

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

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Figure 1. Opioid¹-Related Deaths, All Intent
Massachusetts Residents: January 2000 - December 2016

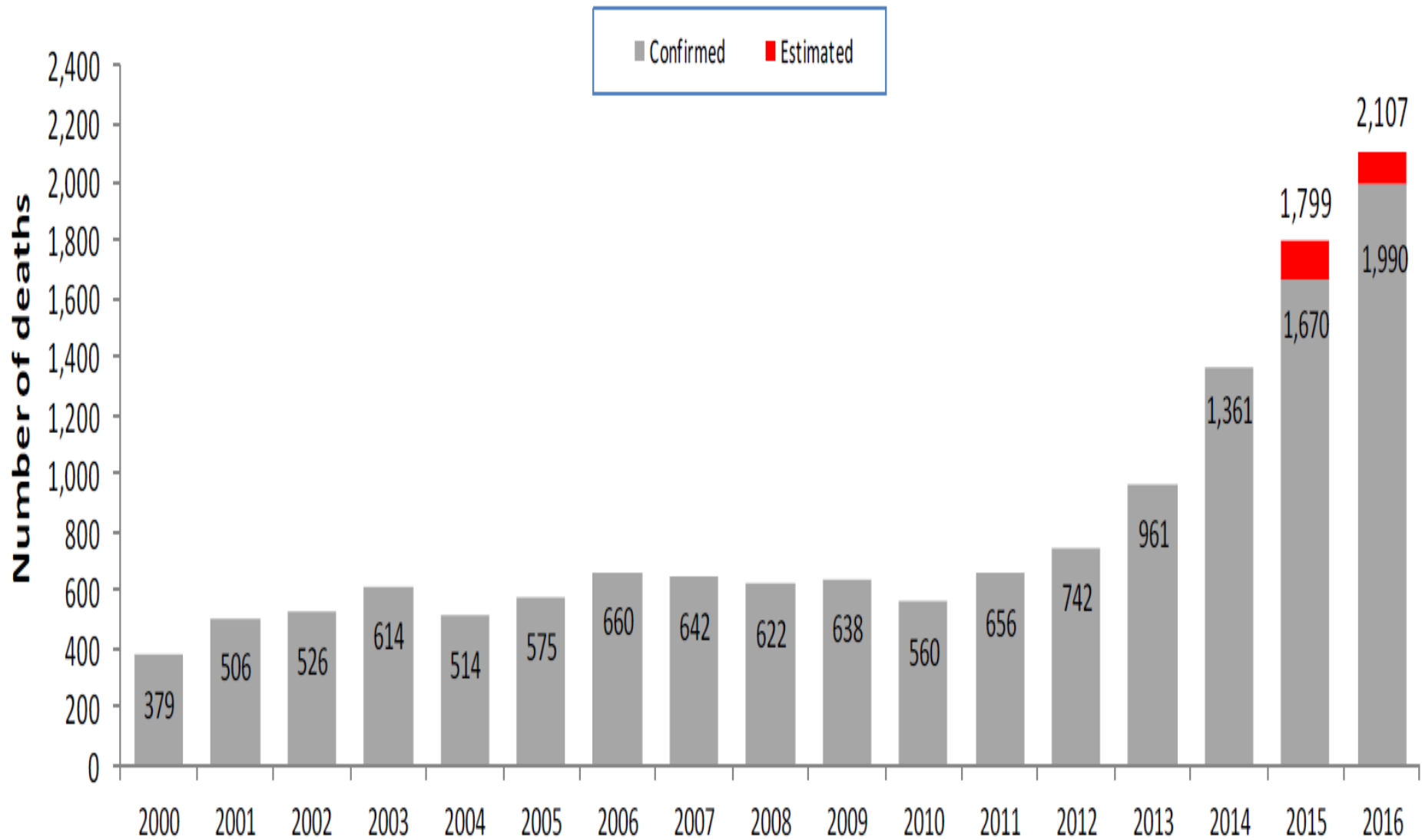
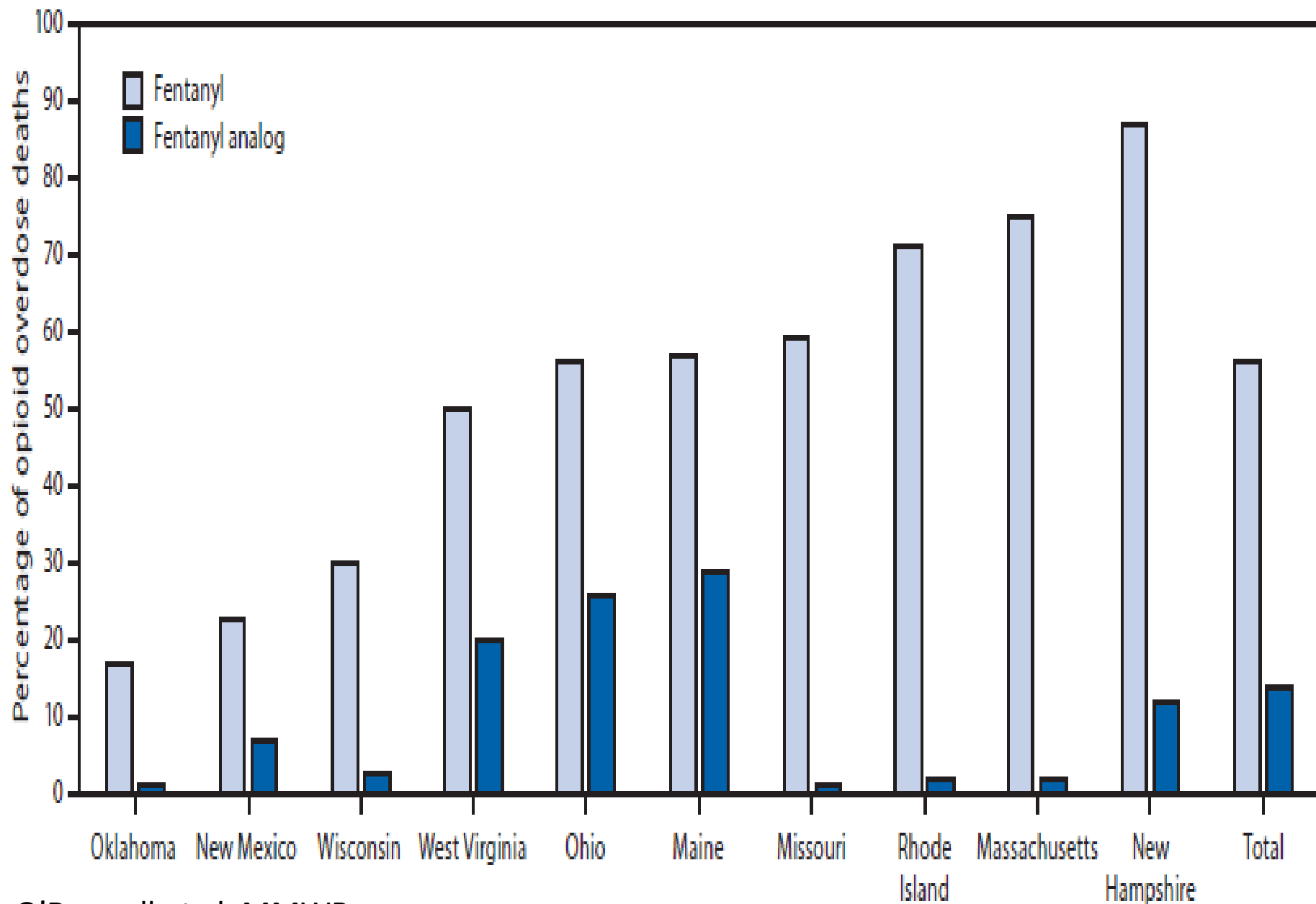


