# 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[1]-Related Deaths, All Intents
## Massachusetts Residents: January 2000 - December 2016

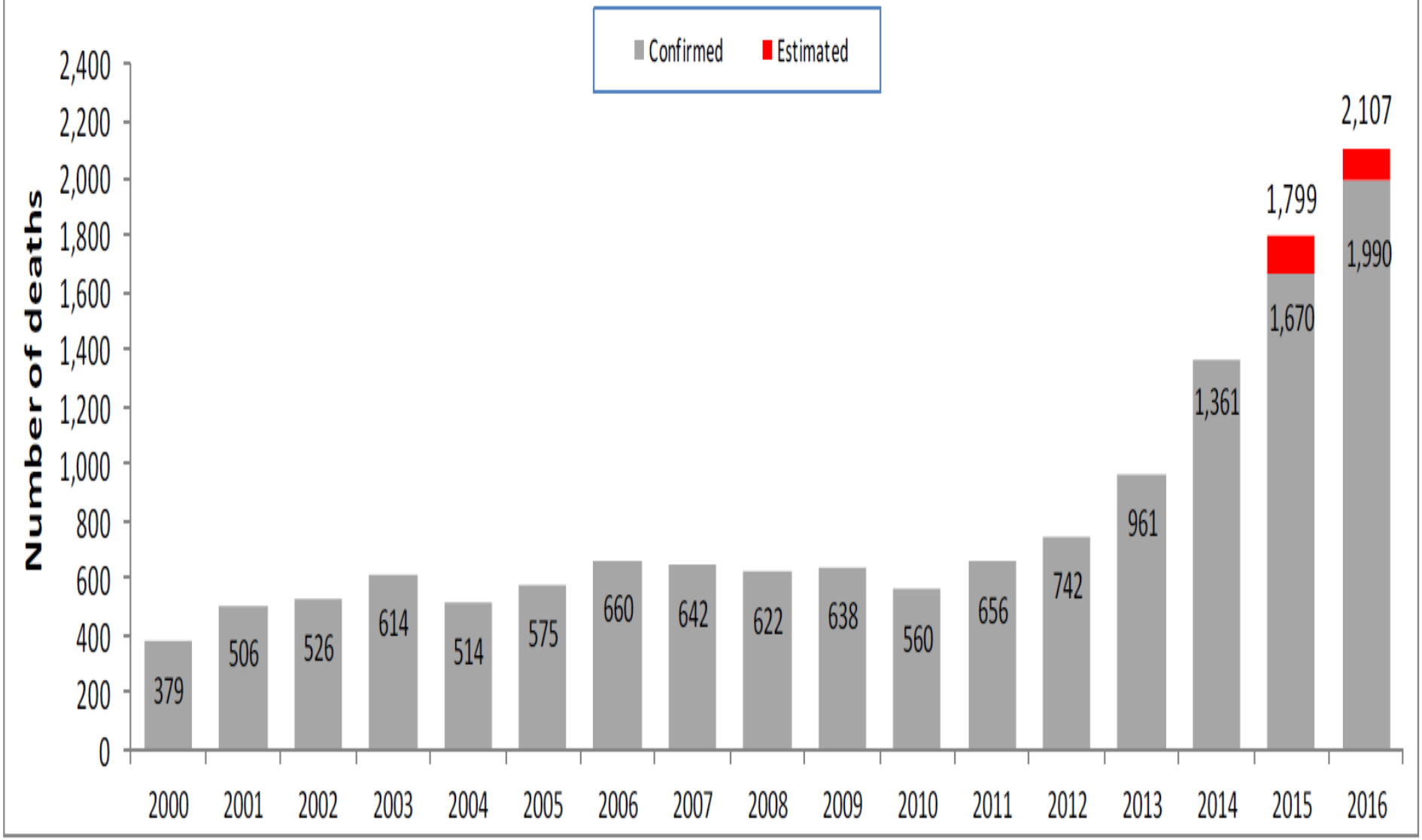
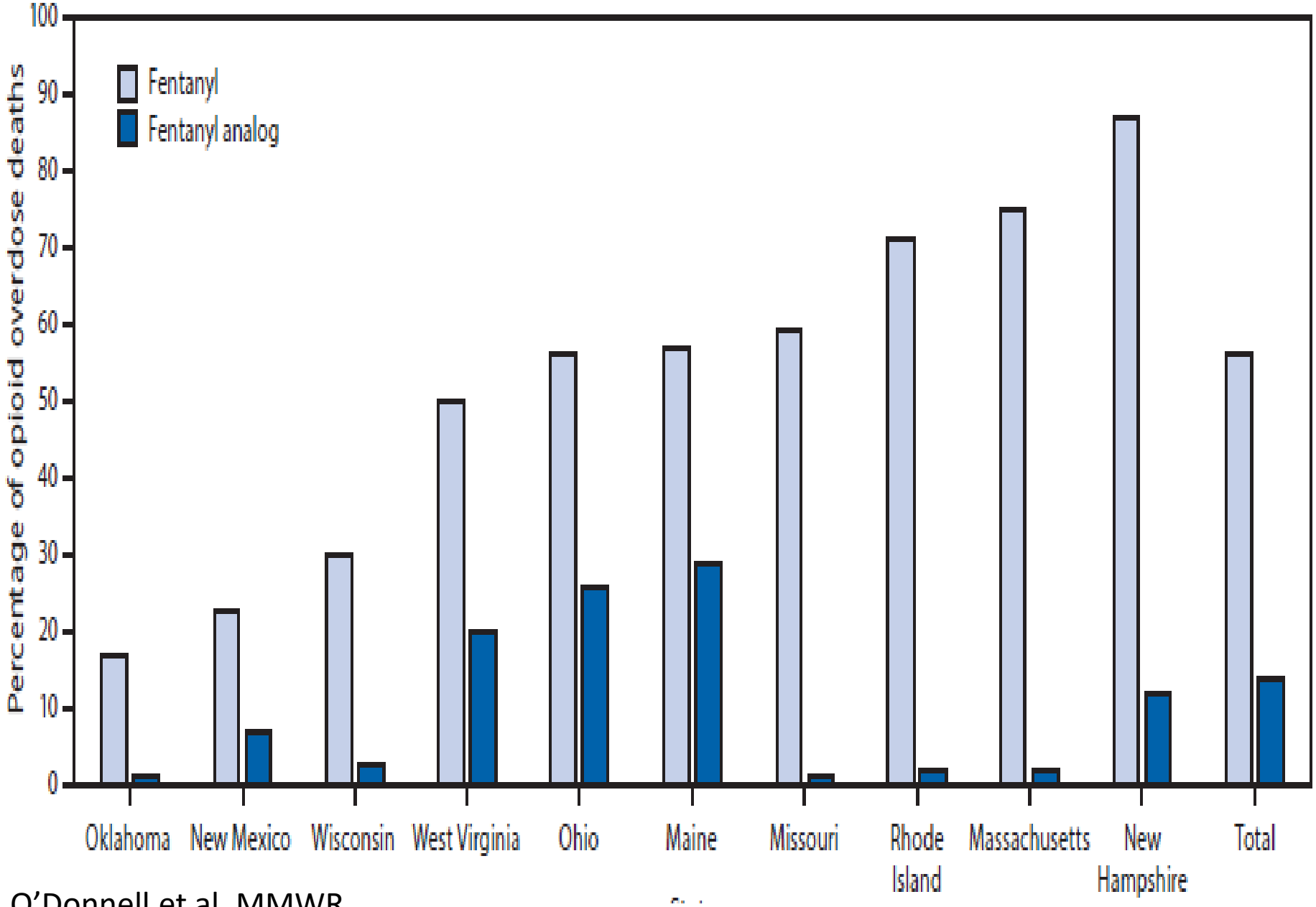


