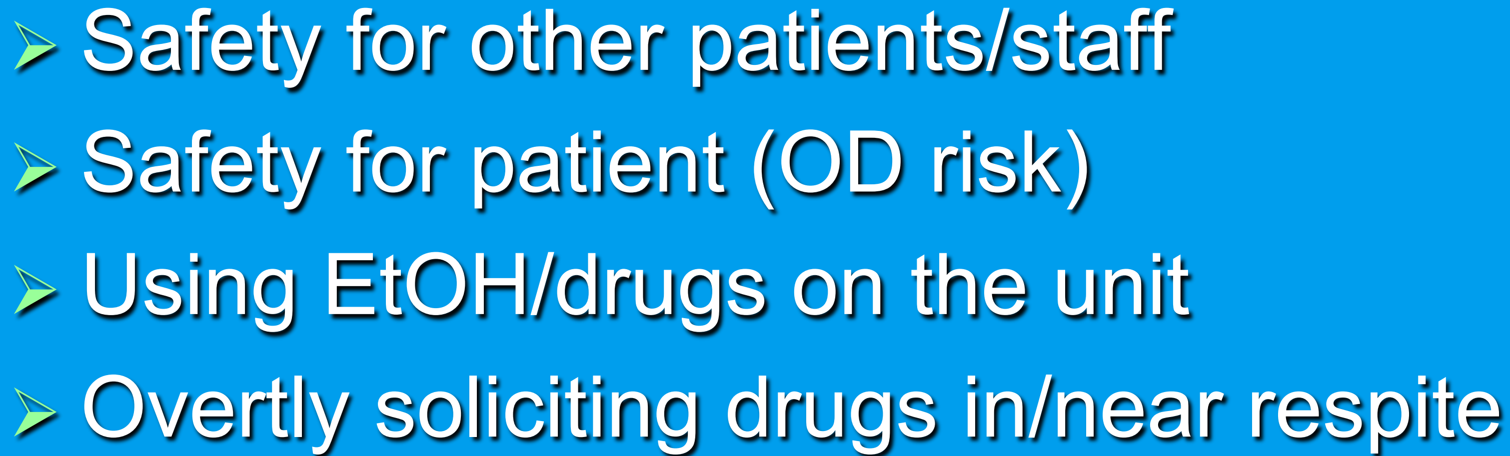
Managing Behavioral Difficulties

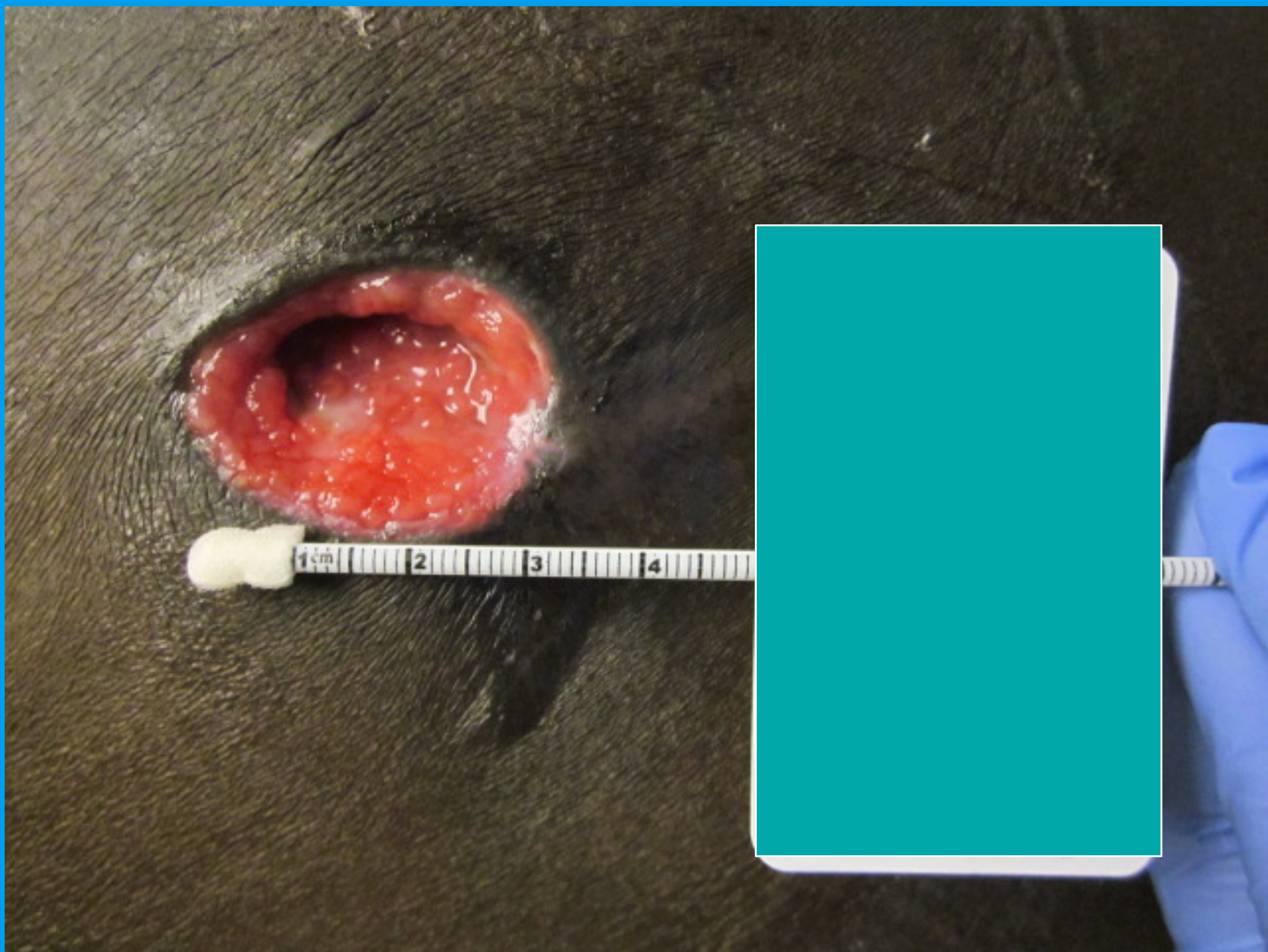


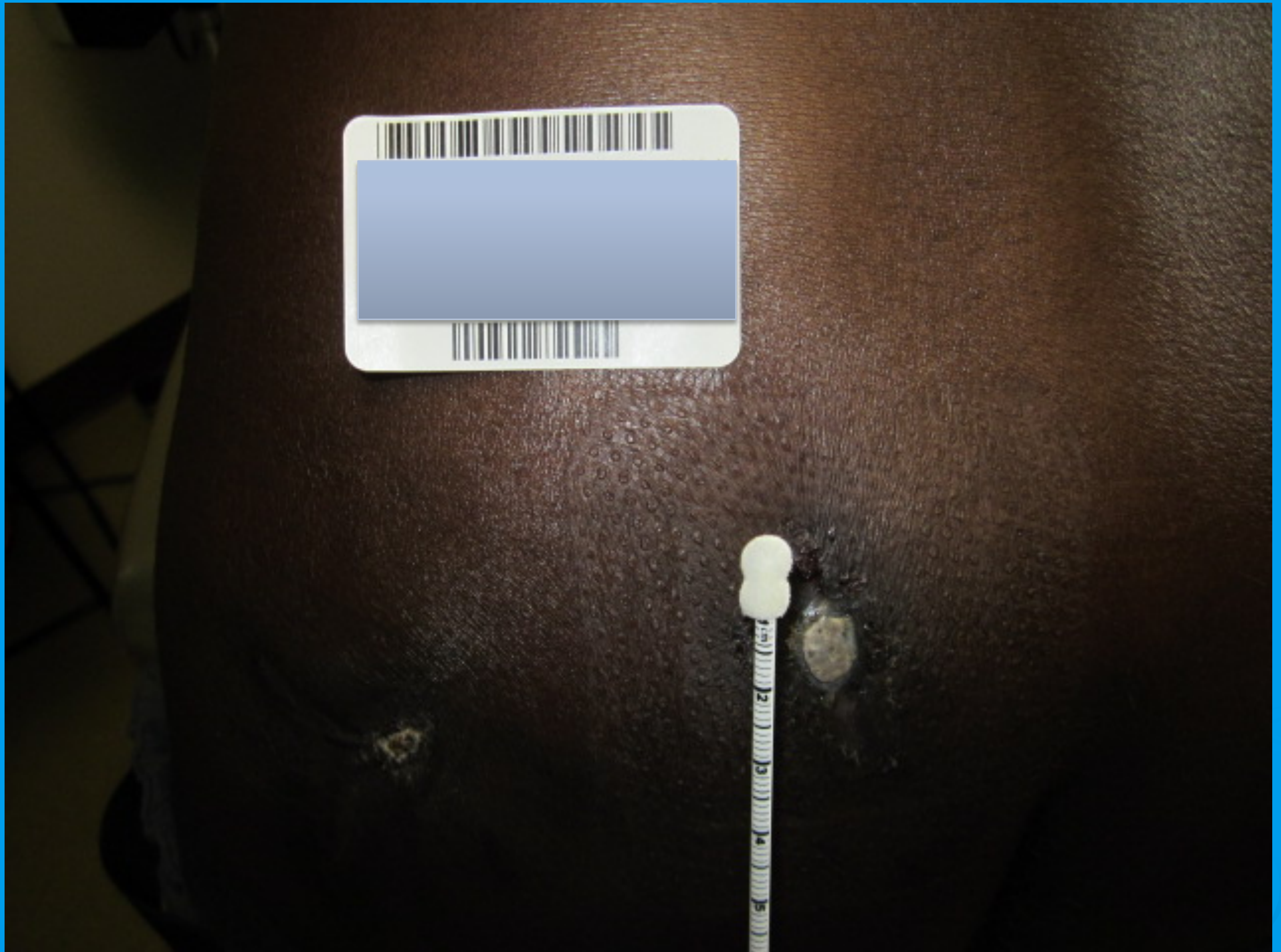
Managing Behavioral Difficulties

- Use of behavioral contacts (often at re-admit). Frequent meetings/conversations
- Staying focused on goal of intervention. Not intended as punishment. Problems seen as opportunities.
- Not being afraid to discharge. Can return.