FIGURE. Percentage of opioid overdose deaths testing positive for fentanyl and fentanyl analogs, by state — 10 states, July–December 2016



Harm reduction is a set of practical strategies and ideas aimed at **reducing** negative consequences associated with drug use.



Naloxone Distribution



Needle Exchange Programs



Peer Support & Community Mobilization

HARM REDUCTION

“ 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

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EXISTING INTERVENTIONS



Medical Observation/Drop-In Sp



Supervised Injection Facili



Legal Support & Policy Refo

¹ Open Society Foundations: “What is harm reduction?” <https://www.opensocietyfoundations.org/explainers/what-harm-reduction>

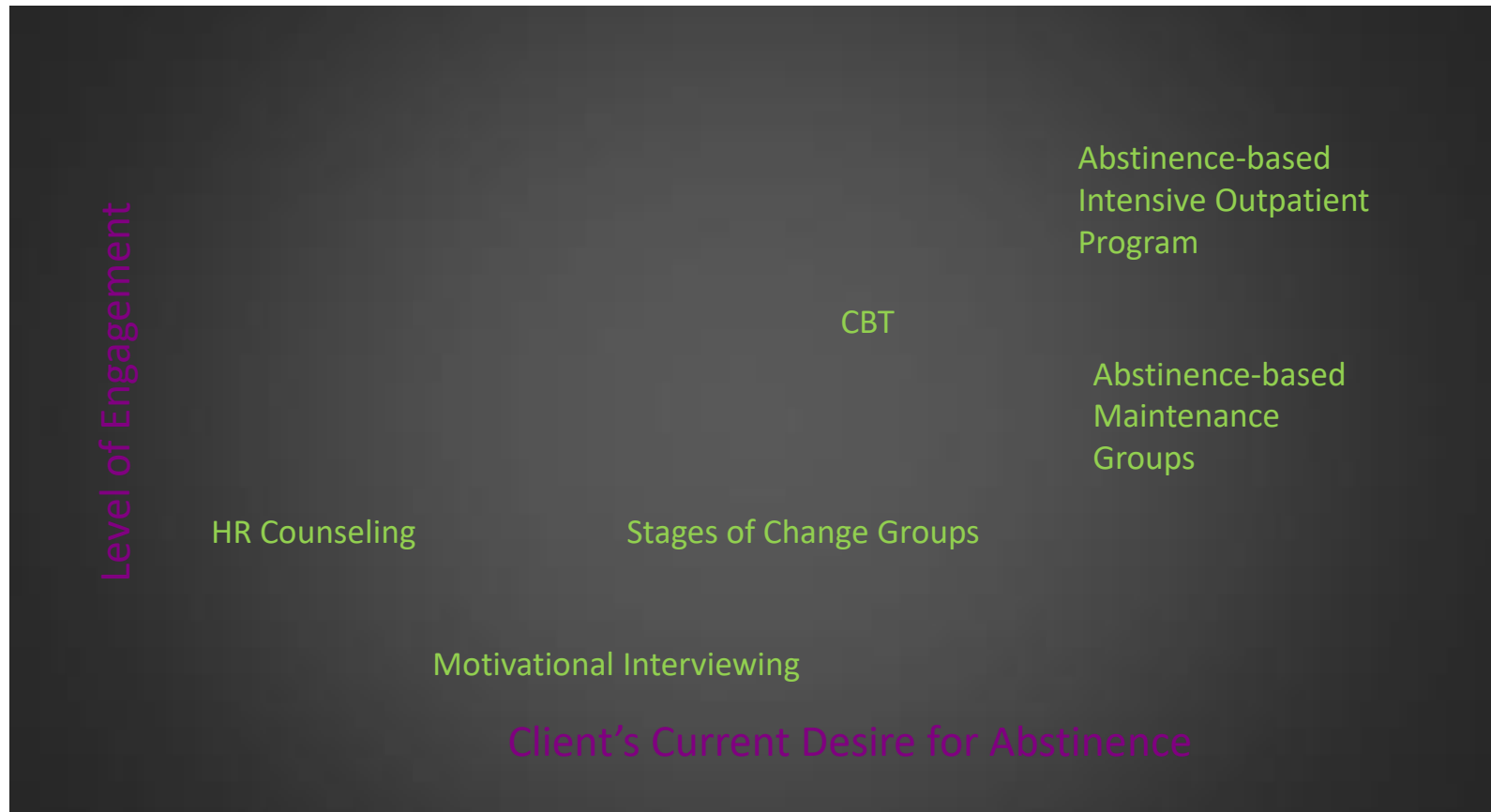
Harm Reduction:

- Acknowledges that substance use is complex and here to stay
- Aware of limitations of abstinence-based traditional treatment
- Client Driven
- Recognizes pros and cons of use
- Focused on Quality of Life
- Complements other approaches

Harm Reduction ≠ :

- Use reduction
- Brief Intervention
- Motivational Interviewing

HR Complements Menu of Options



Levels of Harm Reduction

Individual

Safer Injection Techniques

Community

-Friends Don't Let Friends
Drive Drunk

-Non-abstinence housing

Societal

Decriminalization of Drugs

Evidence Base for HR Based Programs

- RCT HR Outpatient Counseling vs Control
 - Greater program retention
 - Decreased peak alcohol use, alcohol-related harm and positive utox tests
- 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.

Collins S, et al. Randomized Controlled Trial of Harm Reduction Treatment for Alcohol for People Experiencing Homelessness and Alcohol Use Disorder, pending publication

Collins S, et al. Project-Based Housing First for Chronically Homeless Individuals with Alcohol Problems: Within-Subjects Analysis of 2-Year Alcohol Trajectories. [American Journal of Public Health](#) 102(3):511-9 · March 2012

Larimer M, et al. Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems. [JAMA](#). May 2009; 301(13):1349-57

Maher L. Supervised injecting facilities: how much evidence is enough? *Drug and Alcohol Review* 26, 351-353 July 2007

But how does harm reduction fit into a medical respite program?

38 Year-old Male with Opioid Use Disorder

- Significant burn wounds from tent fire
- Received methadone 30 mg/day inpatient + as needed oxycodone for pain
- Will be discharged with a 3-day supply of opioid pain medications.

Referred to respite for wound care and facilitation of specialty follow-up

- Consider him for admission?
- If not, what are the barriers?
- What alternative care options are available?
- Ramifications of declining the referral?
- Ramifications of admitting patient?
- How could you plan for a successful respite stay?
- What if the patient required IV antibiotics?

Patient is Admitted to Respite

- Leaves during day to use drugs
- Day 4, found injecting in his room after curfew
- No missed RN visits
- Has been behaviorally appropriate, no dealing
- Has engaged with his case manager
- RN concerned about triggering other patients

How would you handle this situation?

Thanks for a great discussion!