FIGURE. Percentage of opioid overdose deaths testing positive for fentanyl and fentanyl analogs, by state — 10 states, July–December 2016




O'Donnell et al. MMWR

10/27/17

ORIGINAL INVESTIGATION

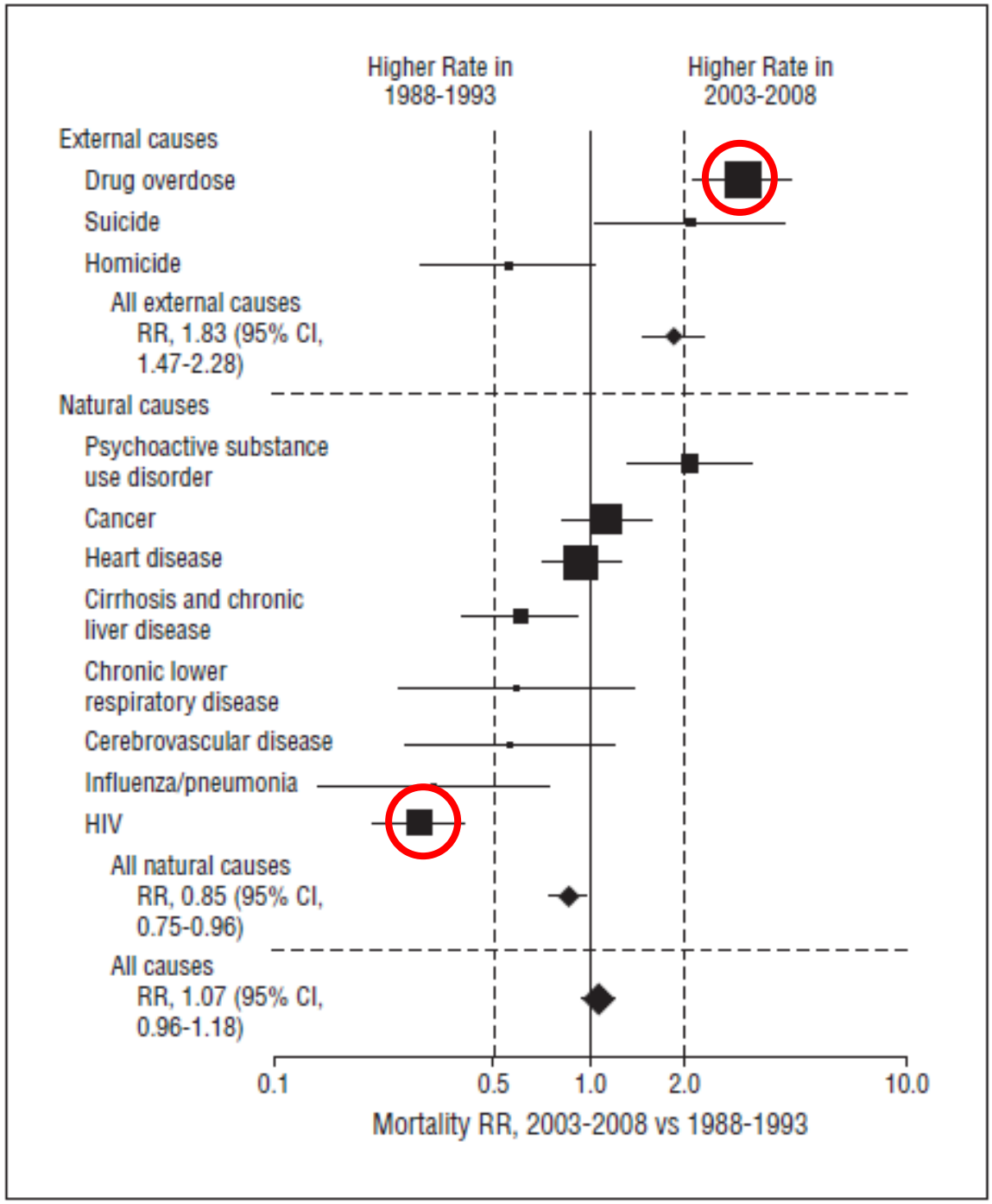
# Mortality Among Homeless Adults in Boston

## *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

Baggett TP, et al. Mortality among homeless adults in Boston: shifts in causes of death over a 15-year period. JAMA Internal Medicine 2013; 173(3): 189-195.