When is the Line Crossed?




1 cm
2
3
4



52 yo heroin dependent patient with an abscess

- Pt underwent operative drainage of abscess and has a 20 X 10 X 5 cm buttock wound
- Patient was on high dose methadone and prn oxycodone in the hospital
- Hospital prescribes 30 pills of oxycodone at discharge
- Questions? Potential problems?

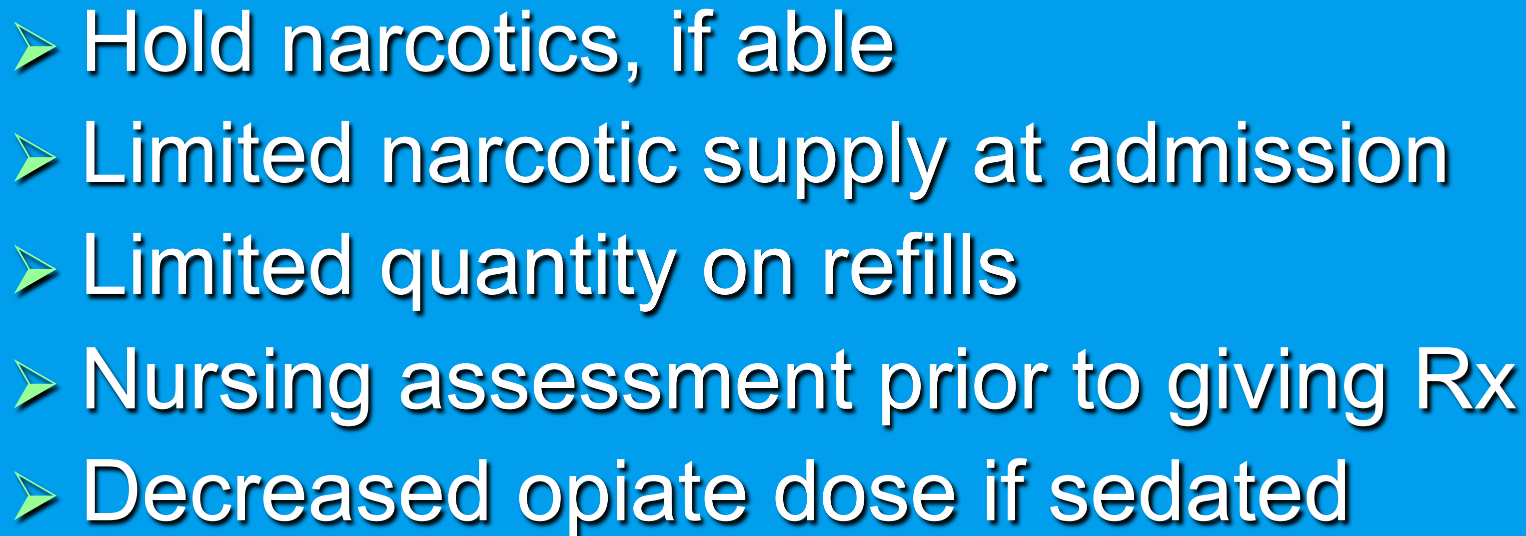
How will patient’s pain be managed?

- Do you ask the hospital to Rx higher dose and quantity of narcotics at discharge? (Implications)
- Do you ask hospital team to initiate a pain service consult?
- Do you accept patient and send him to an ED or clinic for pain meds day 2?
- Does respite staff Rx narcotics?
- Where will narcotics be kept?

Opiate Dependence & Pain Management

- High opiate tolerance/Low pain tolerance
- Pain relief requires dose > daily opiate use
- Patients hold own narcotics
- Unless unit locked, pt may use drugs while on Rx narcotics
- Role of urine tox screens
- benzodiazepines

Overdose Prevention



Overdose Prevention

- IV Treatment Agreement
- Daily IV port assessment
- Bedcheck every 15 min
- Protocol for sedation
- Pros/Cons of narcan
- 23 pts on IV Rx, most completed Tx

Other Safety

- Doors open at all times, no wrap-around curtains
- Panic buttons for staff
- 24hr video coverage
- Night security
- Staffed trained in managing aggressive behavior
- Patients not allowed in other patient rooms

Other components for success

- Training and modeling for staff on Harm Reduction
- Buy-in from community and resources(neighbors, housing providers, medical providers, funders, police, access to case management, methadone clinics, CD treatment, housing first philosophy, etc)

Why Do Harm Reduction?

- Necessity due to realities of addiction
- Addicted patients deserving of care even if not interested/able to stop using
- Even the limited goal of resolving an acute medical issue in an appropriate setting is worthy
- Maintains engagement with opportunity to facilitate change in behavior

Resources

- RCPN Website: Program policies
- RCPN Technical Assistance
- Other Harm Reduction Programs: SF, LA