Higher Rate in 1988-1993
Higher Rate in 2003-2008
External causes
Drug overdose
Suicide
Homicide
All external causes
RR, 1.83 (95% CI, 1.47-2.28)
Natural causes
Psychoactive substance use disorder
Cancer
Heart disease
Cirrhosis and chronic liver disease
Chronic lower respiratory disease
Cerebrovascular disease
Influenza/pneumonia
HIV
All natural causes
RR, 0.85 (95% CI, 0.75-0.96)
All causes
RR, 1.07 (95% CI, 0.96-1.18)
0.1
0.5
1.0
2.0
10.0
Mortality RR, 2003-2008 vs 1988-1993

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

# Harm Reduction: A Critical Tool for Healthy Communities

**Recovery 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 Strategies, especially when people relapse / fall out of treatment**

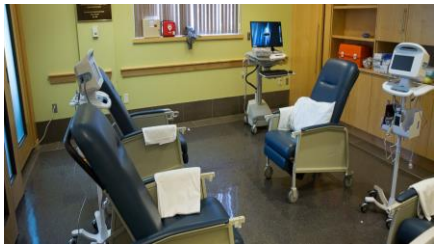

**Naloxone Distribution**

# 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]

+

EXISTING INTERVENTIONS



**Medical Observation/Drop-In Sp**

**Needle Exchange Programs**

**Supervised Injection Facili**

**Peer Support & Community Mobilization**

**Legal Support & Policy Refo**

[1] Open Society Foundations: "What is harm reduction?" https://www.opensocietyfoundations.org/explainers/what-harm-reduction

# 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.

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?

# 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

| | ODs occurring in blocks within 500 m of the SIF* | | ODs occurring in blocks farther than 500 m of the SIF* | |
|---|---|---|---|---|
| | Pre-SIF | Post-SIF | Pre-SIF | Post-SIF |
| Number of overdoses | 56 | 33 | 113 | 88 |
| Person-years at risk | 22 066 | 19 991 | 1 479 792 | 1 271 246 |
| Overdose rate (95% CI)* | 253·8 (187·3–320·3) | 165·1 (108·8–221·4) | 7·6 (6·2–9·0) | 6·9 (5·5–8·4) |
| Rate difference (95% CI)* | 88·7 (1·6–175·8); p=0·048 | .. | 0·7 (-1·3–2·7); p=0·490 | .. |
| Percentage reduction (95% CI) | 35·0% (0·0%–57·7%) | .. | 9·3% (–19·8% to 31·4%) | .. |

SIF=supervised injection facility. Pre-SIF period=Jan 1, 2001, to Sept 20, 2003. Post-SIF period=Sept 21, 2003, to Dec 31, 2005. *Expressed in units of per 100 000 person-years.

***Table 2:*** **Overdose mortality rate in Vancouver between Jan 1, 2001, and Dec 31, 2005 (n=290), stratified by proximity to the SIF**

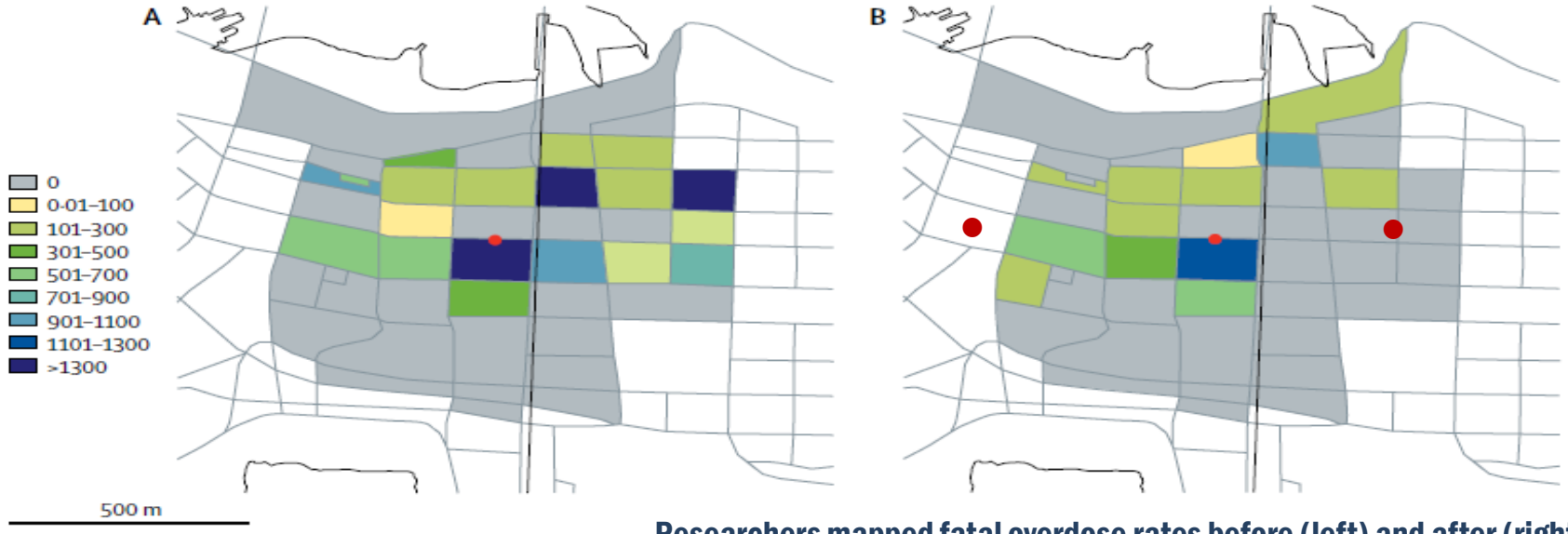



***Figure 2:*** **Fatal overdose rates before (A) and after (B) the openin**
Rates are given in units of 100 000 person-years and were calculate

**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**


Marshall, B. et al. (2011). Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study. *Lancet*, *377*(9775):1429-37.

# 2. SIFs reduce neighborhood burden of drug use

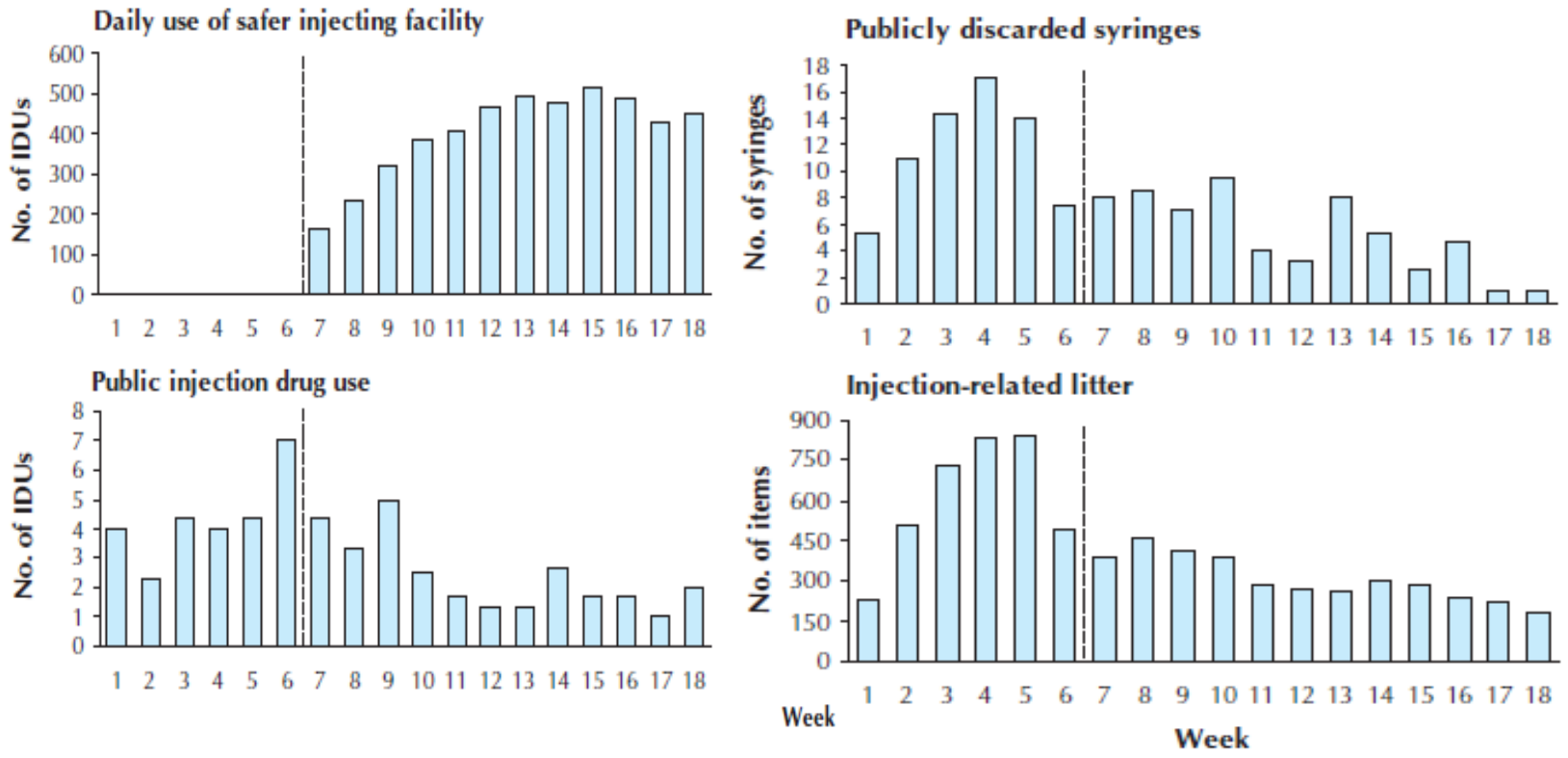



Fig. 1: Mean daily numbers of injection drug users (IDUs) who visited Vancouver's safer injecting facility, IDUs who injected in public, publicly discarded syringes and injection-related litter counted during the 6 weeks before and the 12 weeks after the facility opened. Dotted line represents opening of facility.

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

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# 3. SIFs increase access to substance use disorder treatment

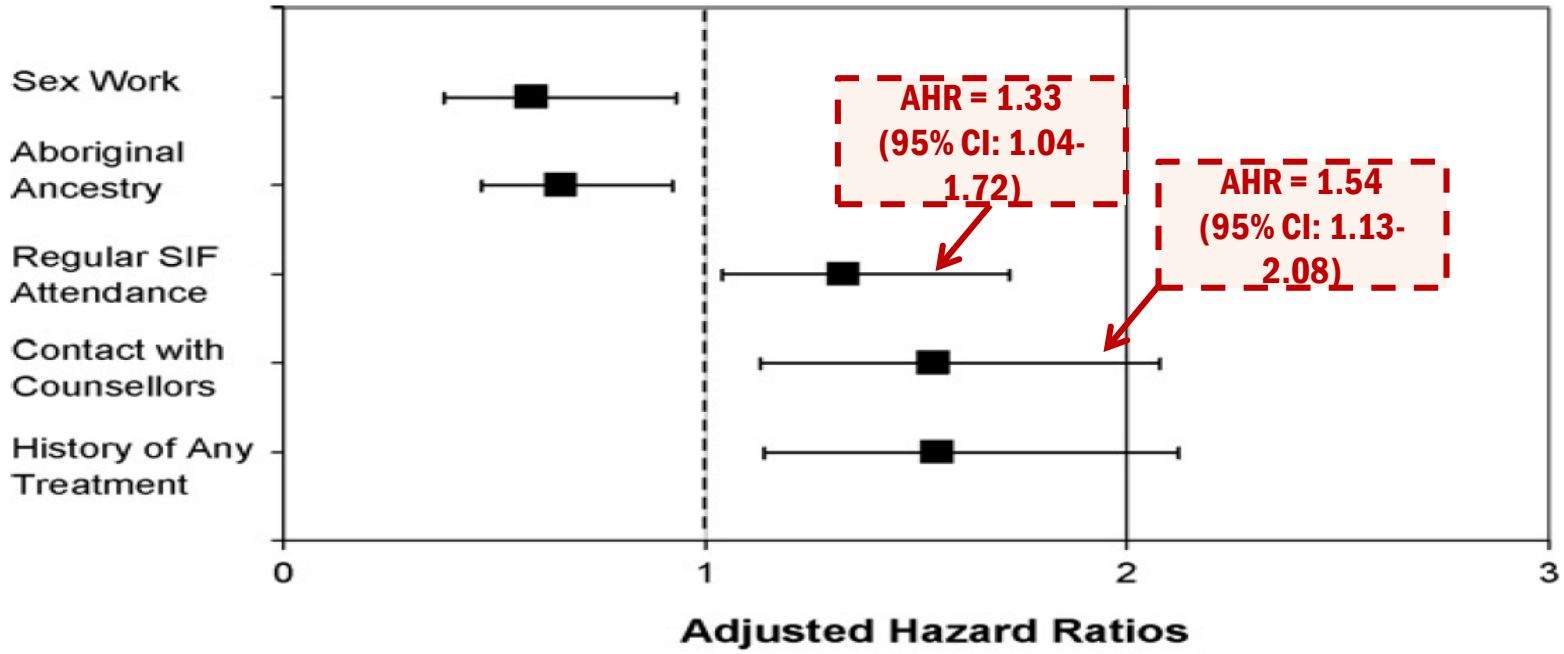


**Figure 1.** Factors associated with time to enrolment in addiction treatment among clients of Vancouver's supervised injection facility. *Notes*: 'Regular SIF Attendance' was measured at baseline and defined as visiting the SIF at least once per week vs. visiting the SIF less than once per week; 'Contact with Counsellors' refers to meeting with an addictions councilor at the SIF and was measured through data linkage to the SIF administrative database; 'History of Any Treatment' was defined as any history of engaging in any type of addiction treatment programs.

K. DeBeck et al (2011). Injection drug use cessation and use of North America's first medically supervised safer injecting facility. *Drug and Alcohol Dependence, 113(2-3) 172-6*

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# 4. SIFs increase access to substance use disorder treatment

**Table 1.** Univariate and Multivariate Cox Proportional-Hazards Analysis of the Time to Entry into a Detoxification Program among 1031 Users of Injection Drugs after the Opening of a Supervised Injecting Facility (SIF).*

| Variable | Unadjusted Relative Hazard (95% CI) | P Value | Adjusted Relative Hazard (95% CI) | P Value |
|---|---|---|---|---|
| Homelessness (yes vs. no)† | 1.43 (1.07–1.91) | 0.02 | 1.42 (1.06–1.90) | 0.02 |
| Binge drug use (yes vs. no)† | 1.44 (1.05–1.97) | 0.02 | 1.35 (0.98–1.85) | 0.06 |
| Ever in treatment (yes vs. no)‡ | 2.70 (1.56–4.65) | <0.001 | 2.43 (1.41–4.22) | 0.002 |
| Weekly use of SIF (yes vs. no)§ | 1.84 (1.34–2.52) | <0.001 | 1.72 (1.25–2.38) | 0.001 |
| Addictions counselor (yes vs. no)†§ | 2.41 (1.55–3.77) | <0.001 | 1.98 (1.26–3.10) | 0.003 |

*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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Wood, E., Tyndall, M. W., Zhang, R., Stoltz, J. A., Lai, C., Montaner, J. S., & Kerr, T. (2006). Attendance at supervised injecting facilities and use of detoxification services. *New England Journal of Medicine*. *354*(23). 2512-2514.

# SIF MYTHS

It's understandable to think that a SIF might increase local drug trafficking or make people less likely to quit...

But in countries where SIFs exist, research has actually

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e.

| SIFs DON'T: | Further Reading |
|---|---|
| **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. Am J Public Health. 2007 Jul;97(7):1228-30. |
| **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. Am J Drug Alcohol Abuse. 2008;34(5):519-25. |
| **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. Subst Abuse Treat Prev Policy. 2006 May 8;1:13. |
| **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%). BMJ. 2006 Jan 28;332(7535):220-2. |
| **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. J Public Health (Oxf). 2010 Sep;32(3):342-9. |